

## I: State Information

### State Information

#### Plan Year

Start Year:

2014

End Year:

2015

#### State SAPT DUNS Number

Number

927049767

Expiration Date

6/30/2018 12:00:00 AM

#### I. State Agency to be the SAPT Grantee for the Block Grant

Agency Name

Cabinet for Health and Family Services

Organizational Unit

Department for Behavioral Health, Developmental and Intellectual Disabilities

Mailing Address

100 Fair Oaks Lane 4 E-D

City

Frankfort

Zip Code

40621

#### II. Contact Person for the SAPT Grantee of the Block Grant

First Name

Michele

Last Name

Blevins

Agency Name

Department for Behavioral Health, Developmental and Intellectual Disabilities

Mailing Address

100 Fair Oaks Lane 4E-D

City

Frankfort

Zip Code

40621

Telephone

502-564-4456

Fax

502-564-9010

Email Address

michele.blevins@ky.gov

#### State CMHS DUNS Number

Number

927049767

Expiration Date

6/30/2018 12:00:00 AM

#### I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name

Cabinet for Health and Family Services

**Organizational Unit**

Department for Behavioral Health, Developmental and Intellectual Disabilities

**Mailing Address**

100 Fair Oaks Lane 4E-D

**City**

Frankfort

**Zip Code**

40621

**II. Contact Person for the CMHS Grantee of the Block Grant**

**First Name**

Michele

**Last Name**

Blevins

**Agency Name**

Department for Behavioral Health, Developmental and Intellectual Disabilities

**Mailing Address**

100 Fair Oaks Lane 4E-D

**City**

Frankfort

**Zip Code**

40621

**Telephone**

502-564-4456

**Fax**

502-564-9010

**Email Address**

michele.blevins@ky.gov

**III. State Expenditure Period (Most recent State expenditure period that is closed out)**

**From**

**To**

**IV. Date Submitted**

NOTE: this field will be automatically populated when the application is submitted.

**Submission Date**

9/3/2013 11:59:58 PM

**Revision Date**

6/30/2014 12:11:20 PM

**V. Contact Person Responsible for Application Submission**

**First Name**

Michele

**Last Name**

Blevins

**Telephone**

502-564-4456

**Fax**

502-564-9010

**Email Address**

michele.blevins@ky.gov

**Footnotes:**



# I: State Information

## Assurance - Non-Construction Programs

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Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

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Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

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Name

Title

Organization

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Footnotes:

Signed Copy attached at end of Application

## I: State Information

### Assurance - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

**PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.**

**Note:** Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
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17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name

Audrey Tayse Haynes

Title

Secretary

Organization

Cabinet for Health and Family Services

Signature:

*Audrey Tayse Haynes*

Date:

8/30/13

Footnotes:

# I: State Information

## Certifications

### 1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

- a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

### 2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
  1. The dangers of drug abuse in the workplace;
  2. The grantee's policy of maintaining a drug-free workplace;
  3. Any available drug counseling, rehabilitation, and employee assistance programs; and
  4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  1. Abide by the terms of the statement; and
  2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
  1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
  2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (d), (e), and (f).

For purposes of paragraph (f) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management  
Office of Grants Management  
Office of the Assistant Secretary for Management and Budget



### 3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

### 4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

### 5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

Name: Audrey Tayse Hynes  
Title: Secretary  
Organization: Cabinet for Health and Family Services

Signature: Audrey Tayse Hynes

Date: 8/30/13

### Footnotes:

# I: State Information

## Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014 [SA]

U.S. Department of Health and Human Services  
Substance Abuse and Mental Health Services Administrations  
Funding Agreements  
as required by  
Substance Abuse Prevention and Treatment Block Grant Program  
as authorized by  
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act  
and  
Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53

Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

Name of Chief Executive Officer (CEO) or Designee: Audrey Jayse Haynes  
 Title: Secretary

Signature of CEO or Designee: Audrey Jayse Haynes Date: 8/30/13

<sup>1</sup> If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

# I: State Information

## Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014 [MH]

U.S. Department of Health and Human Services  
 Substance Abuse and Mental Health Services Administrations  
 Funding Agreements  
 as required by  
 Community Mental Health Services Block Grant Program  
 as authorized by  
 Title XIX, Part B, Subpart I and Subpart III of the Public Health Service Act  
 and  
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

**Title XIX, Part B, Subpart I of the Public Health Service Act**

Section	Title	Citation
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Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6

**Title XIX, Part B, Subpart III of the Public Health Service Act**

Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

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Name of Chief Executive Officer (CEO) or Designee:

Andrey Taysse Hayes

Title:

Secretary

Signature of CEO or Designee<sup>1</sup>:

Andrey Taysse Hayes

Date:

8/30/13

<sup>1</sup> If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

## I: State Information

### Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

[Standard Form LLL \(click here\)](#)

Name Audrey Taysa Hayes  
Title Secretary  
Organization Cabinet for Health and Family Services

Signature: Audrey Taysa Hayes Date: 8/30/13

Footnotes:

## II: Planning Steps

### Step 1: Assess the strengths and needs of the service system to address the specific populations.

#### Narrative Question:

Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities.

#### Footnotes:

# I: State Information

## Certifications

### 1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

- a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

### 2. Certification Regarding Drug- Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
  1. The dangers of drug abuse in the workplace;
  2. The grantee's policy of maintaining a drug-free workplace;
  3. Any available drug counseling, rehabilitation, and employee assistance programs; and
  4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  1. Abide by the terms of the statement; and
  2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
  1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
  2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph, regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management  
Office of Grants Management



### 3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

### 4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

### 5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

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Name	Audrey Tayse Haynes
Title	Secretary
Organization	KY Cabinet for Health and Family Services

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Footnotes:



# I: State Information

## Chief Executive Officer's Funding Agreements (Form 3) - [SA]

U.S. Department of Health and Human Services  
Substance Abuse and Mental Health Services Administrations  
Funding Agreements  
as required by  
Substance Abuse Prevention and Treatment Block Grant Program  
as authorized by  
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act  
and  
Title 42, Chapter 6A, Subchapter XVII of the United States Code

### Title XIX, Part B, Subpart II of the Public Health Service Act

Section	Title	Chapter
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32

### Title XIX, Part B, Subpart III of the Public Health Service Act

Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53

Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

Name of Chief Executive Officer (CEO) or Designee   
 Title

Signature of CEO or Designee<sup>1</sup>: \_\_\_\_\_ Date: \_\_\_\_\_

<sup>1</sup> If the agreement is signed by an authorized designee, a copy of the designation must be attached.

**Footnotes:**

Signed copy and Designation Letter attached at end of Application

# I: State Information

## Chief Executive Officer's Funding Agreements (Form 3) - [MH]

U.S. Department of Health and Human Services  
 Substance Abuse and Mental Health Services Administrations  
 Funding Agreements  
 as required by  
 Community Mental Health Services Block Grant Program  
 as authorized by  
 Title XIX, Part B, Subpart I and Subpart III of the Public Health Service Act  
 and  
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

### Title XIX, Part B, Subpart I of the Public Health Service Act

Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6

### Title XIX, Part B, Subpart III of the Public Health Service Act

Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart I and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

Name of Chief Executive Officer (CEO) or Designee

Audrey Tayse Haynes

Title

Secretary, Cabinet for Health and Family Services

Signature of CEO or Designee<sup>1</sup>: \_\_\_\_\_ Date: \_\_\_\_\_

<sup>1</sup> If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

Signed copy and designation letter is attached at the end of Application



COMMONWEALTH OF KENTUCKY  
OFFICE OF THE GOVERNOR

STEVEN L. BESHEAR  
GOVERNOR

700 CAPITOL AVENUE  
SUITE 100  
FRANKFORT, KY 40601  
(502) 564-2611  
FAX: (502) 564-2517

March 2, 2010

Ms. Barbara Orlando  
Grants Management Officer  
Office of Program Services  
Division of Grants Management  
Substance Abuse and Mental Health Services Administration  
1 Choke Cherry Road, Room 7-1091  
Rockville, Maryland 20857

Dear Ms. Orlando:

I hereby delegate authority to the Secretary of the Cabinet for Health and Family Services, or in his/her absence, the Deputy Secretary of the Cabinet for Health and Family Services, to sign funding agreements and certifications, provide assurances of compliance to the Secretary of the United States Department of Health and Human Services and to perform similar acts relevant to the administration of the Substance Abuse Prevention and Treatment Block Grant until such time as this delegation of authority is rescinded.

Sincerely,

Steven L. Beshear

## I: State Information

### Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

[Standard Form LLL \(click here\)](#)

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Name	<input type="text" value="Audrey Haynes"/>
Title	<input type="text" value="Secretary, Cabinet for Health and Family Services"/>
Organization	<input type="text" value="Kentucky Cabinet for Health and Family Services"/>

---

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### Footnotes:

Not Applicable for Kentucky



## II: Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Narrative Question:

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Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities.

Footnotes:

## II. Planning Steps

### **Step 1: Assess the strengths and needs of the service system to address the specific populations**

*Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the State, intermediate and local levels differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other State agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities as well as youth who are often underserved.*

*Note: Kentucky also addresses the 5 required Criterion for Adult and Children in this section of the application.*

The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) is Kentucky's designated State Mental Health Authority (SMHA) and Single State Agency for Substance Abuse Services (SSA), as well as the State Opioid Treatment Authority (SOTA). Per Kentucky Revised Statute (KRS) 194.030, DBHDID is identified as the primary state agency for developing and administering programs for the prevention, detection and treatment of:

- Mental Health (Adults and Children);
- Substance Abuse Prevention and Treatment Services; and
- Developmental and Intellectual Disabilities.

DBHDID is part of the Cabinet for Health and Family Services (CHFS), which was most recently reorganized in February 2011. CHFS is one of the largest agencies in state government, with nearly 8,000 full and part-time employees. Among other offices and councils, the following are also within the Cabinet:

- Office of the Secretary
- Office of Health Policy (including Certificate of Need and Health Policy Development)
- Office of Kentucky Health Benefit Exchange
- Office of Legal Services
- Office of the Inspector General (Licensing and Regulation Authority)
- Office of Communications and Administrative Review
- Office of the Ombudsman
- Office of Policy and Budget
- Office of Human Resource Management
- Office of the Health Benefit Exchange
- Office of Administration and Technology Services
- Department for Public Health (Local and State Public Health Programs)
- Department for Medicaid Services (Medicaid Authority)
- Department for Aging and Independent Living (Aging, Guardianship, Brain Injury Services)
- Department for Community-Based Services (Adult and Child Protection, Child Welfare)
- Department for Income Support (Disability Determinations, Child Support Enforcement)
- Department for Family Resource Centers and Volunteer Services
- Kentucky Commission on Community Volunteerism and Service
- Kentucky Commission for Children with Special Health Care Needs
- Governor's Office of Electronic Health Information

Within DBHDID, there are three Divisions, including: Administration and Financial Management; Developmental and Intellectual Disabilities; and Behavioral Health. The Division of Behavioral Health is a product of the merger of the Division of Substance Abuse and the Division of Mental Health in July 2004. With an increased focus on the treatment needs of individuals with co-occurring disorders (mental health and substance use) at the national, state and local level, the Division is aimed at ensuring an integrated, seamless service system.

DBHDID's Division of Behavioral Health is comprised of the Director's Office and four Branches. The Branches include:

- *Data Research Branch* – Consists of the Substance Abuse Prevention Program, which targets the prevention of the abuse of alcohol, tobacco and other drugs in Kentucky, as well as the Driving Under the Influence (DUI) Program;
- *Program Development Branch* – Responsible for creating and planning program infrastructure based on assessment of need, promising practices, and stakeholder participation and also functions as the Children, Youth and Family Services Branch;
- *Program Support Branch* – Provides expert support through training, consultation and customer relations and also functions as the Adult Mental Health Branch; and
- *Provider Services Branch* – Provides administrative oversight and promotion of quality assurance with networks of service providers and contractors and also functions as the Substance Abuse Treatment Branch.

A Recovery Services Coordinator, who serves within the Director's Office, is responsible for coordinating consumer and family member support services across the state, and guiding Kentucky towards full implementation of a recovery-oriented behavioral health system. The Coordinator is also committed to identifying disparities, in service provision, with regard to race, ethnicity, age and sexual orientation.

An Executive Administrative Order was executed by the Cabinet for Health and Family Services, effective December 16, 2010, establishing a new Branch within the DBHDID's Division of Administration and Financial Management. The new Outcome Transformation and Education Branch was created to allow the Department to continue to meet quality standards while moving the Department forward with transformation of services to more appropriately meet the needs of individuals with mental/emotional disorders, substance use disorder and those with intellectual and developmental disabilities.

The Substance Abuse Prevention Program of the Division of Behavioral Health is responsible for completing the Annual Synar Report. The Office of Alcoholic Beverage Control enforces the Synar Regulation and conducts the annual Synar survey.

Adult Mental Health Inpatient Facilities

For over 180 years, Kentucky has operated psychiatric facilities that provide evaluation and treatment. Kentucky's state hospitals for adults are displayed in the table below.

State Hospital	Location	Operation	SFY 2005 ADC*	SFY 2012 ADC	SFY 2013 ADC
Western State Hospital	Hopkinsville	State operated	144	108	119
Central State Hospital	Louisville	State operated	108	65	59
Eastern State Hospital	Lexington	Contracted	162	127	127

Appalachian Regional Hospital (ARH) -Hazard Psychiatric Center	Hazard	Contracted	82	81	88
*ADC= Average Daily Census		TOTAL	496	381	393

Census at state hospitals had declined over the past decade as efforts were made to place persons in appropriate community programs. However, fluctuating factors, such as the closing of many psychiatric units within local community primary care hospitals and the implementation of Medicaid managed care in Kentucky has affected state hospital census in recent years.

### Nursing Homes

The Department operates two facilities that provide a nursing level of care for persons with psychiatric disabilities who also need a nursing level of care for a co-morbid condition, or because they are medically fragile. The facilities primarily serve persons who are discharged from state hospitals, or who are at risk of hospitalization in a state facility. They are:

- WSH Nursing Facility, located on the campus of Western State Hospital in Hopkinsville, which had an average daily census of 102 in SFY 2013; and
- Glasgow Nursing Facility in Glasgow, which had an average daily census of 84 in SFY 2013.

Newly constructed facilities to replace Eastern State Hospital (the second oldest psychiatric facility in the country, erected in 1817) and the Glasgow Nursing Facility are scheduled to open in September 2013. DBHDID will operate the Glasgow facility and has contracted with the University of Kentucky Medical Center to operate Eastern State Hospital.

### Specialized Personal Care Homes

To provide a less restrictive alternative for people in state hospitals who qualify for a transitional placement from a hospital level of care, specialized personal care homes for adults with serious mental illness (SMI) were developed in three of the four hospital districts (admissions are not restricted to residents of regions or districts). These homes, which are licensed in Kentucky as "Personal Care", (combination of room, board, and some supervision and oversight) are operated by Regional Boards. The focus of the rehabilitative programming within these facilities is the teaching of skills that will enable residents to be integrated into the community.

The two remaining facilities are:

- Bluegrass Personal Care Home, a forty (40) bed facility located on the campus of Eastern State Hospital in Lexington; and
- Caney Creek Rehabilitation Complex, an eighty (80) bed facility located in Pippa Passes in southeastern Kentucky.

During SFY 2008 and 2009 the Center for Rehabilitation and Recovery (CRR), a thirty-eight (38) bed unit located on the campus of Central State Hospital outside Louisville, began gradually moving some individuals from the CRR facility to smaller scattered-site living situations within the community, while continuing to provide necessary supports to maintain their independent living status. In June 2011, a contract was established between the DBHDID and Seven Counties Services, Inc., (one of the Regional Boards) to operate the

Center for Rehabilitation and Recovery, with the goal of moving all residents into permanent, community-based housing by the end of SFY 2013. In August of 2013, the last resident moved to the community. CRR continues to operate as a Supported Housing program in the community in lieu of a personal care home and has been renamed Housing First/Champions Trace. This, in essence, creates a less restrictive living environment for adults with SMI. This contract mandates that community housing for this population must follow supportive housing principles, utilizing SAMSHA's Permanent Supportive Housing Toolkit. This contract is a performance based contract, based on an evidence based practice and requiring positive outcomes from several performance indicators. (i.e. Occupancy Standards; Data Reporting; Outcome/Functioning; Person Centered Planning; Staff Training; Psychiatric Inpatient Admissions; Successful Transition; and Fidelity to the Supported Housing Model.) Housing First staff is now serving forty-one (41) consumers in the community with services designed to support continued successful community living.

During SFY 2013, a contract was established between the DBHDID and Kentucky River Community Care (one of the Regional Boards) to operate Caney Creek Rehabilitation Complex, with the goal of moving all residents into permanent, community-based housing. This contract is also performance based and mandates that community housing for this population must follow supportive housing principles, utilizing SAMSHA's Permanent Supportive Housing Toolkit. In addition, Caney Creek staff must utilize Assertive Community Treatment (ACT) as a method for meeting the needs of those residents who end up living in the community. This creates another less restrictive living environment for adults with SMI. This is the first year of the contract with Caney Creek and because they have eighty (80) beds as opposed to CRRs thirty-eight (38) beds, the timeline is extended. The goal for SFYs 2014 and 2015 is to continue to monitor and support these programs. As of August 2013, eighteen (18) individuals are residing in the community. The DBHDID will also work with the other specialized personal care home, during SFYs 2014 and 2015, to develop supported housing plans as appropriate, assuring that plans are person centered and individualized by regional strengths and needs.

In August 2013, the Cabinet for Health and Family Services entered into a settlement agreement with Kentucky Protection and Advocacy to develop and implement services to allow 600 individuals with SMI, who are residing in or at risk of entry into Personal Care Homes, to live in the community. By October 2014, the Cabinet will provide assistance to 100 individuals, by October 2015, to 200 additional individuals, and by October 2016, to 300 additional individuals. To operationalize this, DBHDID will reallocate funding from state psychiatric facilities to the 14 Regional Boards to provide the intensive community services needed. These funds, combined with Block Grant funds, will provide the following services:

- Assertive Community Treatment (ACT) is an outreach-oriented service delivery model for people with SMI, which delivers comprehensive community-based treatment, rehabilitation and support services to consumers in their homes, at work and in community settings using a 24-hour a day, 7 day a week team approach.
- Supported Housing provides an array of activities and services to assist individuals with SMI to choose, get and keep regular housing in the community. These activities may include accessing subsidies, locating suitable housing, negotiating leases, acquiring household items, moving the individual into the residence, and teaching housing related living skills.
- Supported Employment (SE) is an approach to vocational rehabilitation for people with SMI that emphasizes helping them obtain competitive work in the community and providing the supports necessary to ensure their success in the workplace.
- Peer Support is social and emotional support that is provided by persons having a mental health condition to others sharing a similar mental health condition in order to bring about a desired social or personal change. The support that is given and

received is developed around principles of respect, shared responsibility and mutual agreement of what is helpful.

The Cabinet is also working toward coverage of these services under Medicaid during SFY 15, and the eventual expansion of these services beyond the 600 served under the settlement agreement.

### Forensic Psychiatric Services

Kentucky Correctional Psychiatric Center is an inpatient psychiatric hospital, located within a correctional system complex, but operated by DBHDID. It primarily provides court-ordered inpatient evaluation and treatment to restore competency to persons charged with a felony offense. When inpatient evaluation is unnecessary, the Center facilitates outpatient competency evaluations through contracts for professional services with Regional Boards. The facility's average daily census in SFY 2012 was approximately 60 people.

Although Kentucky has operated a variety of psychiatric facilities for adults, for over 165 years, the state does not operate any inpatient facilities for children and youth under eighteen years of age.

There are currently 712 (up from 672 last year and from 633 in the previous year) available child psychiatric beds in Kentucky. The average daily census for the 712 beds is 549 and the average length of stay for patients is 25 days. The 712 beds are located in 13 hospitals that are geographically located in 8 of the 14 regions. Other residential care for children includes Psychiatric Residential Treatment Facilities (PRTFs), Private Child Care (PCCs) facilities, Therapeutic Foster Care (TFC). These services are provided by an array of privately operated organizations and most are collectively represented by the Children's Alliance. The Children's Alliance works with state agencies to promote collaboration and create effective public policy for at-risk children and families. The Office of Inspector General, within the Cabinet, is the regulatory agency for licensing all health care facilities, day cares, long-term care facilities, and child adoption/child-placing agencies in the Commonwealth. The child welfare and juvenile justice agencies are the only state agencies authorized to take custody of children. Neither licensing, nor "care, custody and control" of children are a function of the Department for Behavioral Health, Developmental and Intellectual Disabilities.

### Residential Substance Abuse Treatment

Genesis House (Formerly VOLTA): A short term residential treatment facility for individuals with substance use disorders is currently located on the grounds of Western State Hospital in Hopkinsville, Kentucky. During the past couple of years, Genesis House has transitioned from being a strictly state-run facility to being contracted through one of the Regional Boards (Pennyroyal Center). The name was changed to Genesis and they currently accept individuals with co-occurring disorders.

SCHWARTZ CENTER: A short term residential facility (less than thirty (30) days) for individuals with substance use disorders, in Lexington, Kentucky and provided through Bluegrass MH/MR Board, Inc. Also provides some outpatient substance abuse treatment. Currently located on the grounds of Eastern State Hospital, but plans to relocate when the new hospital facility opens in September 2013.

INDEPENDENCE HOUSE: A long term residential substance abuse treatment facility for women who are pregnant. Also provides case management services. Located in Corbin, Kentucky.

**CHRYSALIS HOUSE:** A residential facility for substance dependent expectant mothers located in Lexington, Kentucky. Consists of three (3) residential facilities, a forty (40) unit apartment complex, eighteen (18) scatter-site apartments, a multipurpose community center and two (2) playgrounds. Provides a variety of treatment and skill building services.

**LIGHTHOUSE:** An adolescent Recovery Center for drug treatment and alcohol rehabilitation located in Louisville, Kentucky. Provides long term substance abuse treatment for adolescents.

#### Community Programs

Kentucky is divided into fourteen geographic regions for the purposes of planning and providing publicly funded community mental health, substance abuse and prevention services. Together, they serve all 120 Kentucky counties. For each region, a Regional Mental Health and Mental Retardation Board has been established pursuant to KRS 210.370-210.480 (<http://www.lrc.ky.gov/KRS/210-00/370.PDF>) as the planning authority for behavioral health programs in the region. County and municipal governments do not provide community behavioral health services. A Regional Board is:

- An independent, non-profit organization;
- Overseen by a volunteer board of directors that broadly represents stakeholders (including consumers and family members) and counties in the region; and
- Licensed by the Cabinet for Health and Family Services as a “Community Mental Health Center.”



*Outpatient services are provided primarily through a network of Regional Boards also called “Community Mental Health Centers or Comprehensive Care Centers.”*

*Note of Clarification: Regions 9 & 10 were originally two different Boards but merged some years ago and are now counted as one region, thus there are a total of 14 Boards but they are represented with numbers one through fifteen.*

Kentucky Revised Statute 210.410 authorizes the Secretary of the CHFS to make state grants and other funding allocations to Regional Boards to provide, at a minimum, the following behavioral health services:

- Inpatient Services;

- Outpatient Services;
- Partial Hospitalization or Psychosocial Rehabilitation Services;
- Emergency Services;
- Consultation and Education Services; and
- Services for Individuals with an Intellectual Disability.

Behavioral health services, including mental health services for adults and children, substance abuse services for adults and adolescents, and services for individuals with co-occurring disorders are provided in county level clinics. Services may not be denied to any individual based on age, race, ethnicity or ability to pay. In addition to the clinics, there are fourteen (14) Regional Prevention Centers established to provide technical assistance and training on evidence-based prevention strategies.

### **Implementation of Managed Care in Kentucky**

Kentucky entered the arena of Medicaid managed care in November 2011. At that time Kentucky Medicaid entered into contracts with three managed care organizations (MCOs) to provide services to approximately 540,000 Medicaid enrollees in seven of the eight Medicaid regions of the Commonwealth. Behavioral health was included along with physical health in an effort to provide a more integrated service continuum to those it serves. Under this new arrangement, three MCOs were selected: Wellcare, Kentucky Spirit / Cenpatico, and Coventry / MHNNet. Contracts were enacted for a 30-month period (through June 30, 2014).

In the region that was not initially included, which encompasses 16 counties across three (3) CMHC regions, physical health for Medicaid recipients had already been operating under managed care for nearly a decade. This region, which includes the state's largest metropolitan area (Louisville), was served by the *Passport Health Plan*. As of January 1, 2013, the Louisville managed care region now has integrated physical and behavioral health care through the introduction of two new MCOs (Humana CareSource / Beacon and Passport / Beacon). Beacon will serve as the Managed Behavioral Health Organization (MBHO) for both Humana and Passport. Wellcare and MHNNet also provide MBHO services in the Louisville Medicaid region.

Note: Per the Kentucky Spirit web site at

<http://www.kentuckyspirithealth.com/2013/08/07/exiting-ky-medicaid-program-for-members/>

Kentucky Spirit Health Plan stopped coverage for service to members effective July 6, 2013. On June 29, 2013, the Department for Medicaid Services (DMS) sent letters to all members with information about this change. This letter contained the new health plan assigned to the member and the contact number... To help ensure that our members are supported during the change to other health plans, Kentucky Spirit continues to do the following activities for a reasonable period of time following July 5, 2013: Maintain member services call center staff; Maintain provider services call center staff; Process and pay claims with dates of service up to and including July 5, 2013; Maintain provider relations staff to address provider issues; and Prepare and provide continuity of care forms to the new health plan for all medically fragile members.

In partnership with the Department for Medicaid Services (DMS), the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) has had a significant role in oversight of the managed care rollout, with a focus on the effects on the public behavioral health system. DBHDID meets with each MCO about every six weeks to review data, discuss interface with DBHDID programs (especially continuity of care issues), and formulary and payment issues.

### **Medicaid Expansion in Kentucky**



Calling it “the single-most important decision in our lifetime for improving the health of Kentuckians,” Governor Steve Beshear announced in May 2013 that Kentucky will take advantage of the Medicaid Expansion provision of the Affordable Care Act and seek to expand Medicaid coverage under the Patient Protection and Affordable Care Act anticipated to extend coverage to 300,000 adults earning up to 133 percent of the federal poverty level. This number would nearly cut in half the number of individuals who currently lack health coverage—estimated at 640,000 (17.5% of the state’s population under 65). The Governor made the decision after reviewing both internal and external reports completed by outside research groups including the University of Louisville and Price Waterhouse Coopers. The research shows expanding Medicaid would create 17,000 new jobs and adds \$15.6 billion to the state’s economy between 2014 and 2021. There is opposition to this decision within the Kentucky legislature, and the state’s representatives in Congress -U.S. Senate Republican leader Mitch McConnell and Republican Senator Rand Paul, are both strong opponents of the law and have continuously called for it to be repealed.

In Kentucky, Medicaid or Kentucky Children’s Health Insurance Program (KCHIP) benefits currently are available to:

- Adults if they have disability, serve as the caretaker relative for a child who is eligible for Medicaid and on average has income below 43 percent of (FPL), or are pregnant; and
- Children with family income up to 200 percent of FPL.

Expansion will allow more than 308,000 Kentuckians to access reliable, quality health care. The new threshold of 138 percent of FPL means a single person with no children earning less than \$15,856 per year is eligible to sign up for Medicaid. A family of four with an annual income of less than \$32,499 is also eligible.

Most of the Kentuckians who will be eligible are the working poor. This includes people who work at minimum wage jobs for fewer than 40 hours per week; individuals who are self-employed; or single parents whose children are covered through KCHIP.

A new state website houses information about the expansion, including a white paper written by the Cabinet for Health and Family Services and letters from supporters. Also available is county-by-county data displaying how many citizens will be newly eligible for Medicaid, and how much county jails spent on medical care last year. Visit [governor.ky.gov/healthierky](http://governor.ky.gov/healthierky).

The following is a comprehensive description of the Mental Health services arena in Kentucky and is organized in the federally mandated Criterion 1-5 format for Adults and Children.

## **Criterion 1: Comprehensive Community Based Mental Health Services**

### **1) Establishment of System of Care: Adult Mental Health**

*Narrative Question: Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental illness and substance abuse disorders.*

The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (KDBHDID) administers a recovery oriented, comprehensive, community-based system of mental health care for adults with serious mental illness and their families through contracts with Kentucky's Regional Boards, also known as Community Mental Health Centers (CMHCs). KDBHDID works with the Kentucky Department for Medicaid so that basic services, like outpatient and rehabilitation services, are available and have similar requirements for Medicaid and non-Medicaid eligible consumers.

The KDBHDID contracts with the fourteen private, not-for-profit Regional Boards to provide services to citizens in all 120 counties of the state. Regional Boards are required to specifically describe their current system of care for adults, and to state their plans for development regarding key system components, within the annual Plan & Budget process. These components include:

- Consumer and Family Support
- Emergency Services
- Mental Health Treatment Services, including Co-occurring Treatment for Mental Health and Substance Abuse and Mental Health Services for Deaf and Hard of Hearing
- Case Management Services
- Rehabilitation Services
- Housing Options
- Physical Health Interface
- Continuity of Care

KDBHDID is committed to working collaboratively with Regional Boards to continuously enhance continuity of care, service effectiveness and accountability.

### **1) Establishment of System of Care: Children's Mental Health**

*Narrative Question: Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental illness and substance abuse disorders.*

The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (KDBHDID) administers a comprehensive, community-based system of behavioral health care for children with severe emotional disabilities (SED), and their families. With guidance from SAMHSA's *Leading Change: A Plan for SAMHSA's Roles and Actions 2011–2014*, the department strives to further promote system of care principles and objectives, while at the same time ensuring autonomy at the regional level for service planning and decision making.

KDBHDID contracts with fourteen private, not-for-profit Regional Mental Health/Intellectual Disabilities Boards (Regional Boards) to provide services to citizens in all 120 counties of the state. Regional Boards, in the annual Plan & Budget process, are required to specifically describe their current children's system of care and to state their plans for development regarding key system components, including:

- Family and Youth Involvement and Support
- Clinical Services
- Integration of Services
- Best Practices
- Data and Outcomes
- Planning for Underserved Populations
- Staff Training and Development and
- Promotion of Wellbeing/Prevention of Behavioral Disorders

KDBHDID is committed to working collaboratively with Regional Boards to continuously enhance service access and capacity, youth and family involvement, evidence-based clinical care, seamless transitions between levels of care, integrated care, and positive outcomes for youth and families. Current activities regarding each of these components are discussed throughout this grant application.

Within the Division of Behavioral Health, there is a Children, Youth and Family Services Branch with twenty staff dedicated to the development and implementation of a strong and progressive behavioral health services delivery system and a coordinated system of care for Kentucky's children, youth and families.

## **2) Available Services: Adult Mental Health**

*Narrative Question: Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:*

- *Health, mental health, and rehabilitation services;*
- *Employment services;*
- *Housing services;*
- *Educational services;*
- *Substance abuse services;*
- *Medical and dental services;*
- *Support services;*
- *Services provided by local school systems under the Individuals with Disabilities Education Act;*
- *Case management services;*
- *Services for persons with co-occurring (substance abuse/mental health) disorders; and*
- *Other activities leading to reduction of hospitalization.*

## **HEALTH, MENTAL HEALTH, AND REHABILITATION SERVICES**

### **HEALTH**

The interface between the physical healthcare system and the mental health system is of growing importance to providers of behavioral health services. It is well known that a significant amount of behavioral health services are provided in the physical healthcare arena. Continuity of care across these systems is critical if individuals are going to recover and succeed in establishing chosen roles in the community.

Kentucky is a relatively unhealthy state and struggles with poor health outcomes overall. To maintain focus on improving access to dental and physical health services, a representative of the Department for Public Health was appointed to the Kentucky Mental Health Services Planning Council. That representative has been attending planning council meetings since SFY 2003 and contributing valuable suggestions for collaboration between the physical health and mental health system. Additionally, meetings between the Commissioners of KDBHDID and the Department for Public Health produced an agreement to establish a formal liaison between the Departments for the purpose of improving collaboration and developing strategies for better integration of physical healthcare service with mental healthcare services.

In April 2010, the Governor announced the creation of a Health Information Exchange (HIE) where hospitals and clinics will be able to exchange health information electronically regarding Medicaid clients. Today the Kentucky Health Information Exchange (KHIE) has grown to include 385 participation agreements representing over 860 healthcare locations

around the state. One hundred, eighty-seven (187) of those locations are live and exchange data on KHIE daily. The core components of the KHIE include: a master patient/person index; record locator service; security; provider/user authentication; logging and audits; clinical messages and alerts. The system supports e-prescribing, patient demographics, lab order entry and results, radiology and transcription reports, historical patient diagnoses, medications, procedures, dates of services, hospital stays, and access to the statewide immunization registry, ability to communicate reportable diseases and a provider portal.

In December 2012 Kentucky was selected as one of three states in the nation to receive awards from the Office of the National Coordinator for Health Information Technology for demonstrating strong partnerships between federally sponsored programs, local organizations and state agencies. This collaboration has led to the successful implementation and meaningful use of electronic health records throughout the state. "We're proud of the work being done to improve care of people throughout the state and are thrilled the effort is receiving national recognition," said Polly Mullins-Bentley, Acting Executive Director of Governor's Office of Electronic Health Information. "Current technologies make it easy and safe for doctors, nurses, pharmacists and others to communicate with each other on their patients' behalf. It results in fewer errors and means health care providers and their staff can spend more time actually talking with their patients. That's what we're working toward." "On behalf of ONC, we commend the hard work and dedication of KHIE in facilitating and expanding the secure electronic movement and use of health information in the state of Kentucky," said Peter Banks, ONC Project Officer for Kentucky. "These efforts will increase the quality and coordination of care for all residents in the state."

Kentucky was showcased for achieving the nation's first successful transmission of a secure continuity of care document to the Kentucky Cancer Registry. The collaborative efforts between the Centers for Disease Control and Prevention, Kentucky Cancer Registry, KHIE and the Kentucky REC, enabled the transmission of vital health statistics that will help population health experts study the prevalence and incidence rates of chronic disease across the state. The teams were also recognized for pioneer work in assisting behavioral health facilities. As one of only five states in the nation to receive Substance Abuse and Mental Health Services Administration funding for Health IT implementation, Kentucky is now on path to facilitate the integration of primary and behavioral health care, helping mental health and substance abuse facilities implement electronic health records and transmit data. "Adoption of health information has been remarkable all across the state," said Mullins-Bentley. "This is attributable to our partnership with the Department of Medicaid Services and the state's regional extension centers, whom have been integral in securing early adoption among the provider community." Together, the Kentucky Regional Extension Center and KHIE have helped providers in Kentucky secure more than \$115 million in Meaningful Use incentive dollars.

The Division of Behavioral Health was awarded a two-year SAMSHA grant in June 2003 to develop regional behavioral health emergency disaster preparedness plans for each of the Regional MHMR Boards. As a continuation of that initiative, the Division continues to receive a small amount of funding (2005-2013) from the Kentucky Department for Public Health to help fund a statewide Mental Health/Mental Retardation Disaster Preparedness Coordinator. This Coordinator provides a behavioral health focus for Kentucky's fourteen (14) regional ASPR (Assistant Secretary of Preparedness and Response) healthcare planning coalitions and ongoing interagency collaboration that have resulted in integrated and coordinated responses to emergencies and disasters. Regional CMHC plans continue to be updated annually and the Department continues to designate a program administrator to coordinate regional and statewide efforts.

In July 2012 staff from the Division of Behavioral Health and the Kentucky Department for Public Health (DPH) met for biannual planning purposes and agreed to collaborate in the following ways during emergencies and disasters.

- Designate staff to serve in the DPH's Department Operation Center (DPH DOC) during Level 1 or Level 2 incidents.
- Designate DBHDID staff serving the DPH DOC to report Community Mental Health Center and Department facility assessments and on-going status to Emergency Support Function -8 (ESF-8) and to the Commonwealth Emergency Operations Center through the DOC.
- Designate DBHDID staff serving the DPH DOC to assist with identifying resources to secure services for individuals with behavioral health (mental and substance use) disorders and developmental/intellectual disabilities for shelter, day care, supervision, medication, transportation and housing.
- Develop a written plan/Continuity of Operations Plan (COOP) and train staff on implementation of the plan should it be needed during an event.
- Assist DPH in the development of statistical profiles of persons with functional and access needs by providing data on persons served by the agency.

The Regional CMHC's will continue to participate in local/regional healthcare preparedness planning coalitions. CMHC staff shall assess, identify and monitor shelter needs for individuals with behavioral health, developmental, and intellectual disabilities during emergencies and disasters. CMHC staff shall assist in providing notification to behavioral health, developmental and intellectual disabilities populations and caregivers regarding response and recovery information.

The Program Coordinator continues to sit on the Kentucky Community Crisis Response Board (KCCRB) as the Commissioner Designee. The Kentucky Community Crisis Response Board provides assessments, crisis intervention, service collaboration, and system development following disasters. KCCRB, as the state lead disaster mental health agency, coordinates services, administers FEMA Crisis Counseling grants when necessary following a presidential Declaration, in collaboration with local and regional mental health providers. The KCCRB also provides multi-component crisis intervention services statewide, and is on call 24 hours a day, seven days a week. Regular incident responses include responding to crises with first responders, schools, businesses or community organizations, as invited.

During SFY 2013, DBHDID formed a group to study Medicaid Health Homes. This initial group included representatives from the DBHDID, the Department for Medicaid Services, Kentucky Association of Regional Programs, Kentucky Primary Care Association, CMHCs, and two (one urban and one rural) Federally Qualified Health Centers. This group went to Missouri to study a successful Medicaid health homes initiative. In December 2012, DBHDID, with the support of this group, responded to a Request for Applications (RFA) regarding State Integration and Medicaid Health Homes, a National Council Learning Community, from the National Council for Behavioral Health. The application was awarded in January 2013. The Learning Community brings state leaders together in a group learning model that accelerates change and helps participants tackle confounding problems of integration and Medicaid Health Homes for persons with disabilities. The six (6) month Learning Community covers policy development, clinical models, and implementation strategies. At the end of the Learning Community, group members will have developed a strategic plan for implementing health integration/Medicaid Health Homes for special populations in Kentucky.

## **MEDICAL/DENTAL**

Regional Boards are required to assess the physical health of each consumer they serve during the intake process and at least annually thereafter. Clinicians and case managers work closely with community primary care physicians, local health departments, and other health care providers to address the overall health needs of adults. The Department has assisted several regions in improving tools used to assess physical health concerns and continue to encourage further assessment and integration of physical and mental health care.

During SFY 2010, two Regional Boards received funding to assist with integrating physical and behavioral health services. One region located in rural Western Kentucky (Pennyroyal) received a SAMHSA grant for \$500,000 per year for four (4) years. This area serves individuals with primary needs related to poverty, unemployment, obesity, tobacco use, etc. This grant is targeting adults with SMI with numerous primary care needs in eight (8) counties in Western Kentucky. Another region (NorthKey) located in Northern Kentucky received several smaller grants from the Health Foundation of Greater Cincinnati focusing on integrated care. A \$206,366 grant received in 2007 allowed for the beginning of integration. Five (5) behavioral health clinicians were placed into five (5) separate primary care clinics. A \$155,000 grant received during SFY 2010 allowed for the provision of primary care services in more primary care clinics and seeks to address health disparities experienced by individual with SMI.

Physical health services are available through Medicaid or local “free” clinics that provide indigent health care. A number of Regional Boards have chosen to “partner” with local health providers in developing/constructing clinics with shared space for both mental and physical health. These partnerships have been very successful in better identifying both mental health and physical health problems experienced by members of their community.

For dental care, access to low or no cost services are provided by the dental schools at the University of Louisville and the University of Kentucky (in Lexington). They serve individuals in the clinics located in Lexington and Louisville. The University of Kentucky also provides mobile dental services which reach out to uninsured families in Eastern Kentucky (those who do not make enough money to pay for dental care but who make too much money to qualify for Medicaid assistance). There are four dental vans from the University of Kentucky. Several faith based organizations have provided the financial support needed to start these services and to keep them operating. In addition, some faith based groups have opened free clinics in church buildings, which are staffed by volunteer dentists who come to the region from all over the state for weeklong mission trips. And yet others hold dental events in Wal-Mart parking lots, handing out free samples of toothpaste, dental floss and toothbrushes to anyone who wants them. Still, case managers and clinicians that have knowledge of local resources and well-developed relationships with local providers tend to lead to better access to dental services. There are, in many communities, those dentists who will serve individuals in need who have no ability to pay. However, overall access to dental care is generally considered poor.

## **MENTAL HEALTH**

Suicide prevention is a critical consideration for Kentucky’s system of care. While suicidality is often recognized among vulnerable youth, research consistently indicates youth are not the most vulnerable group. In October 2004, out of concern for deaths by suicide and the impact for a growing number of survivors, a suicide prevention coordinator was hired within the KDBHDID. After gathering together key stakeholders, the KY Suicide Prevention Group (KSPG) emerged as the collaborative group to develop a state suicide prevention plan that guides the state’s response to suicide within the Commonwealth. Key elements of this plan

are awareness, intervention and evaluation. The state suicide prevention plan is currently in the process of being updated.

As a result prevention efforts over 240 trained gatekeepers conduct QPR (Question, Persuade and Refer) awareness trainings throughout the state, nine local coalitions have been established, school-based prevention programs have been introduced to multiple school districts, over 800 clinical trainings have been conducted and statewide media campaigns involving the production of a Kentucky specific video chronicling the impact of suicide on Kentucky citizens have raised the level of awareness throughout the Commonwealth.

The grid below demonstrates the availability of the wide array of services for adults with severe mental illness in each of the fourteen mental health boards. The grid is updated annually based on required Plan and Budget submissions by the Regional Boards.

**Regional Availability of Community Support Services SFY 2013**

	1	2	3	4	5	6	7	8	10	11	12	13	14	15
<b>Services</b>														
<b>Consumer and Family Support</b>														
Training and Advocacy	X	X		X	X	X	X	X	X	X	X			X
Consumer Support Group	X			X	X	X	X	X	X	X	X		X	X
Social Club Drop In	X		X				X		X			X		X
Local NAMI of Kentucky	X	X	X	X	X	X		X	X	X	X	X	X	X
Consumer Conferences			X		X	X		X	X	X	X		X	X
Peer Support	X			X	X	X			X	X	X		X	X
<b>Emergency Services</b>														
Emergency-Help Line	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Walk-In Crisis Services (8-5 M-F)	X	X		X	X	X	X	X	X	X	X	X	X	X
Mobile Crisis Services	X	X					X	X	X	X	X			X
Residential Crisis Stabilization	X		X	X	X	X		X	X	X	X	X	X	X
<b>Mental Health Treatment</b>														
Medication Management	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Community Medication Support	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Outpatient Therapy	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Intensive Outpatient		X			X	X	X	X	X					
Specialized Co-occurring Disorder Services		X				X	X	X	X	X	X	X		X
<b>Case Management Services</b>														
Case Management	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Wraparound Funds	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Specialized Intensive Case		X			X	X			X					X
Assertive Community Treatment		X		X				X	X	X	X			X
Continuity of Care and Specialized Initiatives						X		X	X		X			X
Homeless Outreach	X	X	X	X		X	X	X	X		X		X	X
Payee Services		X	X	X		X	X	X			X	X	X	X
<b>Rehabilitation Services</b>														
Therapeutic Rehabilitation		X	X	X		X		X	X	X	X	X	X	X
Supported Employment	X	X	X		X	X	X	X	X	X		X		X
Educational Services								X	X					X
Other Community Support				X		X					X			X
<b>Housing Options</b>														

Supported Housing Program		X	X	X	X	X	X		X		X	X		X
Residential Support		X		X		X		X	X					X
Housing Development	X	X					X	X			X	X	X	X

**MENTAL HEALTH TREATMENT**

Each regional board provides a full array of outpatient services including, but not limited to, individual psychotherapy, group psychotherapy, psychiatric evaluations, walk-in emergency appointments, psychopharmacology, medication education and peer support groups. Every effort is made to place these outpatient clinics within close geographic proximity for consumers in order assure easy access to needed services. Budget constraints have forced some regions to scale back availability of mental health treatment in less populous, rural counties. Additional areas of focus include:

- Recognizing the need to provide assertive outreach so fewer appointments are missed although most regions do report having a system for following up with missed appointments;
- Assuring medication continuity within the agency when level of care changes;
- Addressing shortages of professional staff, especially prescribers, increasing waiting periods for appointments;
- Assuring continuity of care between Regional Boards and inpatient settings or other community providers, thereby ensuring quality, holistic care;
- Screening adequately for substance use disorders/co-occurring disorders; and
- Providing opportunities for staff training in co-occurring mental health and substance use disorders (screening, assessment and treatment).

**SUBSTANCE ABUSE TREATMENT AND PREVENTION OVERVIEW**

Services provided primarily through contracts with community-based service providers (14 Regional Mental Health and Mental Retardation Boards and their subcontractors, local government agencies and other community-based organizations) include:

- Prevention programming in communities offered through 14 Regional Prevention Centers;
- Juvenile diversion programs; DUI assessment and education programs;
- Consultation with businesses on the development of a drug-free work place and employee assistance programs;
- Social setting detoxification centers, residential treatment centers, outpatient treatment services;
- Specialized treatment services for pregnant women, adolescents and intravenous drug users; and
- Opiate replacement therapy to opiate dependent persons who are high-risk for HIV disease due to their intravenous drug use.

Training, consultation and client evaluations are made available, within budget limitations, to criminal justice agencies and other agencies within the Cabinet for Health and Family Services for clients with alcohol and other drug problems.

The Division of Behavioral Health provides alcohol and other drug abuse prevention and treatment services pursuant to KRS Chapter 222 (Alcohol and Drug Education, Treatment and Rehabilitation). The provision of alcohol intoxication fees is pursuant to KRS 431.100.



Other statutes affecting the Division of Behavioral Health services include: KRS 189A (DUI assessment, education and treatment) and KRS 218A.410 (drug forfeiture).

Effective prevention and treatment of alcohol and other drug abuse will have a major impact on the health and well being of every Kentuckian. From peer pressure of youth to use alcohol and drugs to the risks of being involved in a drunk driving accident, all Kentuckians are at risk for alcohol and other drug related problems. The Division of Behavioral Health has the statewide responsibility for providing leadership and program direction for the implementation of primary prevention, early identification (intervention) and treatment for persons who are alcohol or drug dependent.

### **CO-OCCURRING DISORDERS**

In 2009, the Division of Mental Health and Substance Abuse was renamed the Division of Behavioral Health. Formal steps have been taken by the KDBHDID towards the integration of mental health and substance abuse services across the Commonwealth. Currently, one staff position within the Division of Behavioral Health is dedicated solely to the development, implementation and monitoring of integrated mental health and substance abuse services across the Commonwealth.

Additional steps have been taken by the Division including:

- Evidence-Based Practice “Seed” Grant to Kentucky River Community Care with Mental Health Block Grant Funding (\$25,000) – involvement of Dr. Mee-Lee in region specific consultation and statewide training event
- NIMH / SAMHSA Evidence-Based Practice Planning Grant – Case Study of Integrated Treatment Implementation in Bluegrass Region
- “One Time” training events – Mental Health Institute, Kentucky School, etc. focused on providing mental health training to substance abuse staff and vice versa (substance abuse training to mental health staff)
- Motivational Interviewing training
- Ongoing research on co-occurring financing policy (existing barriers with Kentucky Department of Medicaid Services, study of Michigan system, technical assistance from national consultant)
- Use of “implementation drivers” format to examine implementation of integrated treatment for adolescents (under RWJF Reclaiming Future grant)

Technical assistance was received from the Co-Occurring Center for Excellence (COCE) and from a Dual Diagnosis Capability in Addiction Treatment (DDCAT)/ Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) national trainer during SFY 09. A core team of integration specialists were trained to use the DDCAT/DDCMHT tools. Pilot sites were identified at four (4) Regional MH/MR Boards. These sites agreed to have their adult outpatient programs reviewed for co-occurring capabilities. During SFY 2010, four (4) baseline DDCMHT/DDCAT reviews were completed and three (3) follow-up assessments were done. In 2011 the Division moved on to the assessment of co-occurring capabilities in programs in the ten (10) remaining Regional Boards of the states fourteen (14) Regional Boards. All programs were offered the opportunity to use the data from their DDCAT/DDCMHT reviews to make changes using the Network for Improvement of Addiction Treatment (NIATx) process improvement model to raise any scores below the score of three (3), which is co-occurring capable. Each center formed a change team and submitted an implementation plan. During 2011-2012 all teams participated in monthly coaching calls with the Division co-occurring program administrator and a contracted NIATx coach. In May 2012 the participating programs presented their NIATx change projects in a meeting in Frankfort and received a \$6,000 incentive made possible by a Transformation Transfer Initiative (TTI) grant. At the final presentation meeting the teams were joined by Heather Gotham, co-creator

of the DDCMHT, who worked with them to understand how to use the review data to become co-occurring capable in all seven (7) dimensions of the DDCMHT/DDCAT indexes.

In the current plan and budget applications for 2013 the Regional Boards are encouraged to complete a DDCAT assessment on at least one substance use disorders program and have a score of three (3), co-occurring capable, or adopt an action plans to raise their score to co-occurring capable.

Fourteen (14) CMHCs have participated in DDCMHT/DDCAT reviews and two (2) Kentucky programs have been added to the National Focus on Recovery (FIT) treatment locator map. Two (2) DBHDID employees attended the International Reciprocity and Credentialing (IC&RC) conference on co-occurring disorders in Minneapolis in 2012. One (1) DBH employee participated in the CADC licensure workgroup crafting the bill to create a credential for recovery peer support specialists to work with individuals in recovery from addiction. That bill has been introduced in the current legislative session.

Plans/ goals for Co-occurring Disorders for SFY 2014/2015:

- To continue evaluating the capacity of state programs for providing co-occurring treatment in programs receiving behavioral health block grant funding. The current CMHC plan and budget applications require Regional Boards to become co-occurring capable and to use evidence based practices in their substance use and mental health programs;
- To require the Regional Boards report their use of validated screening and assessment tools as well as how they are applying the American Society of Addiction Medication – Patient Placement Criteria (ASAM-PPC) criteria. The ongoing DDCAT/DDCMHT review provide a means of mapping progress toward co-occurring capability;
- Continue using the DDCAT/DDCHMHT at the program level;
- Continue to support and facilitate new peer led mutual support groups;
- Continue to require the use of evidence based treatment practices;
- Support employment of registered peer support specialists for recovery; and
- Support co-occurring training for providers. Jeff Georgi will present on “co-mingling” disorders and treating specific co-occurring psychiatric disorders at the Kentucky School of Alcohol and other Drug Studies in July 2013.

## **CONSUMER AND FAMILY SUPPORT**

Since the mid-1980s, the DBHDID has been committed to consumer and family involvement in program development and service delivery as a strategy for strengthening informal community supports. This focus has empowered consumers and family members to become more active in assisting Department staff in developing policies, monitoring and providing technical assistance to local programs, and evaluating requests for funding. The Division of Behavioral Health was directed by leadership to convene a workgroup in SFY 2009 with the goal of redesigning the consumer affairs function within the Division. A workgroup was convened that consisted of several adult branch staff members, including the consumer liaison, a representative from the substance use treatment branch, and an adult consumer. A framework for a redesign of the consumer affairs office was developed. Statewide consumer input was gathered at several points along the way, including informal meetings with the Division Director and during two (2) Olmstead/Consumer Advisory Committee meetings.

During SFY 2010, the Division of Behavioral Health began working to implement these recommendations. Department leadership agreed to hire a full time “Recovery Services Coordinator”, who is a self-identified consumer of behavioral health services and who is a part of the management team. Department staff as well as consumers gave input on the job

description for this individual. In February of 2011, a Recovery Services Coordinator was hired.

The Department currently provides funds for a variety of statewide and local consumer and family support initiatives. These initiatives are focused on goals related to advocacy, discrimination reduction, wellness and recovery programs, peer support, education and training, and operating support. During SFY 2010, Division staff used consumer recommendations to rewrite contracts to be awarded to statewide consumer and family groups. These two contracts were renamed, appropriately, as the Recovery Oriented Training and Technical Assistance contract and the Recovery Oriented Family Support Services contract. These two (2) contracts were awarded during SFY 2011, as prescribed by the Request for Proposal (RFP) process monitored by the Finance Cabinet. A Department liaison was designated to monitor these contracts.

The Recovery Oriented Family Support Services contract was awarded to NAMI Kentucky and included requirements for organizing and providing a series of recovery oriented trainings and support activities for family members, utilizing established training modalities and implementation of other support groups that are established as best or promising practices. In addition, NAMI Kentucky must provide at least one "train the trainer" session per year for individuals who will provide the family support group training. This contract also required the provision of leadership in advocacy activities including collaboration with other organizations in supporting improved and evidence based practices such as supported employment, stigma reduction and mental health recovery. New to this contract was the provision of educational symposiums to regional areas across the state, based on needs and requests of local population and the development of a comprehensive needs assessment. NAMI must assure at least monthly contact with training/support staff across the state in an effort to enhance community integration and inclusion and ensure coordination of family support services and other outreach. During SFY 2011, a statewide "train the trainer" training for Family to Family Teachers and Family Support Group Facilitators was held. NAMI provided 18 Family to Family 12 week classes with 225 individuals graduating. NAMI provided monthly family and consumer support groups. NAMI conducted monthly conference calls with Family to Family teachers and support group facilitators to enhance community integration, inclusion and outreach. NAMI Kentucky partnered with DBHDID to host five (5) "Community Conversations" across the state to educate and gather input on the 1915 (i) state plan amendment. NAMI Kentucky, as the family advocacy team leader, partnered with DBHDID to assist with a Individual Placement and Supports (IPS) Supported employment pilot project in four (4) regions in the state, and provided seven (7) educational symposiums to seven (7) different regions in the state. In addition, a listserv was created by NAMI Kentucky to promote mental health and community integration with statewide providers, consumers and family members.

Goals for NAMI Kentucky for SFY 2014/2015 include:

- Working on growing and strengthening NAMI affiliates by making personal visits to their community and having community meetings to enhance community integration, inclusion, outreach and increased efforts in stigma reduction;
- Focusing on educating the local education system and business community on mental illness and resources; and
- Increase the number of trainers for NAMI signature programs.

The Recovery Oriented Training and Technical Assistance contract required the development of a Technical Assistance Center and the provision of recovery oriented trainings across the state. Contractors gathered stakeholders from across the state, including consumers, family members and providers, and developed consensus for the formation of Kentucky System

Transformation, Advocacy, Recovery and Support (KY STARS), a training and technical assistance center focusing on recovery oriented mental health services. During SFY 2012, KY STARS provided education to consumers in state psychiatric hospitals, consumers in treatment at local CMHCs, staff of two state psychiatric hospitals and regional CMHCs, and to Kentucky Peer Specialists and Leadership Academy graduates. KY STARS also provided technical assistance to consumers of peer run programs, staff of local CMHCs, and staff of state psychiatric hospitals. In addition, KY STARS worked to expand the number of peer to peer support groups available across the state and worked to train peers as facilitators of activities that are considered best practices.

KY STARS developed, conducted and analyzed a Comprehensive Needs Assessment of all mental health services in Kentucky during SFY 2011-2012. The Assessment polled over 300 consumers, provider and family members from across the state and looked at major issues in the mental health system, including service gaps, consumer inclusion and cultural competence. The data was broken down by geographical region and has guided KY STARS activities toward the mission of infusing recovery oriented care into all aspects of the Kentucky mental health system.

The KY STARS Training and Technical Assistance Center is located at Participation Station, Inc. This is one of Kentucky's first Peer Operated Centers. KY STARS has provided Participation Station with significant assistance in SFY 2012 with adopting and implementing the SAMHSA Toolkit for Consumer Operated Services. Participation Station is using the Fidelity Assessment Common Ingredients Tool (FACIT) to guide programming and evaluation for the program and has selected the Peer Outcomes Protocol (POP) to measure individual outcomes for the participants in the program.

In SFY 2012, KY STARS worked to develop and facilitate support groups for individuals with co-occurring substance use and mental disorders. Double Trouble in Recovery (DTR) groups, an evidence based practice, are traditional twelve (12) step programs geared toward the special needs of individuals who are also dealing with a psychiatric diagnosis. KY STARS helped initiate and support the development of four (4) new DTR groups, one of which is held in one of the state psychiatric hospitals.

The Recovery Oriented Training and Technical Assistance contract requires the provision of Leadership Academy across the state. The **Leadership Academy** is a three (3) day educational program for persons with a mental illness who have a desire and interest in developing and improving their leadership and advocacy skills. Lessons are geared to address local and state concerns and provide students with practical and useful communication skills. The Leadership Academy consists of two training levels. Level One Training is the general skills training. Level II training is a Train-the-Trainers format, where graduates are able to return to their regions and teach groups. Graduates of the leadership academy are able:

- To identify and assess community issues and needs,
- To create, develop and participate in group action plans,
- To organize local advocacy groups into a respected and effective voice on mental health issues, and
- To participate on boards, councils and commissions.

Since April of 2007, Leadership Academy graduates have attended and participated on Eastern State Hospital's Recovery Mall Leadership Council, by attending monthly meetings. These graduates assist the attendees at the Council meetings in learning recovery skills and in learning how to conduct effective meetings. These meetings benefit both the residents at

Eastern State Hospital who are working on their own recovery, as well as the Leadership graduates who are utilizing their newly learned skills.

During SFY 2013, one (1) Leadership Academy training was held, in Bardstown, Kentucky. Instructors for these trainings are Kentucky Peer Specialists. The goal for SYF 2014/2015 is to continue to provide at least two (2) Leadership Academy trainings per year. As a result of the Leadership Academy Training in Bardstown, Kentucky, the group of consumers trained became so inspired that they negotiated with their local NAMI affiliate and CMHC, and with technical assistance from KY STARS, opened a peer operated center in their area.

During SFY 2012, KY STARS provided training and technical assistance to staff at Western State Hospital to assist with the successful implementation of a Recovery Mall as part of the services offered to inpatient mental health consumers. This program was modeled after the Recovery Mall at Eastern State Hospital and Appalachian Regional Hospital psychiatric facilities. The treatment mall model has now been adopted by three (3) of Kentucky's four (4) state psychiatric hospitals. Feedback from consumers has been very encouraging and many comment that they became more engaged in their recovery.

KY STARS presented a state-wide conference for consumers of mental health services during SFY 2012. This conference was attended by almost four hundred (400) consumers from across the state. Peter Ashenden, from Optum Health was the keynote speaker. He is a national leader in mental health peer support and proved to be an inspiration toward expansion of peer support services in Kentucky.

In regards to peer support services in the state, KY STARS also held a preconference plenary for a selected group of Kentucky Peer Specialists from various geographical areas of the state. Cherene Allen-Caraco, a Certified Peer Specialist from Charlotte, NC presented a full day workshop entitled "Organizational Recovery" in which she taught Kentucky Peer Specialists how to interface with the public mental health system, Community Mental Health Centers, and other provider entities to fully integrate peer support into existing systems.

During SFY 2013, KY STARS presented a state-wide conference for consumers of mental health services as well. Approximately two hundred, fifty (250) attended. Steve Harrington from the International Association of Peer Support was the keynote speaker as well as the speaker for the preconference the day before.

In order to further the cause of expanded peer support services in Kentucky, KY STARS developed a functional website to share programs, recruit new Kentucky Peer Specialists and educate the public.

**Kentucky Peer Specialist Training** is a five day intensive training program for persons with a mental illness who have a desire to learn more about the recovery process and learn how to help others move forward in their own recovery process. The training program was modeled after the Georgia and South Carolina models of Peer Support.

While Kentucky Peer Specialist services are still not a billable service under Medicaid, DBHDID continues to train consumers for this service. During SFY 2012 three (3) peer support trainings were conducted. During SFY 2013 four (4) trainings were held. The manner in which we present these classes has been improved in the following ways:

- Upgrading the curriculum by adopting the second edition of the Georgia training model from the Appalachian Consulting Group which was copyrighted in 2011;
- Improving our delivery model to accomplish greater efficiency and economy. Previously we brought trainers and students from across the state to a single training

location and paid everyone's (up to 28 people) travel, food and lodging for up to six days. It was expensive. We now depend upon community mental health centers to team with us by providing the location so that we can train our students regionally. Students are able to travel back and forth from their homes to the training. Thus we are expanding our reach and we are responsible only for the meals and lodging for the trainers; and

- Expanding our training corps so that we have competent trainers in several regions of the state to facilitate additional trainings, and deliver coaching and continuing education programs.

During SFY 2013, DBHDID began to work toward establishing a Kentucky Peer Support Organization. DBHDID is exploring joining the International Association of Peer Specialists. The Department also began utilizing electronic newsletters on a quarterly basis to improve contacts and disseminate information.

During SFY 2013, DBHDID developed a new curriculum for peer support persons who are interested in serving people experiencing substance use disorders. This is an urgent need since 60% of those with mental health problems also experience substance use disorders and 80% of those with substance use disorders also experience mental health problems.

Three (3) **Peer Operated Programs** are working on the process of establishing fidelity to the SAMHSA Consumer Operated System of Care Model. Participation Station in Lexington, Kentucky, (Bluegrass Regional MH/MR Board, Inc. region) and the Personal Involvement Empowering Recovery (PIER) program in Northern Kentucky (NorthKey Community Care region) are working on fidelity. There is also a new Participation Station in Bardstown, Kentucky. (Communicare, Inc. region) This new program began in March 2013. All three (3) of these programs are completely operated by consumers.

The goals for SFY 2014/2015 are to continue to provide credentialing for peers in Kentucky, both for Kentucky Peer Specialists and persons experiencing substance use disorders. Also, DBHDID hopes to offer peer support as a Medicaid billable service. In addition, DBHDID hopes to foster Consumer Operated programs in all regions through issuing an RFA (Request for Applications) to develop four (4) new programs using Mental Health Block Grant funding. During SFY 2013 an RFA was issued and awarded to four (4) regions. Those regions are currently working on establishing their programs with fidelity to the Consumer Operated Programs model.

KDBHDID and the Regional Boards use a number of strategies to support consumer and family involvement. Block Grant funding supports various consumer involvement activities, including:

- Encouraging increased collaboration between Regional Boards and advocacy organizations;
- Sponsoring or co-sponsoring recovery oriented events in the regions;
- Recovery oriented training and technical assistance from consumers and family members to state psychiatric hospitals and providers;
- Consumer support groups on a regional basis;
- Wellness Action and Recovery Plan (WRAP) trainings for consumers; and
- Reimbursement for consumer and family members to attend state and regional meetings, conferences, and other gatherings.

The DBHDID and the Regional Boards encourage consumer and family member participation in planning, monitoring, and service delivery. To improve on existing weaknesses and build on existing strengths, plans are to:

- Continue to involve consumers and family members in the Behavioral Health Block Grant planning process;
- Design programs, trainings, and outcome measures that incorporate recovery principles;
- Implement Supported Employment training to encourage hiring of consumers;
- Encourage the growth of consumer run services by encouraging processes that establish fidelity to the SAMHSA model of Consumer Operated System of Care;
- Continue to encourage statewide consumer participation at all planning events; and
- Make Recovery Model training available in all regions.

While the DBHDID and the Regional Boards have come a long way in fostering consumer and family member participation in planning, monitoring, and service delivery, many challenges remain, including:

- Lack of dedicated funding for consumer run services;
- Few programs that fully incorporate recovery principles;
- Limited number of consumer run services that can serve as “mentor” programs; and
- Persistent transportation barriers for individuals to attend meetings and other events.

## **EMERGENCY SERVICES**

Since 1995, the DBHDID has made a concerted effort to develop a statewide network of Crisis Stabilization Programs (CSU). These programs, which primarily serve individuals with SMI, can be home-based interventions or residential units and are a major factor in Kentucky’s stabilization of 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;
- Overnight Crisis Beds;
- 23 Hour Observation Beds in Hospitals; and
- After Hours Face to Face Crisis Evaluations.

Regional Boards have flexibility in how they choose to provide emergency services based upon the unique needs and population within their region. As such, the ideal array is not available in every region. For example, 12 of the 14 regions offer residential Crisis Stabilization Units or overnight beds. This flexibility does enable the regions to expand crisis services to meet their unique needs and one region has set aside one (1) bed in their facility to serve the crisis needs of adults with Developmental and Intellectual Disabilities. This has become a need in other areas and the Adult Crisis Directors group shares information and specific protocols when an individual is admitted to a Crisis Stabilization Unit (CSU).

The fourteen Regional Boards report, through their annual Plan and Budget submissions, that:

- All fourteen regions have a 24 hour Crisis and Information line;

- All fourteen regions have qualified mental health professionals on call for emergency evaluations for involuntary psychiatric hospitalization 24 hours a day, seven (7) days a week;
- All regions respond within three (3) hours to a request for involuntary hospitalization evaluation;
- Crisis Stabilization Units are available in eleven (11) regions and an additional region can offer overnight crisis respite beds;
- All regions provide walk-in crisis services in at least one (1) clinic in the region during business hours;
- Training is provided to law enforcement related to accessing emergency psychiatric care in every region; and
- Mobile Crisis Services are available in eight (8) regions.

A growing trend is the centralization of staff that performs various types of emergency evaluations, such as involuntary hospitalization certifications, jail triage emergency evaluations and walk in emergency evaluations. In the past all clinical staff was expected to do these as part of their work. By centralizing this as the sole duty of a few staff, it allows for specialization of screening, risk assessment, forensics, etc. for some staff, while at the same time allowing those who are providing psychotherapy to devote their schedules to the consumers they serve, without disruption. One region has developed a central triage center where all crisis calls, emergency evaluations and involuntary hospitalizations are screened and triaged by qualified mental health professionals who are empowered to arrange for an array of emergency services from expedited appointments to hospitalization at the point of contact. This center will be moving in the upcoming year from the hospital grounds and will be co-located with the regions substance abuse treatment staff which will provide an overlap of treatment options for Individuals with co-occurring disorders. Substance abuse treatment options, especially detoxification services, continue to be a gap in the service array that may improve if treatment becomes a Medicaid billable service in the general benefit package for the Commonwealth.

The goals for SFY 2014/2015 include:

DBHDID is refocusing Emergency Services as the public mental health safety net and expecting the regions to screen, triage and stabilize anyone presenting in crisis. Regions will either offer the full array of crisis services or have a memorandum of understanding with an adjoining region to provide that service and give that consumer in need a warm hand-off to that level of care. Regional boards in three (3) urban areas have begun working with their local hospital programs (University of Louisville, University of Kentucky and St. Mary's) to discuss and jointly plan for high utilizers of emergency services that present at the ER.

Continue to advocate for third-party payor reimbursement for the services based on the importance of the Adult Crisis Stabilization Programs in preventing inpatient hospitalizations. One managed care organization in the state has negotiated a rate for Over-night crisis stabilization.

Continue to look at technology and assessment protocols to strengthen the Jail Triage program. This programming is currently running very stable and anecdotal feedback from the jails always seems highly positive. Our jail triage funding held steady from recent years and we must continue to innovate to protect the gratifying success of the program and continued cooperation from the jail staff.

DBHDID will continue to provide a 40-hour course for law enforcement, considered Mental Health 101 by the Kentucky Department for Criminal Justice Training (DOCJT) twice annually. This course serves as an elective for any law enforcement officer in the state who wants to better understand not only persons with mental illness but also those with developmental disabilities, substance use issues, brain injuries, co-occurring



disorders and persons from the Deaf or Hard of Hearing community. A consumer of behavioral health services participates as an instructor in this training.

The Department will continue to build a working relationship with the Kentucky Department of Veterans Affairs, as well as the Veterans Administration, to explore further opportunities to enhance the current systems' response to veterans with Post Traumatic Stress Disorder, as well as other disorders, and their families. November 2012, the Department hired a program administrator to focus at least one-third of their time strengthening this collaboration with Veterans and their families.

### **REHABILITATION SERVICES** *(Includes Educational and Employment Services)*

The DBHDID incorporates the philosophy of “psychiatric rehabilitation” (outcomes improve when skills are taught in a social setting) and “recovery” (outcomes and satisfaction improve when consumers develop new meaning and purpose in life and grow beyond the catastrophic effects of mental illness) to assist the development of Community Support Services. As psychiatric rehabilitation technology has evolved, KDBHDID has promoted rehabilitation and recovery models through training, education, technical assistance, and targeted funding opportunities.

The DBHDID promotes the use of psychiatric rehabilitation technology by regional programs. The Psychiatric Rehabilitation model developed by the Center for Psychiatric Rehabilitation at Boston University was selected as the exemplary model as it has been extensively documented, validated, and replicated in hundreds of different settings for over two decades. This model also addresses the four major components of Community Support Services identified by KDBHDID with a focus on improving the lives of persons with psychiatric disabilities by enhancing their use of skills and/or environmental supports to live, learn, work, and socialize in the community and role of their choice.

Currently the DBHDID, Kentucky Medicaid, the Regional Boards, and other providers have not adopted a specific model of practice. Some programs have independently adopted a specific model but, without system support, have had difficulty implementing and maintaining a commitment to training and outcome measurement. The Psychiatric Rehabilitation model offers a method that would specifically address improvement in skills, functioning, social environment, and role attainment with a proven process, intervention, and technology base.

The DBHDID supports the provision of three key rehabilitative services at the regional level: **therapeutic rehabilitation**, **supported employment**, and **supported education**. While they each rely on psychiatric rehabilitation technology, they are supported in very different ways.

KDBHDID supports rehabilitation services through the Regional Boards in a variety of ways:

- The Division of Behavioral Health designates a statewide community support program coordinator;
- KDBHDID offers technical assistance and training for Community Support Program Directors who coordinate services for the state's **therapeutic rehabilitation programs** (TRP). **Therapeutic rehabilitation programs** are goal directed services aimed at improving skills in living, working and socializing in communities of one's choice. Technical assistance is provided to regional programs in how to incorporate psychiatric rehabilitation technology into daily programming;
- KDBHDID has an interagency agreement with the Office of Vocational Rehabilitation that uses CMHS Block Grant funds to leverage **supported employment** services for adults with severe mental illness. In SFY 2010, the Department secured funds from

the Johnson & Johnson Dartmouth Community Mental Health Program. This program provides funding and technical assistance for **supported employment** to State Mental Health Authorities (as of SFY 2013, seven (7) of fourteen (14) CMHCs are offering supported employment with “good fidelity” to the Dartmouth model); and

- Improving access to **educational services** through sites that provide Community Support Services remains a priority. According to the Kentucky Adult Literacy Survey, over 340,000 people lack the literacy skills necessary to compete in the workforce. Lack of literacy skills act as a hindrance to the personal advancement of another 656,000 Kentuckians. The lack of available educational services can seriously hinder persons with a severe mental illness in accessing and maintaining employment, and can negatively impact their quality of life. Providing access to educational support services has been a priority for Community Support Program Directors in community mental health settings.

Plan and Budget submissions for SFY 2013 reveal that access to rehabilitation services is available in all 120 of Kentucky’s counties in the following manner:

- All fourteen (14) regions have traditionally provided access to therapeutic rehabilitation program services. However, as of SFY 2013 only ten (10) of fourteen (14) regions provide access to therapeutic rehabilitation services;
- Eleven (11) regions provide access to long term supports through supported employment services for adults with severe mental illness (seven (7) through the Dartmouth model); and
- Three (3) regions have specific educational support available in their programs.

Although adult rehabilitation services are available, access to services is inconsistent and often inadequate to meet the need. Only a fraction of adults with SMI in the state participate in rehabilitation programs offered through the Regional Boards.

Most regions have adopted Illness Management and Recovery, as adapted from the evidence-based practice model articulated by SAMHSA, and have restructured their Therapeutic Rehabilitation services model to deliver this service, utilizing both professional staff and Peer Specialists.

The delivery of quality, timely rehabilitation services is challenged by a number of factors including:

- The current billing system that limits therapeutic rehabilitation as a site based service limiting community skills taught in the natural community;
- Kentucky Medicaid rates for therapeutic rehabilitation are quite low and significantly below the reimbursement rate for outpatient treatment services;
- Funding sources other than Medicaid do not reimburse for therapeutic rehabilitation services or else have challenging processes of reimbursement, so consumers without Medicaid have difficulty accessing this service;
- Therapeutic Rehabilitation Program services are inconsistent and have not adopted a specific model of practice with stated values, principles, practice guidelines, and expected outcomes of service;
- Certified Peer Specialist services is not yet a reimbursable service in Kentucky;
- Supported employment is not reimbursed by Medicaid and there is limited funding for the long term employment supports needed by adults with a severe mental illness;
- There has been difficulty gaining authorization for Therapeutic Rehabilitation Program services from Managed Care Organizations;

- Supported education is not reimbursed by Medicaid and is actually interpreted by some centers as being discouraged due to the possible interpretation of duplicity of services; and
- Difficulties with transportation, especially for consumers who do not receive Medicaid.

## **SUPPORT SERVICES**

### ***Criminal Justice System/Behavioral Health Interface***

Since the implementation of a multi-faceted legislative initiative in 1994, Kentucky has eliminated the use of jails during acute psychiatric crises and the involuntary hospitalization process. Instead, consumers are evaluated in emergency rooms or other safe, secure locations by staff of Regional Boards. These efforts have:

- Increased understanding of mental illness by emergency responders such as ambulance drivers, paramedics, and peace officers;
- Improved access to evaluation and treatment;
- Improved communication among local peace officers, judges, mental health professionals, other community resources and the general public; and
- Reduced the stigma and trauma of involuntary hospitalization.

KDBHDID has intensified efforts to build an integrated service system for individuals with severe mental illness who are involved in the criminal justice system, by collaboration between KDBHDID, the Kentucky Department of Corrections, and other stakeholders in our communities' "safety net" to serve persons with mental illness.

Regional Boards provide training to a number of entities in the criminal justice system in order to assure that persons with serious mental illness are diverted into treatment whenever possible rather than being arrested and booked into jail. In Jefferson County, Louisville Metropolitan area, the Crisis Intervention Team (CIT) within the Police Department has been in place for over seven (7) years and has successfully diverted thousands of individuals into care. During SFY 2012, 68 Louisville Metro Officers were trained in CIT. This made a total number of Louisville Metro Officers trained to date, 675, or over 50% of their 1216 total officer force. Their goal is to make sure at least one (1) CIT trained officer is on each shift. CIT trainings in Jefferson County are not funded by mental health block grant or state mental health monies.

Jefferson County's circuit and district courts also have mental health diversion programs which work with regional board to operate post-booking interventions to divert many consumers into treatment and aftercare rather than long-term incarceration. Female clients with trauma history are represented at rates higher than the national average in therapeutic courts in Jefferson County. This led to a BJA expansion grant. Thru the technical knowledge gained, assessment protocols and more formal treatment modalities to address co-occurring issues were implemented. This region plans for continued expansion of mental health court programs to include Circuit court and a track for Assertive Community treatment. Programming continues to include: Illness Management and Recovery (IMR), Integrated Dual Diagnosis Treatment (IDDT), trauma informed and gender specific groups (including the Hands Off program to address the link between trauma and theft behavior). Cognitive Behavior Therapy (CBT) programming will focus on criminogenic factors that impact recidivism.

In SFY 2002, as the result of a series of investigative reports published in the Louisville Courier Journal related to suicides in local jails, the legislature appropriated \$550,000 to KDBHDID to develop a training curriculum for jail staff to address this issue. During SFY 2003, KDBHDID developed, implemented and monitored this training curriculum on suicide

prevention and recognizing the signs and symptoms of mental illness. Regional board staff were trained in a “model curriculum” and then expected to train the staff in their local jails. In addition to this training, Regional Boards were encouraged to improve their working relationships with the local jails to assure mental health needs were being met for inmates housed in these facilities.

The relationship between Regional Boards and local jails has continued through the delivery of the mental health and suicide prevention triage assessments the Boards have been providing. Funding was also included to provide consultation to the jails on an as needed basis to improve jail personnel’s response to inmates with behavioral health needs. Regional Boards report entering into formal agreements with their local jails in thirty-one (31) counties across the Commonwealth.

With the passage of Senate Bill 104 in 2007, the Kentucky Legislative Session established a statewide curriculum for training of law enforcement officers in the Crisis Intervention Team (CIT) Memphis model. The goal for SFY 2014/2015 is to continue to expand CIT trainings throughout the state. As of this year, over 1168 officers (including sheriff’s departments, local police departments, state police officers, etc.) have been trained as members of Crisis Intervention Teams. Ten (10) regions to date have CIT advisory committees, which also involve mental health professionals, advocates and consumers alongside local law enforcement officers to enhance community collaboration.

KDBHDID has also partnered with the Kentucky Department of Corrections (DOC) on a re-entry project, partially funded by block grant funds. This program allows for strategic planning and case management for inmates with mental illness who are exiting Kentucky prisons and returning to their communities. The Boundary Spanner project employs a re-entry case manager who works to form a bridge of services between the prison system and the individual’s home community. This enables the connection to behavioral health services to be planned and provided a “warm hand off” to the community mental health center. This program has been challenged by the passage of HB 463, which qualifies some offenders to be paroled or released early under mandatory release supervision conditions. This has created a demand for assistance in applying for Social Security benefits and behavioral health services months before the previously anticipated release dates. Other projects that the Department is involved in include a Diversion Program being led by the Kentucky Department of Public Advocacy, which places a social worker in public defenders’ offices across the state to develop diversion alternatives for persons with behavioral health issues.

KDBHDID’s Community Mental Health Centers (CMHC’s) contract language changed for SFY 2012 to allow for individuals within the Department of Corrections Correctional Psychiatric Treatment Unit (CPTU), an all male unit within one prison and the Psychiatric Care Unit (PCU), an all female unit within another prison, who are serving out of or being paroled from one of the two (2) units, to be served as a priority population by the Regional Boards. This will allow high risk individuals who are serving out of or being released from the CPTU and PCU to be seen within fourteen (14) days of release at a CMHC for mental health and medication management services. By having this population be seen as a priority population, the hope is that recidivism will reduce for this group of individuals. KDBHDID’s Adult Services Branch and the Department of Corrections Mental Health Division are working collaboratively to develop a Memorandum of Understanding to include data sharing and collection mechanisms, and to gather information to help facilitate a smooth transition for all parties.

KDBHDID has been actively participating on the Governor’s Reentry Taskforce, helping to develop recommendations for legislation in order to reduce many of the negative outcomes that are associated with incarceration and help to improve the reentry process for individuals

with behavioral health issues. Goals for SFY 2014/2015 are to continue to collaborate with state and local entities in order to improve overall outcomes for individuals with behavioral health issues who are involved in the criminal justice system as well as improve access to substance abuse treatment services.

### ***Services to Persons who are Deaf and Hard of Hearing***

Effective behavioral health and substance abuse treatment begins with communication. If an individual is not provided language access, s/he is essentially blocked from the recovery services available to those proficient in spoken English. This fact is a common barrier for individuals who are Deaf, Hard of Hearing, or Deaf-Blind and need to access the CMHC system and state facilities. The Kentucky Deaf and Hard of Hearing Services (DHHS) staff strives to create an environment where individuals have linguistically accessible and culturally affirmative services. Through training, technical assistance, collaboration with community partners, funding assistance, program development, and policy review, DHHS aims to address unmet needs for the population. The program functions with one (1) full-time staff member. Lack of sufficient numbers of human resources necessitates creativity and collaboration in developing and implementing effective mental health services. Developing a network of skilled direct service professionals is key. Only two (2) regions have specialized staff dedicated to Deaf and Hard of Hearing Services: Bluegrass Mental Health / Mental Retardation Board has two (2) full-time therapists and one (1) part-time case manager. Seven Counties Services has two (2) full-time and one .2 FTE therapists. Most consumers in the CMHC system must still access services through an interpreter and with clinicians who have limited experience with the biopsychosocial effects of hearing loss. Training of clinical staff, interpreters, and peer specialists emphasize the importance of direct communication and lived experience.

Priorities for DHHS for SFY 2014/2015 include the following:

- Obtaining an Eastern Kentucky and a Western Kentucky Regional Coordinator to address the unmet needs in rural areas.
- Establishing a department-wide team to address quality assurance for all programs and services reaching individuals who are Deaf or Hard of Hearing in the Community Mental Health Centers and state facilities.
- Rolling out updated Standards of Care for Deaf and Hard of Hearing Services to be integrated into all Community Mental Health Center and state facility policies and procedures.

In addition, the following objectives for DHHS are noted for SFY 2014/2015:

- Support for four (4) interpreters to attend the Alabama Mental Health Interpreter Training then return to their state hospital regions to provide specific training and outreach to providers, consumers, and fellow interpreters on Best Practices in mental health interpreting. By the end of SFY 2015, at least fifteen (15) Kentucky interpreters will have this specialized training. Graduates will also continue to present a mental health track at the Kentucky Registry of Interpreters for the Deaf Spring Conference.
- Recruit, hire, train, and supervise up to eight (8) AmeriCorps volunteers each year in order to develop the workforce of individuals skilled in providing Deaf Mental Health Care and to address unmet service needs statewide.
- Conduct Communication Assessments for individuals who are Deaf with language dysfluency in order to provide recommendations for effective communication in evaluation and treatment. Work in collaboration with the Administrative Office of the Courts and the Office of Vocational Rehabilitation as well as university American Sign Language professors to develop a standardized protocol, process, and usage plan statewide.

- Address the need for children’s services through collaboration with the Children’s Branch, Kentucky School for the Deaf Statewide Outreach Center, and the parent group Hands & Voices. Participate in statewide outreach events and the Family Learning Vacation each year.
- Continue to reimburse for qualified mental health interpreters in Community Mental Health Centers and to develop partnerships with providers statewide.

The staff within the **Deaf and Hard of Hearing Services** program have been working to positively affect the quality of mental health services for this population. During SFY 2011, over thirty-three (33) training events were held, reaching over five hundred (500) people. During SFY 2011, work with Project SAFE (Safety and Accessibility for Everyone) led to a statewide look at Trauma Informed Care in Deaf Services and several workshops for shelters. A module regarding the needs of Deaf or Hard of Hearing citizens was added to the Department of Criminal Justice Training (DOCJT) “Special Needs” class that is now presented twice a year. In addition, a tri-state conference on adapting substance abuse treatment was presented with national expert Deb Guthman both live and utilizing the Deaf Off Drugs and Alcohol technology for remote participants. Training in SFY 2012 shifted to focus on intensive training for direct service providers and taking our approaches to a regional and national scale. Over thirty-five (35) trainings were held. Highlights included reaching parents of mainstreamed children through outreach events, working with the Child Advocacy Centers to address trauma in children, and collaborating with the KY System to Enhance Early Development (KYSEED) to present workshops statewide for case managers. In addition, technology was used to reach individuals in Developmental Disability / Intellectual Disability programs and those efforts continue in earnest today.

*Addressing Unmet Needs for Direct Service*

Data collected from the CMHCs indicates that those who are Deaf or Hard of Hearing with SMI, SED, or DD/ID designations continue to be under-served in terms of case management, service coordination, or wraparound services. The Eastern Kentucky and Western Kentucky Regional Coordinators will work to address these needs. Their role will also include case finding since under-reporting and under-utilization of services are suspected.

Eastern Kentucky

CMHC	ALL SMI	SMI with CM	ALL SED	SED with CM	ALL DD/ID	DD/ID with CM
Pathways	83	21	9	3	18	7
Mtn	170	28	18	6	9	3
Kentucky River	0	0	0	0	0	0
CRCC	320	31	27	3	19	10
Adanta	0	0	0	0	0	0
TOTAL	573	80	54	12	46	20

## Western Kentucky

CMHC	ALL SMI	SMI with CM	ALL SED	SED with CM	ALL DD/ID	DD/ID with CM
Four Rivers	45	6	8	0	36	21
Pennyroyal	0	0	0	0	0	0
River Valley	51	13	0	0	2	2
Lifeskills	10	2	8	5	1	1

### **Case Management Services**

Case management is an essential Community Support Service because it coordinates an individual's service array, making maximum use of available formal and informal supports. Case management has been available through Regional Boards since 1985 and was first covered by Kentucky Medicaid in 1991. Priority is given to adults with severe mental illness who have the greatest difficulties accessing resources and those with more intense service needs. Kentucky embraces a strengths based model advocated by the University of Kansas (Dr. Charles Rapp) blended with the psychiatric rehabilitation model endorsed by Boston University (Dr. William A. Anthony). Kentucky's Case Managers have caseloads of 25-30 individuals, with a maximum caseload of 35.

During SFY 2008, an Advisory Committee was formed, consisting of key CMHC and KDBHDID staff. The Case management certification training curriculum was updated through the input from this Committee and was placed in an online format. Face-to-face Level I Case Management certification training requirements were decreased from 2 ½ days to 1 day. Newly hired case managers are now able to begin certification training immediately upon hire, by utilizing the information module online. The certification exam was also placed in an online format. Designated Department staff monitors exam status and issues certificates upon completion of all the required elements.

So far in SFY 2013, approximately 45 case managers received Level I Case Management training. Level II Case Management training is scheduled for later in the fiscal year involving advanced documentation and goal setting.

During SFY 2012, three (3) Level II Case Management trainings were held at different geographical venues across the state regarding Motivational Interviewing. DBHDID held one training at Jenny Wiley State Park in the eastern part of the state, one training at Pennyroyal State Park in the western part of the state and one training in Lexington, Kentucky in the central part of the state. Approximately eighty two (82) case managers were trained in Motivational Interviewing techniques.

KDBHDID supports case management through the Regional Boards in a variety of ways:

- The Division of Behavioral Health designates a statewide coordinator of case management services;

- KDBHDID requires and provides certification training for all case managers within six months of employment.
- The KDBHDID provides additional training opportunities for case managers and case management supervisors; and
- Adaptations of evidence-based practices such as Assertive Community Treatment are occurring as pilot projects in a few regions in the state and are being studied for possible expansion and implementation in other regions.

Case management services are available in all 120 of Kentucky's counties. Currently, case managers provide support to approximately 8,933 individuals with severe mental illness in a variety of ways. Plan and Budget submissions from the regions show that:

- Seven (7) regions report having an Assertive Community Treatment Team, although fidelity to the evidence-based practice is low;
- Eight (8) regions report having mobile outreach teams;
- Five (5) regions provide specialized intensive case management for forensic clients and;
- Five (5) regions provide continuity of care case management for special populations.

During SFY 2014/2015, the focus will be on maintaining stakeholder relationships, through the Advisory Committee, and continuing to respond to the needs of providers as well as monitoring the needs of consumers. There will be continued training opportunities for case managers, offered by the DBHDID, designed to enhance the effectiveness of working with adults with SMI.

***Community Medication Support Program (CMSP)***

KDBHDID supports the Community Medication Support Program (CMSP), a drug replacement program that provides low cost medications to the population who are living below poverty level and who do not otherwise qualify for federal or state assistance. This program is the result of a unique collaborative effort by the state operated/contracted psychiatric hospitals, the Regional Boards, KDBHDID, and local pharmacies. The goal of the program is to assist adults with SMI (and children with SED) who have no other means of purchasing prescribed psychotropic medication. Prescriptions are filled at local pharmacies, and then the medications are replaced to the pharmacies by our state operated/contracted hospitals. The program is available in all regions. Eligibility for the CMSP is based on age (18+), income (federal HHS poverty guidelines and no third party payer sources), and KDBHDID criteria of SMI (diagnosis, disability and duration). During SFY 2011, KDBHDID partnered with the Kentucky Prescription Assistance Program (KPAP) administered by the Department of Public Health (DPH) in an effort to support a program for those indigent persons receiving services through Regional Boards to obtain free or reduced pharmaceuticals, including any pharmaceuticals needed for physical health. The goals of this partnership are to significantly increase access to the Pharmaceutical Companies Prescription Assistance Programs (PAPs); mobilize communities to assist their neighbors in obtaining free and reduced cost prescription drugs; expand collaboration with existing organizations who provide services to the underserved and uninsured, reducing duplication of effort; and promote integration between the primary healthcare system and mental healthcare system to provide a continuum of care for those individuals being served. Since its inception in 2008, KPAP has obtained \$90M in free medications overall. In SFY 2014, there will be a .5 FTE employed by each of the Regional Boards and a staff person within the Division of Behavioral Health that will be ensure maximum benefit of this program and systematic operational protocol.



## **Housing Services**

The KDBHDID Housing Coordinator works with consumers, Regional Boards, the Kentucky Housing Corporation (KHC), the Kentucky Interagency Council on Homelessness, other state agencies and non-profit organizations to develop housing options, foster collaboration among housing and homeless programs, and support local efforts through:

- Technical assistance with other agencies and housing services providers;
- Planning and coordination with other agencies;
- Presentations related to housing; and
- Special training events.

Additionally, KDBHDID collaborates with KHC in these key initiatives:

- The Supportive Housing Specialist position, which is jointly funded by the KHC and KDBHDID, works to further integrate the housing needs of persons with mental illness into the state housing finance agency's programs.
- Technical assistance and consultation in developing housing projects is provided to local nonprofits by the Specialist.
- For SFY 2014, KDBHDID will continue to provide \$386,000 in funding to KHC to develop affordable housing options for persons with psychiatric disabilities through the application of funds by Kentucky Housing Corporation in their administration of the Olmstead Housing Initiative. These funds are used for rental assistance and moving expenses; and for SFY 2014, the development of supportive housing units.
- Providing SSI/SSDI Outreach, Access, and Recovery (SOAR) technical assistance and support to case managers, re-entry coordinators and other social services workers throughout the state to give them the knowledge and information needed to successfully assist disabled persons in accessing SSI/SSDI, as a first step toward gaining housing and independence.
- Promoting expansion of local SOAR initiatives by Regional Boards and non-profits across the state.

Regional Boards use a variety of strategies to develop housing options for individuals with severe mental illnesses. Some focus on actual housing development by employing regional housing developers; others focus on housing access by administering their own Section 8 set-aside programs or through collaborative arrangements with local public housing agencies. Information from Plan and Budget submissions from the Regional Boards for SFY 2013 reveals that:

- There are currently 711 units in 61 projects operated by the Regional Boards;
- Many regions also operate a Tenant Based Rental Assistance program or access other assistance, providing over 100 vouchers across the state;
- Nine (9) regions operate housing projects that provide residential support;
- Eight (8) regions have organized formal supported housing programs;
- Seven (7) regions are involved in housing development;
- Eight (8) regions report having developed a regional housing plan; and
- Twelve (12) regions provide specialized housing training to agency staff.

Goals for SFY 2014:

- Continue to provide training and support to the Regional Boards through implementation of SAMHSA Supportive Housing Toolkit;
- Increase access and availability of housing options for priority populations through the application of the Olmstead Housing Initiative funds and other KHC programs, promotion of the "Housing First" model. Our Housing Specialist is on the Advisory Committee for a Housing First program in Louisville through the Phoenix Health Center. DBHDID continues to support this model through Department efforts and through the Interagency

Council on Homelessness. The Center for Rehabilitation and Recovery has actually changed their name to Housing First; and

- Collaborate with Regional Boards and non-profits in establishing local SOAR initiatives.

Goals for SFY 2015:

- Provide technical assistance and support toward promoting fidelity to the Supportive Housing EBP. DBHDID will be providing additional training and assistance to two of our Specialized Personal Care Homes as they move from a PCH model to a Supportive Housing model;
- Continue to work with housing partners in increasing access for the priority populations through "Housing First";
- Continue to promote establishing local SOAR initiatives, and monitor and support existing initiatives.

## **REDUCTION IN INPATIENT PSYCHIATRIC CARE**

### **CONTINUITY OF CARE**

The Department believes that addressing the issue of continuity of care through a well-planned aftercare process is the key to ensuring a successful transition from the hospital to the community. Providing appropriate aftercare following a state hospital stay is critical to reducing readmission rates. The Department requires a Regional Board to provide an outpatient appointment within two weeks of a discharge. KDBHDID also requires the provision of case management services to adults with severe mental illness who are discharged from a state psychiatric facility, are determined by hospital staff to be in need of case management service, and agree to receive this service. As of SFY 2013, DBHDID also requires an outpatient appointment within two weeks of discharge from the treatment units of the Kentucky State Reformatory, a prison in LaGrange, Kentucky that houses two separate mental health treatment units.

The fourteen Regional Boards and the state operated/contracted psychiatric hospitals must work closely together to assure continuity of care. Contracts with all parties address continuity issues such as medications, discharge plans, case management and outpatient referrals. Some Regional Boards function as a single portal of entry for some of the hospitals. Due to the uniqueness of the providers and each individual they serve regular continuity of care meetings between the respective hospital and local Regional Boards is initiated by DBHDID staff. The agenda for each meeting includes the following topics:

- Aftercare performance;
- Community Medications Support Program;
- Olmstead planning;
- Continuity of care systems issues;
- Consumer issues;
- KDBHDID Performance Indicators; and
- Other issues requested as they may arise among participants.

During SFY 2005, KDBHDID worked with each of the state operated/contracted psychiatric hospitals and their assigned Regional Boards to develop a Memorandum of Agreement (MOA) between the two entities. In order to assure a seamless system of care, the need to develop these MOAs was identified to strengthen the relationships between the hospitals and the Boards. The MOAs include the contractual responsibilities each entity has to the

KDBHDID, but also defines and clarifies roles and responsibilities the hospital and Regional Boards have to assure quality continuity of care to patients that they both serve.

KDBHDID strategies to reduce unnecessary psychiatric inpatient utilization include the development of residential crisis stabilization programs, responsive emergency services, assurance of continuity of care and the continued development of other community support services as effective alternatives for adults with serious mental illness who are in crisis.

KDBHDID has responsibility for the monitoring of the Kentucky **Olmstead Initiative** in each of the four state operated/contracted psychiatric hospital regions. Transition teams comprised of the representatives from the hospital, the Regional Board, KDBHDID staff, and other appropriate stakeholders meet on a frequent basis to review transition plans that assure a smooth and timely discharge to the community for identified patients. Funds were appropriated during the 2002 legislative session and in subsequent biennial budgets to pay for individualized and specialized wraparound services to assure the community tenure for each of these individuals.

Continuity of care is a major priority for the Department. A number of challenges are presented to KDBHDID and the Regional Boards. These include:

- Private psychiatric beds have been closing or are being converted to acute care beds which generate more revenue;
- The loss of private psychiatric beds in local private hospitals has placed a strain on state operated psychiatric hospital by increasing admissions;
- While crisis stabilization programs have existed in all fourteen (14) regions since SFY 2004, confidence in their appropriateness as alternatives to hospitalization remains low among many psychiatrists and utilization remains relatively low in some programs;
- Supervised residential options are sparse throughout Kentucky, thwarting efforts to discharge individuals with complex service needs; and
- The unavailability of adequate funding for community-based services as alternatives to hospitalization remains a barrier to good continuity of care.

Budget cuts in SFY 2009 resulted in one region reducing staff in their crisis stabilization unit and subsequently reducing the level of care for that program. One other region closed its community-based crisis stabilization unit and moved it to the grounds of the state psychiatric facility in order to be more cost efficient. Budget issues in SFY 2012 resulted in one region closing their crisis stabilization unit. Plans for SFY 2014/2015 are to continue to support appropriate utilization of regional crisis stabilization units as a diversion to inpatient care.

A crisis services/emergency services workgroup has been formed by DBHDID during SFY 2013. This workgroup consists of DBHDID staff responsible for crisis services in adult and children's areas, as well as an outside consultant. Goals for this workgroup include a redesign of data gathering methods as well as more detailed review methods for each crisis unit.

A project entitled **DIVERTS** (Direct Intervention: Very Early Treatment System) was implemented in the Western State Hospital Catchment area during SFY 2007, as a partnership between KDBHDID, the four respective Community Mental Health Centers (CMHC) and the National Alliance of the Mentally Ill (NAMI). The goal was to reduce psychiatric hospitalizations. Approximately two million dollars that had originally been budgeted to the psychiatric hospital in Western Kentucky was instead allocated across the four Boards serving that hospital "catchment" area. The aim of this project was to reduce admissions to the hospital. Regions have been creative in addressing the issue of lowering

hospitalization rates by providing specialized case management and other support services. Results have been good. One of the four regions reduced hospitalizations by 49% in SFY 2007 and by 5% in SFY 2008. Further reductions in hospitalizations have occurred in each fiscal year. The goal for SFY 2014/2015 is to continue the trend of reducing psychiatric hospitalizations.

An expansion entitled **DIVERTS II** is being finalized for SFY 2014/2015. This project reallocates over four (4) million dollars from psychiatric facilities to the remaining CMHCs to be used to relocate adults with SMI from residential personal care homes to homes in the community. Details continue to be established but services utilized will include four (4) evidence based practices, **Assertive Community Treatment (ACT)**, **Supported Employment (SE)**, **Supported Housing**, and **Peer Support**.

**Geographic Area Definition – Children’s Mental Health**

*Narrative Question: Establishes defined geographic area for the provision of the services of such system.*

Kentucky is divided into fourteen geographic regions for the purposes of planning and providing publicly funded community mental health, substance abuse prevention, and substance abuse treatment services. Together, the Regional Boards serve all 120 Kentucky counties. For each region, a Regional Board has been established pursuant to KRS 210.370-210.480 as the planning authority for community mental health programs in the region. County and municipal governments do not provide community mental health services. A Regional Board is:

- An independent non-profit organization;
- Overseen by a volunteer board of directors that broadly represents stakeholders and counties in the region; and
- Licensed by the Cabinet for Health and Family Services as a “Community Mental Health Center.”



*Originally, the Regional Boards were totally aligned with the Area Development Districts but in recent years Pathways serves two Development Districts, FIVCO and Gateway.*

The Department for Community Based Services has nine (9) regional districts. The Department for Juvenile Justice and the Administrative Office of the Courts follow judicial

districts. For public health services, seventy-four (74) counties are served by 15 district health departments and forty-six (46) counties are served by a health department in their county. There are 174 school districts across the state.

## 2) Available Resources Children's Mental Health

*Narrative Question: Describe available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:*

- *Health, mental health, and rehabilitation services;*
- *Employment services;*
- *Housing services;*
- *Educational services;*
- *Substance abuse services;*
- *Medical and dental services;*
- *Support services;*
- *Services provided by local school systems under the Individuals with Disabilities Education Act;*
- *Case management services;*
- *Services for persons with co-occurring (substance abuse/mental health) disorders;*  
*and*
- *Other activities leading to reduction of hospitalization.*

## **HEALTH, MENTAL HEALTH AND REHABILITATION SERVICES**

### **Health**

The interface between the physical healthcare system and the behavioral healthcare system is of growing importance to providers of behavioral health services. It is well known that a significant amount of behavioral health services are provided in the physical healthcare arena. Continuity of care across these systems is critical if children and families are to get the most beneficial services possible.

Regional Boards are required to conduct a physical health screening of all clients served. Department staff has assisted several regions in improving tools used to assess physical health concerns and continues to encourage further assessment and integration of physical and behavioral healthcare.

Per contract obligation, the five managed care organizations (MCOs) providing Medicaid services submit data to KDBHDID on a regular basis. The following 4 of the 13 reports provide information about physical health of children and adolescents:

- Behavioral Health Pregnant and Postpartum  
This report identifies the utilization of behavioral health services provided to pregnant and postpartum members. The postpartum period covers sixty (60) days after the date of delivery. All claims activity paid or denied during the reporting period is to be reported.
- EPSDT for Behavioral Health Population  
This report identifies the utilization of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services by the behavioral health populations. All claims activity

paid or denied during the reporting period is to be reported. All provider types billing for mental health or substance abuse services are to be reported.

- Behavioral Health Annual Wellness  
This report associates wellness checks provided to behavioral health populations by procedure code. All claims activity paid during the reporting period is to be reported.
- Behavioral Health and Chronic Physical Health  
This report identifies the chronic physical health issues associated with children and adults who also are defined as one of the four major behavioral health populations. All claims activity paid or denied during the reporting period is to be reported. All provider types billing for mental health and substance abuse services are to be reported.

These reports are reviewed by department staff. Department staff then meets with each MCO approximately every six to eight weeks for planning and technical assistance.

### Mental Health and Rehabilitation Services

All Regional Boards have a designated Children's Services Director. These Directors, along with other leaders, seek to ensure that the mental health service needs of children and families in their service region are assessed, addressed and evaluated in a structured, yet flexible manner. Such services are designed to meet the holistic needs of children with SED, as well as those of the general population of children served in their region.

A review of the information from the SFY 2014 Annual Plan and Budget applications reveals that Regional Boards continually strive to address barriers and meet the clinical service needs of children and families. Some examples of this include:

- Nine regions can get a child in for an initial intake appointment for a non-emergency in the same week that they contact the center;
- Eight regions provide walk-in crisis services for children and their family members during the evenings and weekends after clinics have closed;
- All regions offer off-site therapy services at the home of the child and throughout the community;
- The CMHCs employ 359 Service Coordinators to provide targeted case management to children and adolescents with SED;
- Eight of the fourteen regions offer specialized summer programs;
- Thirteen regions employ at least one designated Early Childhood Mental Health Specialist who provides therapeutic services for children birth to five years of age and education and consultation to others working with this population. In addition, the regions report employing 352 additional staff who have experience serving children birth through five and their families;
- Three regions have a Youth Representative on the Regional Interagency Council; and
- Six regions have a Parent Representative on the Center's Board of Directors.

Kentucky's Medicaid State Plan includes the Rehabilitation Option for behavioral health, including statewide coverage for therapeutic rehabilitation and targeted case management for children with SED. Eight of the Regional Boards operate day treatment programs and three Regional Boards operate partial hospitalization programs. There are additional Day Treatment programs, across the state, that are operated by the school districts and several private hospitals operate partial programs. Two Regional Boards also operate residential substance abuse programs for adolescents that offer integrated mental health services.

The Regional Boards rely heavily on their Kentucky IMPACT programs that offer targeted case management services, utilizing wraparound, to ensure that children with SED receive needed services and supports. Over \$5 million in state general funds is allocated to the Regional Interagency Councils that govern these Kentucky IMPACT programs. These funds

are used to support program operation, including employment of Family Liaisons and flexible funds to meet the needs of youth and families. Kentucky IMPACT is available to children with SED regardless of whether they are Medicaid recipients. Most of the Kentucky IMPACT programs offer therapeutic aide services whereby a child is assigned an aide that will act as a mentor and skills-building coach. Many of the children, receiving IMPACT services, work to improve organizational skills, impulse control skills, social skills and coping skills. Services may occur on or off site to allow for “real life” learning experiences. The majority of IMPACT services occur in the home, school or community. Some IMPACT programs also offer after-school and/or extended summer programs where children may receive individual and group therapeutic services, as well as mentoring services. The table below represents an overview of the Available Services Array for Children provided by each of the fourteen Regional Boards across the state.

Children's Array of Services: Availability by Region from Plan & Budget Application for SFY14

Children and Youth Services Array/Number of Counties														
Regions	1	2	3	4	5	6	7	8	10	11	12	13	14	15
<b>Services</b>														
Clinical Services (Individual, Collateral, Family - provided by a Child Clinician at least 50% of time spent serving children and families)	9	8	6	10	8	7	8	5	10	5	8	8	10	17
Psychiatric Services (provided by a Child Psychiatrist-with at least one year of specialized child training)	9	2	6	8	8	7	8	2		5	8	8	8	17
Early Childhood Specialist	9		5	1	8	7	8	5	10	5	3	1	9	17
Other Early Childhood Clinician (who has received training and is supervised by the ECMH Specialist)				10	8	7	8	5	10	5	5	8		4
Paid Full-time Family Liaison			6	10		7		5	5		1			4
Paid Part-time Family Liaison					8		8							
Paid Full-time Kentucky Family Peer Support Specialist			6		1	1	8		5					
Paid Part-time Kentucky Family Peer Support Specialist							8					1	1	
Service Coordination for Children Age 0-5	9	4	6	10	8	7	8	5	10	5	8	8	10	17
Therapeutic Child Support Services		8		6		7	8		10	5	2	8	10	
School-Based Services	9	7	6	10	8	7	8	5	10	5	8	8	10	17
Intensive In-Home Services				10	8	1			5			8	4	17
After School Program		4			4				1			8		
Specialized Summer Program				7	8	1	3	1	10	5	8	8	9	
Respite Care		5		6	8	1		5	10					
Day Treatment Program					2	1	8			5		1		
Treatment Foster Home(s)		5		7				5		5				
Partial Hospitalization Program	1		1				8							
Crisis Services (M=Mobile, U=Unit, O=Other)	O	M	O	U	U	U M	M	U	U	U	U	U	2U	M



## **EMPLOYMENT**

Youth served in the Kentucky IMPACT programs across the state are given an opportunity to practice skill sets to prepare them for employment. Such vocational skills training may include writing resumes, job interviewing, and assistance retaining employment.

Supported Employment services are a needed service for transition age youth and are being addressed through several targeted initiatives, including the Johnson & Johnson/Dartmouth Supported Employment grant and the Kentucky Partners for Youth Transition trainings.

### **Kentucky Partners for Youth Transition**

The Department began coordinating an interagency workgroup in January 2008 to work collaboratively to promote and utilize best practices across all communities and systems that touch the lives of young adults (14-25 years old) with behavioral health concerns called Kentucky Partners for Youth Transition. Independent Living skills, employment skills and housing supports are important goals for the partners. The partnership includes seventeen agencies and advocacy organizations as well as youth/young adults and family members. The Partnership hopes through its efforts:

- Youth with serious behavioral health concerns will have earlier, faster and easier access to the developmentally appropriate care that they need.
- That the folks who work with youth will have the specialized skills necessary to adequately support youth through their transition age years – focusing on positive youth development and the transition domains of education, employment, living situation, and the life in the community.
- That youth will feel supported through the care they receive and that they will travel seamlessly through this care.

Successes around employment, housing and independent living from the Partnership and individual agencies that have/are taking place include the following:

- Kentucky's child welfare department, Department for Community Based Services, has made transition planning a priority and they have several initiatives occurring currently to better identify supports for youth prior to leaving care.
- Workgroup members are becoming educated on asset development and are sharing training and grant opportunities with young adults.
- The Kentucky Office of Vocational Rehabilitation is focusing on Asset Development by training staff on the FDIC Money Smart Curriculum to use with the young adults they work with. This will assist these young adults in becoming financially stable and increase their independent living skills, which will increase their opportunity to secure stable housing.
- The Partnership developed a best practice curriculum that can be used across disciplines and teaches the current best practices for working with transitioning youth. The six hour training for case managers/service coordinators is called Transition Age Youth Launching Realized Dreams (TAYLRD). The training has been held five times around the state to approximately 290 participants.

At their February 2013 quarterly meeting, the Partners engaged in a priority setting exercise to determine goals for the coming year. The top three priorities were improving access to resources, staff training and youth empowerment.

## **HOUSING**

Regional Boards strive to offer community based programs for children with SED that will allow them to remain in their own homes and communities, rather than in residential settings. They collaborate with the Departments for Community Based Services (DCBS-child welfare agency) and Juvenile Justice to maintain children in their own homes and communities whenever possible and when in the best interest of the child.

KDBHDID does not assume custody of children within the state, nor do it operate a children's psychiatric hospital or any other residential program for children. The Regional Boards, under contract with the Department, do offer a limited amount of residential care. Therapeutic foster care is offered in four of the fourteen regions, with a total of 72 foster homes. There are also a few Boards that offer overnight respite services on a limited basis. There are ten residential crisis stabilization units for children across the state, with a total of 96 beds. Ten Regional Boards offer mobile crisis stabilization services and may contract for overnight beds with a variety of providers (e.g., 23 hour acute hospital beds, private crisis stabilization residential program beds and private child care beds). Collectively, the five regions without a unit report availability of an additional 10 beds.

The Department for Community Based Services (DCBS-child welfare agency), within the Cabinet for Health and Family Services, is responsible for investigating child dependency, abuse and neglect and making recommendations to the courts. When deemed necessary, the Department for Juvenile Justice (DJJ), within the Justice Cabinet, also may assume custody of children. The Department collaborates with these two state agencies to ensure that the behavioral health needs of children are appropriately identified and addressed. DCBS and DJJ contract with Regional Boards and private providers to meet the residential needs of children in their custody.

#### Child Hospitalization Data

KDBHDID and Regional Board program staff, particularly emergency services staff, monitor children's psychiatric hospitalization rates. The Office of Health Policy within the Cabinet for Health and Family Services collects hospital utilization data and reports on it annually. In calendar year 2012, Kentucky experienced its first full year of managed care of Medicaid. There were 694 psychiatric beds within 13 hospitals available for youth aged birth to 17 years. 192 of these beds are for youth between the ages of 0-12 years old and 546 of these beds are for youth between the ages of 13-17 years old. The hospitals experienced 9,694 admissions, 165,045 inpatient days, and an average length of stay of 17.31 days for the year. On an average day, 451 children were utilizing these psychiatric beds (occupancy – 65%); *(Comparatively, in 2006, there were 633 beds; 7,705 admissions; 195,533 inpatient days; and the average length of stay was 25 days. In 2004, there were 612 beds, 8,536 admissions, 187,892 inpatient days and the average length of stay was 21.6 days.)*. 43% of the children's psychiatric beds are located in the state's largest city, Louisville; there are no beds in far western Kentucky nor in the four far eastern CMHC regions of the state.

Psychiatric Inpatient Utilization - Statewide - Children 0-17 Years of Age						
Year	Licensed Beds	# of Psy Beds	Admissions	Inpatient Days	ADC	ALOS
2012	1,285	694	9,694	165,045	451	17.31
2011	1,217	738	8,977	207,364	568	23.5
2010	1,220	735	8,532	215,193	590	25.23
2009	1,167	726	8,192	212,983	584	26.75
2008	1,183	712	7,949	200,754	549	25.23
2007	1,160	672	7,581	201,332	552	26.37
2006	1,118	633	7,705	195,533	536	25
2005	1,102	613	7,729	185,943	509	25.9
2004	1,102	612	8,536	187,892	513	21.6

**EDUCATIONAL SERVICES (INCLUDING SERVICES PROVIDED BY LOCAL SCHOOL SYSTEMS UNDER IDEA)**

DHBDID staff collaborates extensively with state and local educational agencies in support of IDEA and other initiatives focused on simplifying access to and coordinating services for children and youth with emotional and behavioral needs.

Currently, there are numerous school-based mental health initiatives across the state. Various models for school-based and off-site service provision continue to be studied and assessed for feasibility and effectiveness. KDHBDID has sponsored several training seminars featuring national presenters to educate personnel of the Regional Boards and school districts. These have been well attended and partnerships between school districts and Regional Boards continue to grow statewide.

**KyCID**

The Department is most involved with promoting an integrated, multi-tiered approach that includes mental health promotion, early intervention, and intensive interventions utilizing a model of Positive Behavior Interventions and Supports (PBIS). The PBIS model encourages the involvement of mental health staff and parents at every level of intervention and support (universal/primary, targeted/secondary, and intensive/tertiary.)

KDE created the Kentucky Center for Instructional Discipline (KyCID) in late 2004. Goals of the program include:

- Enhance schools' ability to achieve proficiency by 2014;
- Involve families, schools, community, and related agencies to understand and support the model;
- Promote healthy school climate and effective school leadership;
- Support creation of local and regional capacity to implement and sustain the PBIS model; and
- Utilize ongoing data collection for decision-making on multiple levels.

Staff from KDHBID and the Kentucky Partnership for Families and Children (KPFC) serves on the KyCID steering committee to ensure that mental health and family involvement is supported at all levels of training and implementation. For additional information, please see [www.kycid.org](http://www.kycid.org).

#### Kentucky Interagency Transition Council for Persons with Disabilities

Chaired by the Division of Exceptional Children within KDE, the Kentucky Interagency Transition Council for Persons with Disabilities is made up of over 22 state agencies, including DHBDID. Their mission is to facilitate the work of state, regional and local agencies as they assist young persons with disabilities (all types) in moving from school to community living and employment. The Department's participation on the Council has offered a valuable forum for sharing of program information and resources as well as data to better address the needs of young people served by the various agencies.

#### Kentucky Educational Collaborative for State Agency Children

The Kentucky Educational Collaborative for State Agency Children (KECSAC) was established through legislation in 1992. KECSAC is a statewide collaborative that works with state agencies, school districts and local programs to ensure that state agency children receive a quality education comparable to all Kentucky students. "State Agency Children" are those children in the custody or supervision of the Commonwealth and who are being served in programs funded and/or operated by DJJ, DCBS, or KDBHDID in the state of Kentucky. KECSAC Advisory Group members include representatives from the following six agencies:

- Kentucky Department of Education
- Department of Juvenile Justice
- Department for Community Based Services
- Department for Behavioral Health, Developmental & Intellectual Disabilities
- Eastern Kentucky University and the College of Education
- Local Education Agencies

KECSAC is the responsible entity for assuring that the benefits of the Kentucky Education Reform Act are extended to children in the custody of state agencies, in day treatment programs, and schools on the campuses of residential programs. KECSAC links the schools, family and children's services, community mental health, juvenile justice, private providers, and institutions of higher learning. The Department's participation on KECSAC has enhanced communication between treatment and education providers and prompted more opportunities for cross-disciplinary training.

#### **SUBSTANCE ABUSE TREATMENT AND PREVENTION OVERVIEW**

Substance use among children and adolescents, and their caregivers, is often identified by Regional Board clinicians as a contributing factor to the poor mental health and overall wellbeing of clients they serve. While funding sources for substance abuse treatment services are quite limited for youth, the use and abuse of nicotine, alcohol, inhalants, prescription and illegal drugs is addressed in the treatment provided. Clinicians and case managers utilize education (prevention and intervention), treatment and referral mechanisms available through school districts, law enforcement agencies, private providers and Regional Board Prevention programs.

Regional Boards serve youth with substance abuse disorders in their outpatient programs, as well as in the IMPACT (targeted case management) program. Several Regional Boards have specialized inpatient and intensive outpatient substance abuse programs for youth.

One Regional Board in southeastern Kentucky is a Robert Wood Johnson Reclaiming Futures site and expansion of the model statewide is underway. Department staff are

available to provide technical assistance and coaching to the regions that plan to submit a proposal to the RF national program office to become an official Reclaiming Futures site. The goals of Reclaiming Futures include:

- Assess teens in the juvenile justice system that are using drugs and alcohol or are at risk for use;
- Provide increased drug and alcohol treatment for youth and streamline community resources and services; and
- Help at-risk youth become more responsible for their actions by linking them with community services and leadership activities.

Services provided primarily through contracts with community-based service providers (14 Regional Mental Health and Mental Retardation Boards and their subcontractors, local government agencies and other community-based organizations) include:

- Prevention programming in communities offered through 14 Regional Prevention Centers;
- Juvenile diversion programs; DUI assessment and education programs;
- Consultation with businesses on the development of a drug-free work place and employee assistance programs;
- Social setting detoxification centers, residential treatment centers, outpatient treatment services;
- Specialized treatment services for pregnant women, adolescents and intravenous drug users; and
- Opiate replacement therapy to opiate dependent persons who are high-risk for HIV disease due to their intravenous drug use.

Training, consultation and client evaluations are made available, within budget limitations, to criminal justice agencies and other agencies within the Cabinet for Health and Family Services for clients with alcohol and other drug problems.

The Division of Behavioral Health provides alcohol and other drug abuse prevention and treatment services pursuant to KRS Chapter 222 (Alcohol and Drug Education, Treatment and Rehabilitation). The provision of alcohol intoxication fees is pursuant to KRS 431.100. Other statutes affecting the Division of Behavioral Health services include: KRS 189A (DUI assessment, education and treatment) and KRS 218A.410 (drug forfeiture).

Effective prevention and treatment of alcohol and other drug abuse will have a major impact on the health and well-being of every Kentuckian. From peer pressure of youth to use alcohol and drugs to the risks of being involved in a drunk driving accident, all Kentuckians are at risk for alcohol and other drug related problems. The Division of Behavioral Health has the statewide responsibility for providing leadership and program direction for the implementation of primary prevention, early identification (intervention) and treatment for persons who are alcohol or drug dependent.

## **MEDICAL, DENTAL AND VISION CARE**

### **Medical Care**

Kentucky implemented managed care of its Medicaid program in the highest populated area of the state (Louisville/Jefferson County and 15 surrounding counties) in 1997. Passport Health Plan has been awarded the contract to oversee medical and dental care in that region since that time. On November 1, 2011, Kentucky Department for Medicaid Services

expanded managed care into the remaining 104 counties of the state. Three private companies were awarded contracts (Kentucky Spirit Health Plan, Coventry Cares of Kentucky, and WellCare of Kentucky) to provide care. On January 1, 2013, four private companies were awarded contracts for managed care in Louisville and the surrounding area (Passport Health Plan, Humana-Care Source, WellCare of Kentucky and Coventry Cares of Kentucky). Eleven of Kentucky's fourteen community mental health centers had little to no experience with doing business with managed care organizations and three were familiar with the requirements of Passport Health Plan. The agencies have restructured their organizations and processes to comply with the pre-authorization and billing requirements of the five managed care organizations.

Regional Boards are required to complete physical health screenings for all new clients and to update this information at least annually. Data is now being collected through the IMPACT Outcomes Management System on health concerns among children, with SED, served by Kentucky IMPACT (a targeted case management for children with SED), and the most commonly reported concerns include allergies and asthma. The prevalence of and risk for obesity and diabetes are also high among Kentucky's youth.

According to the Centers for Disease Control, thirty-five percent of low-income children between two and five years of age in Kentucky are overweight or at risk for becoming overweight. According to the Youth Risk Behavior Survey (2009), 61% of public high school students did not participate in sufficient moderate physical activity. Over 33% are overweight or obese (at or above the 85<sup>th</sup> percentile for body mass index). Almost 15% of high school students are seriously overweight, and an additional 15% are heavy enough to be considered "at risk" of becoming overweight adults. Obesity among Kentuckians is epidemic and Kentucky's children are among the most obese in the nation. A statewide plan to address this epidemic is a public/private partnership, The Partnership for a Fit Kentucky, which supports the Kentucky Department for Public Health's CDC Obesity Prevention Grant. The focus is on promoting nutrition and physically active communities. This website is a clearinghouse of the Partnership for a Fit Kentucky's initiatives. The intent is to link resources, network programs, provide tools that work, and strengthen partnerships in order to develop cutting edge initiatives. More information about this initiative can be found on the web site [www.fitky.org](http://www.fitky.org).

There are School-Based Health Centers in a handful of schools (9 of 174 school districts) across the state; the Kentucky School-Based Health Center Collaborative is advocating for legislation and funding to sustain such Centers. Schools and community health organizations across the country have concluded that providing medical services in the school building is one of the most effective approaches to reducing health problems and healthcare costs.

### Oral Health

Kentucky Department for Medicaid Managed Care has contracted with managed care organizations to provide dental care to Medicaid members.

Kentucky has one of the worst oral health profiles for children of any U.S. state; the state lacks dental providers in poor and rural areas, and many of its providers historically have not accepted Medicaid. A 2005 report produced by the nonprofit group Kentucky Youth Advocates revealed that half of the state's children between ages two and four had cavities and that only a third of those children covered by Medicaid had used dental services in the past year.

The Kentucky Oral Health Coalition, is a statewide group of dental providers, public health professionals, advocates, educators, and others working together to improve the oral health of all people in Kentucky. The coalition began in March 2012 and is staff by a well-known Kentucky children's advocacy organization, Kentucky Youth Advocates. This coalition is

currently working to increase oral health literacy; increase school based oral health care; and increase the number of dentists accepting Medicaid. Learn more about the Kentucky Oral Health Coalition at [www.kyoralthcoalition.org](http://www.kyoralthcoalition.org). Kentucky Youth Advocates reports that poor oral health stems from multiple factors including lack of access to care, lack of importance placed on oral health, lack of oral health knowledge, lack of money to pay for care, and many others.

The Kentucky Department for Public Health's Oral Health Program believes that children learn best when they are healthy, and dental health is a key component of overall health. The Oral Health Program provides the following initiatives to help children maintain good dental care: a fluoride varnish program, a sealant program, a community water fluoridation program, a rural school fluoridation program, a fluoride supplement program, oral health education and Healthy Smiles Kentucky. The [Healthy Smiles Kentucky](#) initiative was created by Governor Steve Beshear to improve the dental health of Kentucky's children, particularly in Appalachia. Healthy Smiles Kentucky is made possible by a combination of federal grant funds and state general funds. The main components of the initiative are: the ABCD training program; community oral health coalitions; and the Smiling Schools program.

The University of Kentucky College of Dentistry in coordination with other agencies provides a myriad of dental services for children:

- Inpatient and outpatient specialized dental services for children at the University of Kentucky Children's Hospital and the UK Medical Center. This includes the provision of services for dental patients with special needs. (physical, medical and other special needs);
- Primary dental services at an indigent care clinic serving north Lexington and a clinic in south Lexington;
- Seal Kentucky - a mobile dental sealant program providing on-site dental screening and preventive dental sealant services at eastern Kentucky elementary schools;
- East Kentucky Mobile Dental Program - provides dental prevention and treatment services on-site at elementary schools in central and eastern Kentucky;
- Western Kentucky Mobile Program - provides dental prevention and treatment services on-site at nine elementary schools in three western Kentucky counties;
- "Ronald McDonald" Mobile Dental Program - in partnership with Ronald McDonald Foundation provide on-site services at underserved preschools and elementary schools in Fayette and surrounding counties; and
- School-Based Dental Clinics in Rural Kentucky.

The pediatric dentistry program at the University of Louisville School of Dentistry provides services to patients between 6 months and 14 years of age. Special needs patients of any age are accepted. The program focuses on preventive dentistry such as cleanings, x-rays and fluoride treatments in addition to fillings, stainless steel crowns and extractions. Emergencies or outpatient treatment is provided at Kosair Children's Hospital for very young children with excessive decay or special needs of any age.

Several faith based organizations have provided the financial support needed to start these services and to keep them operating. In addition, some Christian groups have opened free clinics in church buildings, which are staffed by volunteer dentists who come to the region from all over the state for weeklong mission trips. And yet others hold dental events in Walmart parking lots, handing out free samples of toothpaste, dental floss and toothbrushes to anyone who wants them. Still, case managers and clinicians that have knowledge of local resources and well-developed relationships with local providers tend to lead to better access to dental services. There are, in many communities, those dentists who will serve children in

need who have no ability to pay for dental care. However, overall access is generally considered poor.

In 2008 the General Assembly passed HB 186 which requires a dental screening the first year that a 3, 4, 5 or 6 year-old child is enrolled in a public school, public preschool or Head Start program. The law took effect for the 2010-2011 school year. Supporters hope this law will decrease the number of school days that Kentucky's students miss due to pain associated with dental problems and will establish a dental home for children from early in life, so that more children receive routine dental care and become less reliant on costly and sometimes invasive emergency care in childhood and later in life.

### Vision Care

Kentucky Medicaid provides coverage for members of all ages for most examinations and certain diagnostic procedures performed by ophthalmologists and optometrists. Professional dispensing services, lenses, frames and repairs are covered for persons under age 21.

All Kentucky children are required to have an eye exam by a board certified Optometrist or Ophthalmologist before they enter school. This is in addition to the requirement for immunizations and dental and hearing screenings. For children with vision problems, the Kentucky Lions Eye Foundation (KLEF) is a great resource for assistance with screenings, exams, and eye glasses. Though located in Louisville, KLEF serves citizens across the state by operating the Vision Van, Eye Clinics around the state and providing thousands of photo screenings at the Kentucky State Fair. KLEF includes specialty services for children at their Pediatric Clinic.

Visually Impaired Preschool Services (VIPS) is a Kentucky non-profit agency that provides assessments, early intervention services, child care consultation and play groups/classes for infants, toddlers, and preschoolers who are blind or visually impaired. For parents and caregivers, VIPS provides various opportunities for education and support. While their main offices are located in Lexington and Louisville (metropolitan areas of the state), there is also an Outreach Program that serves rural areas of the state.

### **SUPPORT SERVICES**

All fourteen Regional Boards offer to their communities, consultation and education services regarding behavioral health care and services. There are a number of ancillary support services that are offered in the children's array of services including, but not limited to:

- Respite Services;
- Intensive In-home Services;
- After School Programs;
- Family Peer Support;
- Specialized Summer Programs;
- Therapeutic Child Support Services; and
- Transition Planning for Transition Age Youth.

### Youth and Family Involvement and Support

Across all regions of Kentucky, parents' voices are most consistently heard through their membership on Local and Regional Interagency Councils (LIACs and RIACs). These Councils are responsible for the identification of children with SED and for coordination of the services that they receive. These representatives also make up the State Family Advisory Council (SFAC), which serves in an advisory capacity to the State Interagency Council to Children with an Emotional Disability (SIAC).



The majority of regional Kentucky IMPACT programs, which serve children with SED and their families, also have "Family Liaison" staff positions. These individuals provide peer-to-peer mentoring, facilitate the creation and maintenance of local parent support groups/family network activities, provide education and offer technical assistance on a variety of topics to families and service providers.

A review of the information from the SFY 2014 Annual Plan and Budget applications submitted by Regional Boards reveals that there are ongoing efforts to maintain and increase youth and family involvement at all levels of the service system (The number in parentheses indicates the change from the SFY 2013 Annual Plan and Budget applications. If there is no number, then there is no change.), including:

- Parents participating on Regional Interagency Council (RIAC) in thirteen regions;
- Youth participating on RIACs in three regions (+ 1);
- A parent of a very young child participating on RIAC in nine regions (-1);
- Paid Family Liaisons in eleven regions;
- Kentucky Family Peer Support Specialists in five regions (-1);
- The RIAC Parent Representative participates on the CMHC Board of Directors in seven regions (+3);
- A Dad-specific support group/activity is held in one region (first year collecting this data);
- Outreach to Parents by the Family Liaison and/or Kentucky Family Peer Support Specialist takes place in eleven regions (+1);
- No transition age youth participates on the CMHCs' Board of Directors at this time (-2);
- Parents/caregivers participate in the development of training and professional development materials in six regions and as presenters (or co-presenters) of trainings in eight (+3) regions;
- Youth participate in the development of training and professional development materials in seven regions (+4) and as presenters (or co-presenters) of trainings in six (+4) regions;
- Parents contribute to the development of newsletters and other written materials in 10 regions (+2);
- Youth contribute to the development of newsletters and other written materials in six regions (+6);
- Youth Councils are active in eleven regions (+3);
- Parents receive advocacy and leadership training in nine regions (+1);
- Youth receive advocacy and leadership training in seven regions (+1);
- Parents and youth attend an annual mental health conference at no charge in one region;
- Parents receive a Kentucky IMPACT or Impact Plus orientation in eleven regions;
- Family Fun Events are held in thirteen regions (+3);
- Parenting skills trainings are held in twelve regions (+1);
- A resource library either dedicated for use by parents/youth or available to parents and staff is available to youth and parents/caregivers in thirteen regions (-1);
- Parent/family support groups are held in twelve regions;
- Youth support groups are held in eight regions (+2);
- Educational/training events for families/caregivers are held in all fourteen regions (+1); and
- A parent newsletter is regularly published in ten regions (+2).

KDHBDID tries to lead by example that the voices of youth, parents and caregivers should help shape not only individual treatment decisions, but also program development and policy determinations at the local, regional, and state levels. This principle is strengthened by the advocacy efforts of parents and youth at various points in the system of care. In support of this vision, significant portions of state general funds and approximately 4 percent of Block Grant funds are allocated to family and youth support initiatives.

### Opportunities for Family Leadership

Opportunities for Family Leadership (OFL) is a unit within DHBDID which offers a resource line for parents and caregivers to access education, resources and support. The toll free number for the resource line is (800)374-9146. OFL provides numerous services for families and youth and the systems that serve them, including:

- Training in advocacy, communication, cultural competency, collaboration and legal rights in schools;
- Awarding mini-grants for parent and youth support groups to develop local training events and provide community resource libraries. Over 250 training events are held each year by parent and youth groups.
- Providing technical assistance to ensure Standards of Practice for Family Liaisons and Kentucky Family Peer Support Specialists across the state are met and approving required trainings per the Standards of Practice;
- Awarding mini-grants for parent and youth support groups to develop local training and awareness events;
- Distributing reader friendly versions of Client Rights and Grievance Procedures, and supporting documents to parents, youth and others to ensure that these policies and procedures are understood by everyone; and
- Providing technical assistance to organizations and individuals with regard to children's behavioral health, developmental and intellectual disabilities and substance abuse services and supports. Resource information and training opportunities are among the many items provided on OFL's web site at <http://dbhdid.ky.gov/dbh/OFL.asp>.

### Kentucky Partnership for Families and Children

The Kentucky Partnership for Families and Children (KPFC) is a statewide, family organization working to ensure "that all families raising youth and children affected by behavioral health challenges will achieve their fullest potential." KPFC's mission is to empower families affected by behavioral health challenges to initiate personal and systems change. The board of directors consists of twenty-one to thirty-one members: twelve parent representatives from various community mental health center regions, two transitional-age youth representatives, seven child-family serving agency representatives, and ten flexible positions to assist with identified needs. As a family organization, over 51% of KPFC's board of directors must be parents/primary caregivers raising children with behavioral health disabilities and more than 50% of staff are also parents/primary caregivers that have raised, or are raising, children with behavioral health disabilities.

KPFC's programs and/or activities include:

- Dissemination of a quarterly newsletter via hard-copy or e-newsletter to over 3,000 members;
- Participation on numerous committees with various child-family serving agencies to represent parent and youth voices and perspectives;
- Operation of a web site ([www.kypartnership.org](http://www.kypartnership.org)) and a toll-free phone number (800-369-0533) for parents to access information about KPFC and resource information statewide;
- Provision of an infrastructure for Kentucky Youth MOVE which is comprised of 14-26 year olds who have a behavioral health challenge;
- Coordination and facilitation of the Kentucky Family Leadership Academy and the Kentucky Family Peer Support Specialist Core Competency Training;
- Partnerships with regional community mental health boards to establish Regional Youth Councils and to assist in the identification of youth leaders that will help facilitate the meeting;

- Distribution of resource information and learning opportunities for families raising young children from birth to five that have an emotional-social delay;
- Opportunities for teens (13 – 26 years old) with behavioral health challenges and their parents to learn, connect and network as part of the youth and parent movement; and
- Strengthening of Kentucky's family-driven and youth-guided system of care.

### Early Childhood Mental Health

KDHBDID and the Department for Public Health (DPH) co-administer Kentucky's Early Childhood Mental Health (ECMH) Program, with DPH staff having lead responsibility for program oversight and financing, and KDBHDID staff serving as clinical liaison to the program. Funds are contracted to the fourteen CMHCs for regional program administration.

The ECMH Program was created in state fiscal year 2003 as a component of the early childhood development initiative supported by state tobacco settlement funds, KIDS Now. The primary goals of ECMH are:

- To provide program and child level consultation to early care and education (child care) programs regarding social, emotional, and behavioral issues;
- To provide training for child-serving agencies and individuals on working with young children with social, emotional, and behavioral needs and their families; and
- To provide evaluation, assessment, and therapeutic services for children from birth through the age of five and their families.

ECMH funds the equivalent of fourteen ECMH Specialists, resulting in one or two Specialists per Community Mental Health Center region. The Specialists' time is devoted solely to their regional ECMH programs, and to building the capacity of regional providers to better meet the social, emotional and behavioral needs of children 0-5 and their families.

The ECMH Specialists provide approximately the below listed numbers of services annually:

- 500 children receive clinical (outpatient) services;
- 100 training opportunities to approximately 1,300 child care providers;
- 70 training opportunities to approximately 700 mental health professionals; and
- 3,000 consultations to child care centers.

In 2008, Kentucky was awarded its third SAMHSA CMHS system of care cooperative agreement named Kentucky's System to Enhance Early Development (KY SEED). KY SEED supports an integrated system of care designed to improve the lives of children age birth to five who have social, emotional, and/ or behavioral challenges and their families, by providing coordination of and access to effective services and supports. This has been done through merging the existing infrastructure and service delivery systems of the Kentucky IMPACT and ECMH Programs.

The goals of the KY SEED grant have been the following:

- Goal 1: To promote community environments that support child and family well-being.
- Goal 2: To create sustainable family and youth guided networks.
- Goal 3: To expand access to high quality, developmentally appropriate services and supports.
- Goal 4: To support local communities to implement and sustain an effective service delivery system.
- Goal 5: To enhance state and regional infrastructure that encourages sound policy and decision making.

In its sixth and final year, KY SEED funds continue to develop an integrated system of care designed to significantly improve coordination of, access to, and effectiveness of services for

young children (birth to 5) who have social, emotional, and/or behavioral challenges and their families. The services and supports being implemented are evidence based, promising and practice-based strategies and developing needed services and building capacity for our young children. KY SEED ensures the family and youth voice is incorporated across the system of care as they are involved at the state, regional, and local level. Improving linkages among entities serving families of young children is being established by the development of KY SEED State Implementation Team (SIT) that serves as an advisory council to the State Interagency Council (SIAC) that is the governing body for KY SEED.

KY SEED has reached out to the funded communities to determine special populations to ensure cultural competency has been addressed. KY SEED has rolled out statewide in four cohorts of Regional Interagency Councils (RIACs). Currently, children and their families are receiving services in eleven of the 17 eligible RIACs.

### **CASE MANAGEMENT SERVICES (SERVICE COORDINATION)**

In Kentucky, targeted case management services for children through the Kentucky IMPACT program are referred to as “Service Coordination” provided by “Service Coordinators.” Kentucky IMPACT is a strengths-based, highly individualized, and collaborative model of case management utilizing Wraparound to address needs across life domains. These life domains include family, financial, living situations, educational/vocational, behavioral/emotional, psychological, social/recreational, health, legal, cultural and safety.

Legislation enacted in 1990 created eighteen Regional Interagency Councils (RIACs) that govern the regional Kentucky IMPACT programs. Each RIAC is comprised of local representatives from the primary child serving agencies and a parent of a child with SED. A Local Resource Coordinator (LRC) serves as staff to the RIAC, and generally manages the regional IMPACT program. While Regional Boards employ the LRC, and IMPACT staff, each RIAC creates and monitors program policy and procedures and provides on-going consultation to the staff of their IMPACT program.

Each RIAC serves as the gatekeeper for children entering and exiting Kentucky IMPACT services. Each RIAC receives an annual per capita allocation from KDHBDID for Service Coordination, RIAC staff support, and resource development. In consultation with its corresponding Regional Board, each RIAC determines how the funds will be obligated for the support of service delivery. Eligibility criteria for acceptance of a child into Kentucky IMPACT are not determined by insurance coverage or a family’s ability to pay.

Flexible funds, set aside by RIACs, may be used to purchase needed goods and services when there is no other available resource. Common expenditures may include tutoring services, summer camp fees, or therapeutic interventions provided to children by trained professional or paraprofessional mentoring staff. Regional Boards act as the fiscal agents for the funds but, again, decision-making authority regarding the use of these funds rests with each RIAC.

#### **Service Coordination 101**

Service Coordination 101 Certification Training is required in order to bill the Kentucky Medicaid Program or KDBHDID for Targeted Case Management Services. Service Coordinators/Case Managers and their supervisors must complete this training within six months of employment. This three day training is offered four times during the calendar year and provides certification for the following Service Coordinators/Case Managers and their supervisors:

- IMPACT Service Coordinators
- IMPACT Local Resource Coordinators

- Supervisors of Service Coordinators
- Department for Community Based Service (DCBS) staff providing Medicaid-funded Targeted Case Management, and their supervisors
- IMPACT Plus Case Managers (i.e., any IMPACT Plus sub provider who will be providing Targeted Case Management services)
- IMPACT Plus supervisors of Case Managers, Behavioral Health Professionals/Behavioral Health Professionals under clinical supervision

The training includes information about Medicaid regulations, the IMPACT and IMPACT Plus programs' history and philosophy, as well as the Wraparound philosophy which includes working with families in collaborative partnerships, and building teams to support children and families. Participants practice leading a child's service team and brainstorming ways to address potential challenges. Small and large group activities are incorporated into the training. Participants must complete all required sessions to receive certification. Certification is required to bill Medicaid and KDBHDID for services.

#### Wraparound Refresher Trainer

KDBHDID staff developed a Wraparound Refresher Training because experienced Service Coordinators expressed a need for the training. In fiscal years 2012-2013, seven trainings were held around the state with staff attending from eleven regions. In total, 219 Service Coordinators received the one-day training. More trainings will be scheduled as requested.

#### Team Observation Measure

In SFY 2013, KDBHDID included the Team Observation Measure (TOM) as a new requirement in the CMHC contract. The TOM assesses adherence to standards of high-quality wraparound during team meetings. It consists of 20 items, with two items dedicated to each of the 10 principles of wraparound. Each item consists of 3-5 indicators of high-quality wraparound practice as expressed during a child and family team meeting. Working alone or in pairs, trained raters indicate the whether or not each indicator was in evidence during the wraparound team meeting session. These ratings are translated into a score for each item as well as a total fidelity score for the session overall. Trained Observers complete a TOM with 10% of each Wraparound Facilitator's active child and family teams within a 6 - month timeframe. Teams are selected for observation using a systematic random sampling method. Fidelity data is submitted via an online data entry system within two weeks of completion of the team observation. Regional reports are provided on a frequent basis.

KDBHDID provides TOM trainings to regional staff. The TOM Observer Trainings are scheduled on an "as needed" basis. Two trainings are scheduled for September 2013 and another in January 2014. In SFY 2012, 53 regional staff received the training and in SFY 2013, 79 staff received it.

### **SERVICES FOR YOUTH WITH CO-OCCURRING MENTAL HEALTH AND SUBSTANCE USE DISORDERS**

Services for youth with co-occurring mental health and substance use disorders are coordinated by the Adolescent Treatment Coordinator. This position began in the Department in 2009 as a result of work that stemmed from our Kentucky Youth First Adolescent Treatment Grant. The Adolescent Treatment Coordinator works with each of the CMHCs to implement and sustain evidence-based practices, applies for and implements federal grants for adolescent services, and is now active in increasing adolescent treatment providers. Kentucky Medicaid notified providers on July 3, 2013 that substance abuse services for children under the age of 21 are covered under the EPSDT program and that providers may bill for substance abuse services as a primary diagnosis for children under the age of 21 who

are enrolled in the Medicaid program or the Kentucky Children's Health Insurance Medicaid Expansion Program (KCHIP).

The Department works closely with the Kentucky Adolescent Substance Abuse Consortium (KASAC). KASAC is a coalition of public and private providers of residential and community-based substance abuse services who are committed to enhancing the quality and types of treatment services available to adolescents through collaboration, support, education, and advocacy. For additional information please visit [www.kasac.org](http://www.kasac.org).

The State Interagency Council (SIAC) has in their strategic plan to address the needs of youth with co-occurring mental health and substance abuse disorders. Recommendations have been established with regard to the role of SIAC and RIACs in serving youth with co-occurring disorders.

Operated within the Regional Boards' Prevention programs is the Early Intervention Program (EIP). EIP is a collaborative between KDHBID and the Office of the Governor (Governor's Title IV Drug Free Communities and Schools funds) and provides multifaceted prevention and intervention services targeting specific needs related to alcohol, tobacco and other drug behavior and choices for youth and their parents. It was established in 2001 and operates under the authority of Kentucky Revised Statute (KRS) 189A in accordance with Kentucky Administrative Regulation 908 KAR 1:315. Target populations include:

- Youth convicted of "Under 21/Zero Tolerance", driving with a blood-alcohol content of .02-.08. These youth are required to go through an Early Intervention Program to satisfy the requirements of their offense. There are seventeen certified Early Intervention Specialists across the Commonwealth to provide these services.
- The second target population is juveniles who are at risk of becoming involved or who already are involved with the Juvenile Justice System and youth who are identified as using or at risk for using substances.

For additional information about this program, please visit their website at: <http://dbhdid.ky.gov/dbh/sa-rpc.aspx>.

#### **OTHER ACTIVITIES LEADING TO REDUCTION OF HOSPITALIZATION**

Children in Kentucky experience high rates of out-of-home care, including psychiatric hospitalization. A Kentucky IMPACT Outcomes report of 2011 data created by the University of Kentucky Center on Drug and Alcohol Research (CDAR) reveals that "the majority of caregivers (79.7%) reported that their children lived with their parents (see table below). The next most frequently reported living arrangement was home with other family members either in kinship care (not considered foster care in Kentucky's child protective service system) or not in kinship care. A smaller percent of caregivers (11.9%) reported other living arrangements for their children in the past 6 months, including foster care, inpatient psychiatric hospitals, emergency shelters, crisis stabilization, residential treatment program, and medical hospital. The table below does not show this detail, but the out-of-home placement that the highest percentage of caregivers reported their children living in was inpatient psychiatric hospital (3.1%, n = 25) but this represented a very small percent of the children. Only 4.3% (n = 34) caregivers reported that their children had lived exclusively in one of the out-of-home placements."

PERCENT OF CAREGIVERS REPORTING SPECIFIC LIVING ARRANGEMENTS THROUGHOUT THE 6 MONTHS BEFORE BASELINE FOR CHILDREN (N=795)

With parents (biological or adoptive)	79.7%
With other relatives	19.7%
Other Out-Of-Home living situations (e.g., foster care, inpatient psychiatric hospital, residential treatment, crisis stabilization, with friends)	11.9%

Children’s Crisis Services

Crisis stabilization programs have become a formal part of Kentucky’s array of services provided by the Regional Boards. These programs use state general revenue funds administered by the Division of Behavioral Health as well as Medicaid funds and others, when appropriate.

There are several models of community-based crisis stabilization in place across the state. Services in these models include the following:

- Mobile Crisis Services
- Crisis Stabilization Unit
- Intensive In-home Services
- Walk-in Crisis Services
- Intensive Outpatient Services
- Crisis Case Management
- Crisis Therapeutic Foster Care and Other Residential Overnight Services
- Crisis Respite
- Crisis Transportation Services

Crisis stabilization units provide short-term stabilization services (typically three to ten days). Most units are comprised of six to twelve beds and offer an array of assessment, treatment and referral services. Of the Regional Boards, nine have residential units and the remaining ones have mobile crisis stabilization programs that utilize beds for overnight residential services from other sources when needed. All of the Regional Boards provide walk-in crisis services during business hours and eight offer walk-in crisis services (at limited locations) during evening and weekend hours after clinics have closed.

Department staff facilitates quarterly Children’s Crisis Stabilization Peer Group meetings for Program Managers. Best practices, data reports, department updates and national trends are discussed and disseminated during these meetings.

**Criterion 2: Mental Health System Data Epidemiology**

**1) Estimates of Prevalence: Adult Mental Health**

*Narrative Question: An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children.*

Kentucky’s earliest estimates of the prevalence of serious mental illness were based on national work. In 1980, the U.S. Department of Health and Human Services (USDHHS) estimated that 3.14 percent of the population had some level of mental disorder, and that 0.75 percent of the population had a mental disorder that causes prolonged disability.

With the passage in 1992 of P.L. 102-321, the Community Mental Health Services Block Grant, Congress required the Center for Mental Health Services (CMHS) to develop a national definition for “adults with serious mental illness.” CMHS was further required to develop an “estimation methodology” based on the definition that state mental health

agencies must use to estimate needs in their state plans. While P.L. 102-321 limits CMHS Block Grant spending to persons who meet the federal definition, it does not require states to serve everyone covered by the definition. The federal definition of “adults with a serious mental illness” was published on May 20, 1993.

Early planning in Kentucky for adults with serious mental illness, using the 0.75 prevalence rate for adults with persistent disability, estimated that approximately 28,000 adults in Kentucky should be the priority population for services. Kentucky's mental health planning has historically focused on this subset of the population in development of its Community Support Program system.

A work group comprised of consumers, family members, and providers reviewed the federal definition and Kentucky's statutory definition of “chronic mental illness”; its recommendations were reflected in Administrative Regulations published in 1994. The regulation provided for operational definitions of the target population of adults with serious mental illness consistent with national policy. Kentucky's definition of “adult with serious mental illness,” as currently operationalized, uses the following criteria for age, diagnosis, disability, and duration: Kentucky's definition is narrower than the definition promulgated in the federal register for “Adult with Serious and Persistent Mental Illness.” Historically, stakeholders have supported the Department's desire to focus limited funding on adults who meet the state's narrower definition.

Variable	Criteria
<b>Age</b>	Age 18 or older
<b>Diagnosis</b>	Major Mental Illness <ul style="list-style-type: none"> <li>• Schizophrenia and Other Psychotic Disorders</li> <li>• Mood Disorders</li> <li>• Personality Disorders (when information and history depict persistent disability and significant impairment in areas of community living)</li> </ul>
<b>Disability</b>	Clear evidence of functional impairment in two or more of the following domains: <ul style="list-style-type: none"> <li>• Societal/Role Functioning: Functioning in the role most relevant to his/her contribution to society and, in making that contribution, how well the person maintains conduct within societal limits prescribed by laws, rules and strong social mores.</li> <li>• Interpersonal Functioning: How well the person establishes and maintains personal relationships. Relationships include those made at work and in the family settings as well as those that exist in other settings.</li> <li>• Daily Living/Personal Care Functioning: How well the person is able to care for him/herself and provide for his/her own needs such as personal hygiene, food, clothing, shelter and transportation. The capabilities covered are mostly those of making reliable arrangements appropriate to the person's age, gender and culture.</li> <li>• Physical Functioning: Person's general physical health, nutrition, strength, abilities/disabilities and illnesses/injuries.</li> <li>• Cognitive/Intellectual Functioning: Person's overall thought processes, capacity, style and memory in relation to what is common for the person's age, gender, and culture. Person's response to emotional and interpersonal pressures on judgments, beliefs and logical thinking should all be considered in making this rating.</li> </ul>



<b>Duration</b>	<p>One or more of these conditions of duration:</p> <ul style="list-style-type: none"> <li>• Clinically significant symptoms of mental illness have persisted in the individual for a continuous period of at least two- (2) years.</li> <li>• The individual has been hospitalized for mental illness more than once in the last two- (2) years.</li> <li>• There is a history of one or more episodes with marked disability and the illness is expected to continue for a two-year period of time</li> </ul>
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The 1999 federal methodology for estimating adults with serious mental illness requires states to use the national estimate of 5.4 percent for the prevalence of adults with serious mental illness, and a rate of 2.6 percent for adults with serious and persistent mental illness (SMI).

The following table uses the federal SPMI prevalence rate of 2.6% and the 2010 census data to estimate the percentage of the targeted population served by the Regional Board during SFY 2012.

<b>Regional Boards</b>	<b>Adult Census 2010</b>	<b>Estimated Prevalence (2.6% of the Adult Census)</b>	<b>Kentucky Adults with SMI Served in SFY 2012</b>	<b>Penetration Rate - SMI Served</b>
Four Rivers	161,545	4,200	2,478	59%
Pennyroyal	158,100	4,111	3,485	85%
RiverValley	161,977	4,211	2,285	54%
LifeSkills	217,231	5,648	2,041	36%
Communicare	200,640	5,217	2,883	55%
Seven Counties	730,843	19,002	8,718	46%
NorthKey	326,235	8,482	3,060	36%
Comprehend	42,757	1,112	726	65%
Pathways	170,601	4,436	2,592	58%
Mountain	119,756	3,114	3,050	98%
Kentucky River	89,550	2,328	2,088	90%
Cumberland River	181,110	4,709	3,226	69%
Adanta	160,202	4,165	2,291	55%
Bluegrass	595,449	15,482	4,513	29%
<b>TOTAL</b>	<b>3,315,996</b>	<b>86,216</b>	<b>43,436</b>	<b>50%</b>

**Criterion 2.1: Estimate of Prevalence – Children’s Mental Health**

*Narrative Question: An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children.*

Using 2010 census data and the state’s agreed upon prevalence rate estimate of five percent, Regional Boards are aware of the number of children in potential need of services. The Boards also rely heavily on indicators and recommendations from the local communities, parent networks and Regional Planning Councils. Kentucky Kids Count, the annual report distributed by Kentucky Youth Advocates is also helpful for program planning. ([www.kyyouth.org](http://www.kyyouth.org).)

In Kentucky, criteria for determining whether a child has SED were included in the enabling legislation (KRS 200.503) for the Kentucky IMPACT program in 1990. These criteria include the following. A child who:

1. Is under age 18 or under age 21 and was receiving mental health services prior to age 18 and the services must be continued for therapeutic benefit;

AND

2. Has a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is listed in the current addition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders; and presents substantial limitations which have persisted for least one year, or are judged by a mental health professional to be at high risk of continuing for one year without professional intervention in at least two of these five areas:

- Self Care
- Interpersonal Relationships
- Family Life
- Self-Direction
- Education

OR

- Is a Kentucky resident and is receiving residential treatment for an emotional disability through the interstate compact; or
- Has been removed from the home by the Department for Community Based Services (Kentucky's child welfare agency) and has been unable to be maintained in a stable setting due to a behavioral or emotional disability.

The following denotes the child population and the estimated number of children with a severe emotional disability (SED) and thus percentage served.

Estimated 2010 Child Census – 1,023,371

Estimated Number of Children with SED (5% of Kentucky's child population) – 51,169

Kentucky MH Children Served SFY 2011– 55,566 or 5% (of Kentucky's child population)

Kentucky MH Children Served SFY 2012– 59,317 or 6% (of Kentucky's child population)

Kentucky SED Children Served SFY 2011 – 25,978 or 51% (of the 5% SED population)

Kentucky SED Children Served SFY 2012 – 28,578 or 56% (of the 5% SED population)

Regional Boards	Child Census 2010	Estimated Prevalence (5% of the Child Census)	Kentucky Children with SED Served in SFY 2011	Penetration Rate of Children with SED Served in SFY 2011	Kentucky Children with SED Served in SFY 2012	Penetration Rate of Children with SED Served in SFY 2012
Four Rivers	44,367	2,218	1492	67%	1,438	65%
Pennyroyal	51,686	2,584	616	24%	637	25%
RiverValley	51,495	2,575	1042	40%	1,010	39%
LifeSkills	66,964	3,348	1641	49%	1,430	43%
Communicare	68,477	3,424	2660	78%	3,037	87%
Seven Counties	228,248	11,412	6241	55%	6,527	57%
NorthKey	112,412	5,621	1937	34%	2,133	38%
Comprehend	13,721	686	398	58%	537	78%
Pathways	48,935	2,447	1362	56%	1,528	62%

Mountain	34,337	1,717	1076	63%	1,115	104%
Kentucky River	25,212	1,261	588	47%	1,373	109%
Cumberland River	55,508	2,775	2850	103%	3,042	107%
Adanta	47,054	2,353	1748	74%	1,902	81%
Bluegrass	174,955	8,748	2568	29%	3,082	35%
<b>TOTAL</b>	<b>1,023,371</b>	<b>51,169</b>	<b>25,978</b>	<b>51%</b>	<b>28,578</b>	<b>56%</b>

Kentucky's Regional Boards continue to better identify children with SED and to serve more children with SED. The Boards served 2,600 more children statewide in SFY 2012 than in SFY 2011, a 5% increase. Kentucky's estimated prevalence rate falls in the low range of estimates derived from local studies and cited in "Prevalence of Severe Emotional Disturbance in Children and Adolescence" (Friedman et al, 1996). This study acknowledges the lack of epidemiological data and concludes that regardless of the estimated prevalence rate that may be used, children with severe emotional disabilities are greatly under-served, a conclusion Kentucky planners share.

#### Data Sources Used

- Kentucky MIS Client/Event Data Set
- Kentucky State Data Center/US Census Bureau 2010
- Friedman, R. M., Katz-Leavy, J. W., Manderscheid, R., & Sondheimer, D. (1996). Prevalence of Serious Emotional Disturbance in Children and Adolescents. In R. Manderscheid and M. Sonnenschein (Eds.) *Mental Health, United States: 1996* (pp. 71-89). Washington, DC: U.S. Government Printing Office, DHHS Publication Number (SMA) 96-3098.
- U.S. Census Bureau's Decennial Census and National Center for Health Statistics, processed by Kentucky Population Research at the University of Louisville Urban Studies Institute.
- [Kentucky Revised Statute 200.503](#)

### Criterion 3: Integrated Services

#### 1) System of Integrated Services

*Narrative Question: Provides for a system of integrated services appropriate for the multiple needs of children without expending the grant under Section 1911 for the fiscal year involved for any services under such system other than comprehensive community mental health services. Examples of integrated services include:*

- *Social services;*
- *Educational services, including services provided under the Individuals with Disabilities Education Act;*
- *Juvenile justice services;*
- *Substance abuse services; and*
- *Health and mental health services.*

KDBHDID has established collaboration with many child- and youth- serving state agencies, community partners, families, and youth to address the behavioral health needs of children and adolescents. Many of those partners are represented on the State Interagency Council for Services to Children with an Emotional Disability (SIAC), a body composed of Commissioner-level members of child- and youth-serving state agencies, a parent and a youth member.

## State Interagency Council

KDBHDID continues to promote activities that build the infrastructure for coordinated and integrated services for children with SED, and their families. Model examples of collaborative efforts found in the regions are often shared with others through technical assistance by the department. As discussed in Criterion 1, the State Interagency Council for Services to Children with an Emotional Disability (SIAC) is a group of representatives, from the primary child-serving agencies, and a parent of a child with an emotional disability, who maintain and oversee a framework of collaborative services for children with emotional disabilities. The hallmark program of this framework is Kentucky IMPACT, but other programs and initiatives may also fall under their auspices. There are eighteen Regional Interagency Councils among the fourteen Regional Board service areas and these Councils work under the umbrella of the SIAC. The table below illustrates the composition of the SIAC and RIACs. Some RIACs also have developed Local Interagency Councils (LIACs) at the county level to mirror the composition of the SIAC and RIACs, but to enhance the ability to develop resources at the local level and to problem solve when systemic issues may arise. The Chair of SIAC rotates each year but the Chair for RIACs is legislatively mandated as the DCBS (child welfare) representative.

### **Composition of IMPACT Interagency Councils**

<b>SIAC Representative</b>	<b>Domain</b>	<b>RIAC Representative</b>
Parent of a child with a severe emotional disability	Family Members	Parent of a child with a severe emotional disability
Commissioner, KDBHDID	Behavioral Health	Director of Children's Services, Regional MHMR Board
Commissioner, Department for Community-Based Services (DCBS)	Child Welfare	Service Region Administrator, Department for Community-Based Services
Commissioner, Department of Public Health (DPH)	Public Health	Representative, County Health Department
Commissioner, Department for Medicaid Services	Medicaid	Not mandated as there is no regional/local counterpart.
Commissioner, Department for Juvenile Justice	Juvenile Justice	Regional Program Manager Department for Juvenile Justice
Executive Director, Dependent Children's Services within Administrative Office of the Courts	Courts/Diversion	Court Designated Worker selected by local district judges
Executive Director, Family Resource and Youth Services Centers (FRYSCs)	Prevention and Early Intervention	FRYSC Directors who are located in Elementary, Middle and High Schools across the state
Commissioner's Designee, Department of Education	Education	Special Education, Local Education Authority

Youth Representative	Youth	Youth/young adult who has received mental health services for an emotional disability
Executive Director, Commission for Children with Special Health Care Needs	Health	Not mandated as there is no regional/local counterpart.

An integrated service system for the children and families served by Regional Boards is stronger in some areas of the state than in others. Examples of truly integrated services are sometimes found in communities where professionals and community members are well acquainted and have a long history of working together to achieve commonly held goals for their service recipients. Often where resources are the scarcest, creativity is strongest. Larger communities, while generally having the advantage of more resources, may face greater challenges in coordinating their efforts. Human Services Council meetings in many urban and rural counties serve as an opportunity to share agency information and exchange referrals regularly. In addition, there are numerous other networking and case conferencing mechanisms in place at the local level to encourage and support general agency and client specific information exchange and collaborative planning.

Partners learning the details of each others' specific job roles and their designated service areas is generally a beneficial starting place for assuring that children and families are served in the most effective and least restrictive manner. Most agencies do have specified service areas but adjustments are sometimes made to accommodate special circumstances. The fourteen Regional Board service areas do not completely align with any of the partner agency service areas; however all try to learn each others' county configurations so that they may best serve shared clients.

The interagency structure of Kentucky IMPACT drills down to the level of the child's service team. When a child is admitted to Kentucky IMPACT, a Service Coordinator is assigned to convene an interagency service team. The team consists of the child (when appropriate), his parent(s), his teacher(s), and other involved parties who work with or may otherwise be involved with the child and his family. A Regional Board is also the substance abuse and mental retardation planning authority for its region and most often provides these services as well, Services may be accessed by the Regional Interagency Councils (RIAC) through the Board's representation on the RIAC. This is generally the Children's Services Coordinator who has knowledge of all programs in the service area.

The RIACs are also staffed by a Regional Board employee, the IMPACT Local Resource Coordinator (LRC). The LRC is generally the IMPACT program manager but in some regions, these are separate staff positions.

Staff within the Department continually strive to develop relationships with staff of partner agencies that serve children with SED and their families. The following provides a bit of detail about some of the current focused partnerships.

## **SOCIAL SERVICES**

### Psychotropic Medications Workgroup

The recent national attention to the needs of children and youth in foster care, particularly pertaining to the oversight and management of the use of psychotropic medications with this vulnerable population, as well as an examination of our own state data has prompted a sense of

urgency to comprehensively address this issue in a cross-agency manner in order to ensure that youth receive valid assessments and effective care.

Comprised of Commissioners of the state's primary child-serving agencies, family members, and young adults, the SIAC serves as the governing body for Kentucky's system of care development and oversight. As part of its annual strategic planning, the SIAC identified the need for improved management of psychotropic medication use among all children in Kentucky and identified this as a priority issue.

Creating and implementing integrated oversight and monitoring protocols that ensure the appropriate use of psychotropic medications for children in foster care requires thoughtful collaboration across complex systems. In February, 2012, the SIAC wrote a letter in support of the state's application for technical assistance in response to CHCS' RFA titled, "Improving the Use of Psychotropic Medication among Children and Youth in Foster Care: A Quality Improvement Collaborative".

Although Kentucky did not receive the award, SIAC partner agencies commit to:

- Serve as the multi-stakeholder governing body to oversee the design, implementation, and evaluation of quality improvement efforts;
- Designate a Standing Committee of the SIAC to promote best practices for psychotropic medication use; and
- Support the efforts of a core team of the Standing Committee that will partner with Continuous Quality Improvement committee of the SIAC.

The SIAC partner agencies made the following recommendations:

There is clear and convincing evidence that collaborative planning and service implementation among all child serving entities is the most effective way to ensure a future adult population of productive citizens. Therefore, SIAC recommends:

- Increasing access to Evidence Based Practices across child serving systems
- Increasing use of mental health expertise and consultation to inform medication practices at the client and system level
- Implementation of system-wide screening and assessment to identify mental health needs; using standardized, evidence-based assessments
- Enhancing systems for informed and shared decision-making (consent and assent)
- Enhancing medication monitoring through improved Quality Assurance and Clinical Review Process (Medical) to include accurate health records
- Developing integrated data sharing systems to ensure care coordination and effective monitoring and oversight
- Ensuring all stakeholders (children/youth/family/practitioners/child welfare workers, etc.) have access to complete and accurate information
- Youth engagement and empowerment

#### Foster Care and Independent Living Council

Hosted by the Children's Alliance, the Foster Care and Independent Living Council is a membership council composed of member agencies of Children's Alliance that provide foster care and independent living services. Department staff participate in these meetings as do other partner agencies.

Most recently, there has been interest in collaboratively planning some training opportunities as well as some discussion about using like assessment and outcomes measurement tools. The Department recently collaborated on a grant application submitted by DCBS regarding the use of EBPs and other clinical services for youth in their care.

### Kentucky Partners for Youth Transition

The population estimates from the Kentucky State Data Center indicate that there are approximately 686,853 transition aged youth (14-25 year olds) living in Kentucky. National data suggests that 5% or 34,343 of these youth will have a severe emotional disturbance (SED) or serious mental illness (SMI). Collectively, the Regional Boards serve approximately 6% of the state's youth aged 14 – 25 years old. Youth with severe emotional disturbances (SED) or serious mental illnesses (SMI) face extreme challenges as they transition to adulthood:

- Over 60% of youth with SED/SMI will not complete high school. Employment, continuing education, and independent living skills are often serious limitations.
- These youth have higher rates of substance abuse
- Youth with SED/SMI are 3 times more likely to be involved in criminal activity
- SED/SMI conditions generally continue into adulthood.
- Young adulthood is also a high-risk period for developing new disorders

Research has shown that youth with SED/SMI who have support in coordinating their transition age years (such as vocational and educational support, life skills training, and case management services) have much greater positive outcomes in employment and high school and college achievement; as well as being less likely have mental health or substance abuse issues that interfere with their lives.

Department staff created and continues to facilitate a statewide initiative to address the needs of the specialized population of youth transitioning to adulthood who have behavioral health concerns, including those with SMI or SED and those with co-occurring substance use disorders. Named the *Kentucky Partners for Youth Transition* and adopted as a workgroup of the SIAC, the group has grown to include over 12 state agencies, parents and youth, and other stakeholders and has several committees. In November 2012, the Partners chose the following as the top three priorities to guide their work in the upcoming years:

1. Transition Resources (for youth and professionals)

- Resources for youth that are tech savvy
- User friendly resources
- Coordinated Website with all youth resources

Subgroup Members: Christie Penn, Nina Begley, Helen Willis, Kathy Eversole, Angela Winkfield, Leslie Jones, Janice Johnston

2. Specialized Training for Staff on Transition Issues

- Training staff on transition issues
- Intentional coordination of individual treatment/care/transition plans
- Educating professionals on available resources
- Expand the TAYLRD training to additional agencies

Subgroup Members: Karen King-Jones, Vickey Reilly, Marilyn Rodgers, Cheryl , Janine Dewey, Janice Johnston

3. Youth Empowerment

- Involvement in Youth Empowerment Summit
- Helping identify permanent connections
- Educating young adults on available resources
- Peer to peer support

Subgroup Members: Paula Saenz, Kate Tilton, Janice Johnston

Other areas of interest that may work into the subgroups listed above:

- College and career advising
- Positive media attention related to issues around youth transition

- Updating legislators and staying informed of legislative actions related to
- Standardized expectation for comprehensive

### Regional and Local Voices

At the regional and local levels, CMHC Children's Services Directors report the following specialized arrangements with Department for Community Based Services (social services) (DCBS) for providing priority behavioral health services for their clients:

- Designated clinical staff whose primary function is to provide mental health and substance abuse services to DCBS referrals at the DCBS offices.
- Providing therapy services in the local DCBS offices in counties that do not have a CMHC clinic.
- Providing therapeutic foster care services.
- Providing Emotional Injury Assessments and Emotional Injury Treatment.
- DCBS referrals receive priority scheduling and we reserve top priority funds to provide services to DCBS involved families at their request.
- Ongoing collaboration with DCBS staff, to include DCBS referral of all children 0 to 6-years-old with open abuse cases for triage and assessment;
- Agency staff on-site at DCBS weekly to provide consumer assessments, staff consultations, and to involve consumers and their families in the process of treatment.
- Team meetings to review high priority/intensive cases and discuss treatment goals and coordinate joint outcomes.
- Priority scheduling for DCBS clients.
- Arranged for a referral form to be used to guide DCBS referrals into their intake system and allowing the Center to contact those families directly upon receiving the DCBS referral.
- Timeframes for exchange of information. Associates (SRAA) on a quarterly basis to discuss new services, any change in service array, any possible grant collaborations, and any other issues that may arise.
- Arranged partnership referrals with DCBS for crisis stabilization units, parenting and crisis response.

### **EDUCATIONAL SERVICES, INCLUDING SERVICES PROVIDED UNDER THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT**

KDBHDID staff collaborates extensively with state and local educational agencies in support of IDEA and other initiatives focused on simplifying access to and coordinating services for children and youth with emotional and behavioral needs.

#### Kentucky Educational Collaborative for State Agency Children

The Kentucky Educational Collaborative for State Agency Children (KECSAC) was established through legislation in 1992. KECSAC is a statewide collaborative that works with state agencies, school districts and local programs to ensure that state agency children receive a quality education comparable to all Kentucky students. "State Agency Children" (SAC), are those children in the custody or supervision of the Commonwealth and who are being served in programs funded and/or operated by DJJ, DCBS, or DBHDID in the state of Kentucky. KECSAC Advisory Group members include representatives from the following six agencies:

- Kentucky Department of Education
- Department of Juvenile Justice
- Department for Community Based Services
- Department for Behavioral Health, Developmental & Intellectual Disabilities
- Eastern Kentucky University and the College of Education
- Local Education Agencies



KECSAC is the responsible entity for assuring that the benefits of the Kentucky Education Reform Act (KERA) are extended to children in the custody of state agencies, in day treatment programs, and schools on the campuses of residential programs. KECSAC is a true partnership that links the schools, family and children's services, community mental health, juvenile justice, private providers, and institutions of higher learning.

#### Kentucky Post School Outcomes Advisory Group

KDBHDID is a partner on the **Kentucky Post School Outcomes Center (KyPSO) Advisory Group** ([www.kypso.org](http://www.kypso.org)). This group came together to fulfill the Federal Department of Education, Office of Special Education Programs requirement that all States follow up with former students who had Individual Education Programs (IEPS) to determine the percent of youth who are no longer in secondary school, had IEPs in effect at the time they left school, and were:

1. Enrolled in higher education within one year of leaving high school.
2. Enrolled in higher education or competitively employed within one year of leaving high school.
3. Enrolled in higher education or in some other postsecondary education or training program; or competitively employed or in some other employment within one year of leaving high school”.

Kentucky's survey goes above the federal requirement and asks about other post school outcomes, such as:

- Satisfaction with work and school;
- Goals;
- Barriers;
- What Helped;
- Interaction with community agencies;
- Community involvement; and
- Free time.

This Advisory Group consists of various community partners such as Education, the Department for Community Based Services and the Office of Vocational Rehabilitation. They have partnered with the Human Development Institute and the University of Kentucky in the system development of this initiative.

In 2012, KyPSO published their first Youth One Year Out (YOYO) data (2011). The survey included 157 youth who had an IEP for an Emotional Behavioral Disability. Of those, 18% had been in higher education post school, 41% competitively employed, 13% enrolled in other higher education, 22% were employed with supports, and 28% had not been enrolled in higher education or working competitively post school.

#### Kentucky Interagency Transition Council for Persons with Disabilities

Chaired by the Division of Exceptional Children within the Kentucky Department of Education, the Kentucky Interagency Transition Council for Persons with Disabilities is comprised of representatives from 22 state agencies, including KDBHDID. The Council meets for the purpose of collaborating in the design, delivery, and improvement of statewide transition services for young adults (ages 14 - 21) with disabilities (of all kinds) from school to college and employment.

#### Regional and Local Voices

Ten of fourteen CMHC Children's Services Directors report offering educational and/or vocational services and supports to children or youth transitioning to adulthood. Examples of the services and supports include the following:

- Supported employment services

- Active coordination between Child and Adult Targeted Case Management 24 months prior to transition.
- Ongoing interface with supported employment and Vocational Rehabilitation services 12 months prior to transition.
- Share information about transitioning, training opportunities, Job Corps, community supports, and higher education.
- Transition to adulthood skills, services and supports incorporated into Service Coordination.

## **JUVENILE JUSTICE SERVICES**

### Kentucky Adolescent Treatment Dissemination & Enhancement Grant

Kentucky was fortunate to be awarded a SAT-ED grant in 2012, which is called the Kentucky Adolescent Treatment Dissemination/Enhancement Grant (KAT-ED), KAT-ED builds upon the work of a 2005 – 2009 CSAT Adolescent Treatment Infrastructure grant – *Kentucky Youth First*; over a decade of work with Robert Wood Johnson’s *Reclaiming Futures*; and Kentucky’s 2012 Policy Academy. Funds from this cooperative agreement will be used to implement evidence-based screening, assessment, treatment, and continuing care recovery services for youth with substance use disorders and youth with co-occurring substance use and mental health disorders and their families. Funds will be used for both infrastructure development and treatment enhancement in two high-need geographic regions of the State: Northern Kentucky (Campbell County) and Southeastern Kentucky (Whitley County). Efforts will build upon existing Reclaiming Futures Change Teams to enhance a coordinated network that will develop policies, expand workforce capacity, and disseminate evidence-based practices to improve integration and efficiency of the adolescent behavioral health service delivery system and to improve outcomes for youth and families. These local communities will serve as demonstration sites to support wide-scale replication across the state. The project period begins September 30, 2012 and will run through September 29, 2015. The award is for \$961,386 per year for 3 years to cover costs of treatment for youth, training, infrastructure development, administration and evaluation.

The Grants Management Team will be comprised of state members that will include representatives from the Administrative Office of the Courts, KY Partnership for Families and Children, the Division of Behavioral Health and the State Interagency Council (SIAC) administrator. SIAC will provide oversight for the grant. SIAC members will receive information from an appointed interagency workgroup that will review and analyze required information from the sites. The SIAC will use this data to make recommendations regarding state level policy development; removal of barriers to implementation and dissemination; and assist with replication of best practices.

This grant selected local community-based treatment providers to work collaboratively with the community to improve access and delivery of treatment and supports. For the purposes of this project, the counties of Whitley and Campbell will serve as the implementation sites. These counties were selected based on high need as well as demonstrated readiness for system change. Whitley and Campbell Counties both detain youth for status offenses at rates surpassing the state average, and Campbell County is the among the highest counties in Kentucky with a disproportionate rate of complaints against Black youth filed at about 2 to 3 times greater than their representation in the general population. Both counties have operationalized the Reclaiming Futures Framework for youth with juvenile justice involvement and have participated in SAMHSA – funded system of care initiatives and both counties are participating in the Juvenile Detention Alternatives Initiative (JDAI). Finally, the counties represent geographic diversity that will allow for evaluative comparisons important to future replication.

The participants of focus are youth ages 12 - 18 who are at risk for having a complaint filed and those who have a complaint filed against them but are eligible for diversion and their families. These youth will receive an evidence-based screening at the pre-diversion or diversion level of the justice system. Overall goals of the grant include:

1. Divert youth with substance use and co-occurring mental health and substance abuse issues from juvenile justice to appropriate services and supports within their community using a KY adapted version of the Reclaiming Futures framework.
2. The two implementation providers (identified through an RFA process) will receive training and coaching in the use of the evidence based Global Assessment of Individual Needs (GAIN) screening and assessment instruments and in the use of the evidence based treatment approach, Adolescent Community Reinforcement Approach (A-CRA) while acting as a learning laboratory to provide feedback in order to assist the State with broader implementation efforts and replication;
3. The State will work to discover and remove barriers to successful access and utilization of quality treatment interventions for the population of focus and their families and expand workforce capacity and dissemination for both A-CRA and GAIN
4. Complete a Financial Map and develop a process to use this information for planning services and supports within the system of care for the population of focus and their families.

Currently, youth are being assessed for mental health and substance abuse issues by the Administrative Office of the Courts (AOC) as well as the Department for Juvenile Justice (DJJ). There have been clinical staff trained in assessment methods/tools in most every CMHC and there are state and national trainers within Kentucky to continue to provide training and coaching on the use of the Global Assessment of Individual Needs (GAIN) family of screening and assessment tools. Due to turnover and difficulty with adoption of the GAIN within some treatment provider agencies, the momentum of the assessment has waned. There is a need to encourage the use of the assessment tool as it is not being utilized by the CMHCs consistently.

The need to enhance treatment options for adolescents with juvenile justice involvement is especially pronounced. While some adolescents will engage in troubling behavior, appropriate and consistently-applied discipline can ensure youth have opportunities to learn from mistakes and become successful contributing adults. Unfortunately, Kentucky, like many states has responded to such troubling behavior by detaining youth, including those who commit status offenses, an approach shown to be ineffective and highly expensive (Nelson, 2008). In fact, Kentucky detains youth charged with status offenses at the second highest rate in the nation, even though the most populous county in the state does not use this practice (KYA, 2011). With national estimates of approximately 70% of youth with juvenile justice involvement meet criteria for a diagnosable mental health disorder and about 61% have a co-occurring substance use disorder (National Center for Mental Health and Juvenile Justice, 2006), adolescents with juvenile justice involvement present a unique challenge to the system of care. Not only is the intensity of their needs likely to be greater, but proper response to their multiple needs requires increased collaboration, continuity of care, and the ability to recruit and retain providers who are equipped to treat multiple needs. Unfortunately, many of the youth do not receive much needed behavioral health treatment that could prevent initial involvement with the juvenile justice system or reduce the likelihood of recidivism. The Kentucky Department of Juvenile Justice (DJJ), one of five departments under the Kentucky Justice and Public Safety Cabinet within the Executive Branch, is responsible for statewide detention services, residential placement/treatment services, probation, community aftercare/reintegration programs and youth awaiting adult placement or court. Of Kentucky youth coming into contact with the juvenile justice system, 32% are committed

to the DJJ, 28% are informally adjusted (diverted), and 40% of cases are probated (Kentucky Department for Juvenile Justice, 2006). Thus, the need for accessible and effective treatment is paramount throughout the system.

### Regional and Local Voices

All fourteen CMHC Children's Services Directors report that their Center gives priority to serving children and youth referred by the court system.

## **SUBSTANCE ABUSE SERVICES**

### State Interagency Council

A fairly comprehensive array of services for youth with emotional disorders is available to varying degrees across Kentucky. This is less the case for youth identified with substance abuse treatment needs. While Kentucky has over 20 years of experience in providing behavioral health services to children, youth and their families through a system of care interagency infrastructure called Kentucky IMPACT and utilization of the State Interagency Council (SIAC). SIAC meets monthly to oversee coordinated policy development, comprehensive planning and collaborative budgeting for Kentucky's system of care for children. In addition to representatives from sister agencies from within the Cabinet, there are representatives from AOC, DJJ, Department of Education and parents and youth. SIAC has developed formal recommendations for state and local community changes to support youth with substance use and co-occurring disorders and within the realm of case management services. The SIAC has established a workgroup to focus on adolescent substance abuse and juvenile justice. The purpose of this workgroup is to promote comprehensive, integrated services for youth with substance use or co-occurring substance use and mental disorders.

### Reclaiming Futures

There are two nationally recognized Reclaiming Futures sites and two sites that are working as state Reclaiming future sites. Reclaiming Futures is a proven national model working toward systems change to address youth with substance abuse and juvenile justice issues. Working with the National Reclaiming Futures Office and Kentucky Youth Advocates a "Kentuckyized" version of the model and implementation guide has been completed to address youth with complex issues, who may be status offenders that are being detained and the disproportionate minority contact of youth within our juvenile justice system. A third Reclaiming Futures site established through a SAMHSA/MacArthur Policy Academy/Action Network grant has been established using the Kentucky version of the Reclaiming Futures implementation guide. This third site has focused on working with youth in a pre-diversion status that has focused efforts on screening, assessing, and treating youth on "the front end" of the juvenile justice system as a means of avoiding net widening into the juvenile justice system.

### Kentucky Adolescent Substance Abuse Consortium

The Kentucky Adolescent Substance Abuse Consortium (KASAC) is a group of concerned individuals who come together to advocate for the quality of and access to adolescent substance abuse and co-occurring disorders treatment through collaboration and education. KASAC is committed to providing training opportunities that target the needs of professionals who work with adolescents and focus on state-of-the-art and evidence based practices. KASAC is a partnership of many treatment providing agencies and other stakeholders, including KDBHDID.

## **HEALTH AND MENTAL HEALTH SERVICES**

### Physical Activity, Nutrition, Tobacco, Asthma Plus: A School Resource Guide

Staff from the Public Health, Behavioral Health and Education collaborated have collaborated to create two editions of the Physical Activity, Nutrition, Tobacco, Asthma Plus ([PANTA Plus](#)) School

Resource Guide (2006 and 2011). The Guide assists schools as they work towards a coordinated approach to school health. It provides the framework, structure, tools and resources to strengthen and expand school health programs and policies. The Guide includes information about the connection between health and academics; emerging, promising and best practices; designing and planning policies and programs; assessing the school health environment and use of data; encouraging environmental change; and promoting overall health of students, staff and the school community.

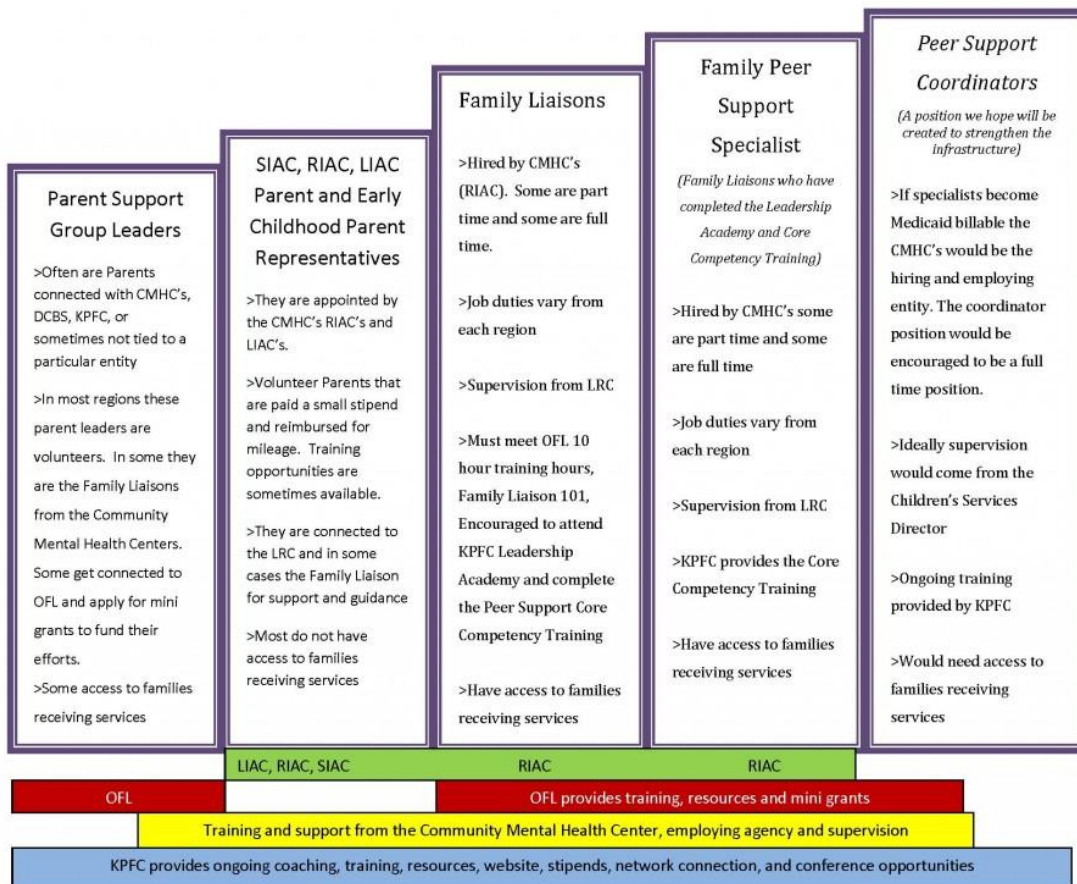
#### Early Childhood Mental Health

Staff from the Department for Public Health and KDBHDID meets regularly as they share oversight of the Early Childhood Mental Health Initiative and the designated Specialists. There is also shared oversight of the Bioterrorism Preparedness program.

### **FAMILY AND YOUTH INVOLVEMENT**

#### Kentucky Partnership for Families and Children

In creating a “family-driven and youth-guided” system of care, the Kentucky Partnership for Families and Children (KPFC) along with many partners are working to create an infrastructure that invites youth and parents across the state to “Join the Movement.” The Kentucky Family and Youth Movement Steering Committee is working to increasingly empower youth with behavioral health challenges and their families through leadership development and advocacy skills. Furthermore, the principle of this movement focuses on the benefits of family peer-to-peer and youth peer-to-peer involvement. Peer-to-peer involvement gives hope, fosters support and allows for increased opportunities for our youth and families. As the movement grows and strengthens, Kentucky’s youth and parent voice will be a tipping point for positive, long-term change. ([www.kypartnership.org](http://www.kypartnership.org)).



### Youth M.O.V.E. Kentucky

The Kentucky Partnership for Families and Children (KPFC) coordinates a statewide youth council for transition aged youth (14 – 26 years old) called Youth M.O.V.E. Kentucky. The Council consists of eighteen youth members who have an emotional or behavioral health diagnosis. The Council is required to meet at least four times per year. The council's goals are:

- Reduce the stigma related to children's mental health challenges;
- Improve members' leadership skills;
- Provide a united voice to advocate on behalf of ourselves and other youth with behavioral health disabilities; and
- Access to a peer group that can provide support.

Youth M.O.V.E. Kentucky provides a Youth Representative on the State Interagency Council (SIAC).

Activities of Youth M.O.V.E. Kentucky include:

- Provide a Youth Representative on the State Interagency Council (SIAC).
- Advocate for the development of Regional Youth Councils across the state.
- Assist with KPFC's annual Youth/Parent Conference.
- Provide training to professionals and parents on issues related to youth.
- Sit on various local and state committees.
- Serve as board members on the KPFC Board of Directors.
- Develop awareness materials for youth, parents, and professionals.
- Serve as Youth Trainers for various trainings such as the KY Family Leadership Academy, Service Coordination 101, Trauma Informed Care, Wraparound Fidelity.

- Speak at events such as Children’s Mental Health Awareness Day to share experiences and concerns.
- Bring a focus on issues we are concerned about such as:
  - Reducing seclusions & restraints;
  - Successful transition to adulthood;
  - Youth rights and voice in treatment;
  - The need for peer to peer support; and
  - Adequate insurance coverage for youth and young adults.

### Regional Youth Councils

Regional Youth Councils are active in eleven of the fourteen CMHC regions. The councils are usually (but not always) started and supported by the Kentucky IMPACT program within each region of the state. The Kentucky IMPACT program and the Community Mental Health Center decide how the council in their region is organized – when and how often they meet, where, ages of youth, and who is eligible (i.e. IMPACT only, any youth with an open chart, etc.). Generally, the youth council meets once a month for an hour and a half.

Regional Youth Councils support positive youth development by:

- Building assets that are supported by nurturing adults and communities.
- Ensuring that youth have the opportunity to explore talents and interests and to develop a sense of competence and personal identity.
- Encouraging youth to engage in leadership and develop a sense of control over their future.

The areas that the youth councils focus on are:

- Independent living skills – employment, education, medical, self-care, healthy relationships, housing, transportation;
- Peer to peer support – having access to a peer group that has issues similar to their own, peer mentoring;
- Community service – giving back, connecting with their community in a positive way, seeing that they have the ability to help others;
- Leadership development – developing appropriate and effective skills to have a voice in their own treatment, on their own team, and possibly within their community or state; and
- Youth engagement and empowerment – strong partnerships with adults, understanding their diagnosis and symptoms as well as the services they are receiving/could receive

## **Criterion 4: Targeted Services to Homeless, Rural, and Older Adult Populations**

### **1) Outreach to Homeless: Adult Mental Health**

*Narrative Question: Describe State's outreach to and services for individuals who are homeless*

KDBHDID recognizes the importance of system coordination among the numerous agencies and programs involved with services to this population. At the state level, KDBHDID participates in the Kentucky Interagency Council on Homelessness (KICH), a group of state and local providers, consumers and government officials, established as a result of Kentucky’s participation in a Homeless Policy Academy funded by the Departments of Housing and Urban Development (HUD) and Health and Human Services (HHS). The goal of

this group is to develop statewide systems and policies, and forge partnerships among state agencies and private social service organizations to achieve local solutions to homelessness. The Council drafted a Homelessness Prevention Plan and Kentucky's Ten-Year Plan to End Homelessness.

KDBHDID, KICH and Kentucky Housing Corporation (KHC) are currently collaborating on two (2) initiatives: the SSI/SSDI Outreach, Access, and Recovery (SOAR) Technical Assistance Initiative - which provide training for case managers and homeless service workers in assisting eligible persons in applying for disability benefits; and the development of case management training for homeless service providers. The manual for this training will soon be posted on the KICH website. Efforts are also underway to increase access and availability of housing options for homeless individuals through the promotion of the "Housing First" model.

Most Regional Boards offer individualized services designed to alleviate homelessness as well as to provide "mainstream" mental health treatment to persons who are homeless and mentally ill. Regional Boards report in their system of care plans for adults with severe mental illnesses the following level of participation:

- All Regions give a service priority to homeless individuals;
- Twelve (12) Regions participate in routine regional Continuum of Care meetings;
- Seven (7) have received Continuum of Care funding;
- Ten (10) Regions do consultation with local shelters;
- Nine (9) Regions regularly visit local homeless shelters;
- Nine (9) Regions provide a walk-in psychiatric clinic;
- Eight (8) Regions have staff dedicated to homeless individuals; and
- Four (4) Regions do street outreach.

KDBHDID received \$473,000 from SAMHSA/CMHS for SFY 2013 for homeless services through the Projects for Assistance in Transitioning from Homelessness (PATH) Grant. The Department continued to contract with the seven (7) Regional Boards awarded funding in SFY 2012; three (3) urban, two (2) rural and two (2) that are a combination of urban and rural, to provide homeless services within their area.

The seven (7) PATH regions are:

Bluegrass Regional MHMR Board, Inc., which subcontracts and works with the HOPE Center, a private non-profit shelter and homeless service provider, to provide outreach, screening and diagnostic services, case management, mental health treatment, rehabilitation and staff training in the Lexington / Fayette County area.

LifeSkills, Inc., which provides outreach, case management and training in the Bowling Green / Warren County area.

NorthKey Community Care, which utilizes a multidisciplinary outreach team employed by the CMHC to provide screening, treatment, and case management, and subcontracts with Welcome House of Northern Kentucky, a private non-profit shelter and homeless service provider, for case management and payee services. The program serves the northern region of Kentucky, just south of Cincinnati, Ohio. The majority of clients served in the PATH program come from Boone, Campbell, and Kenton counties which are the most urban areas.

Seven Counties Services, Inc., which provides outreach, assessment, 24 hour crisis intervention, case management, referral and linkage to community resources and supportive

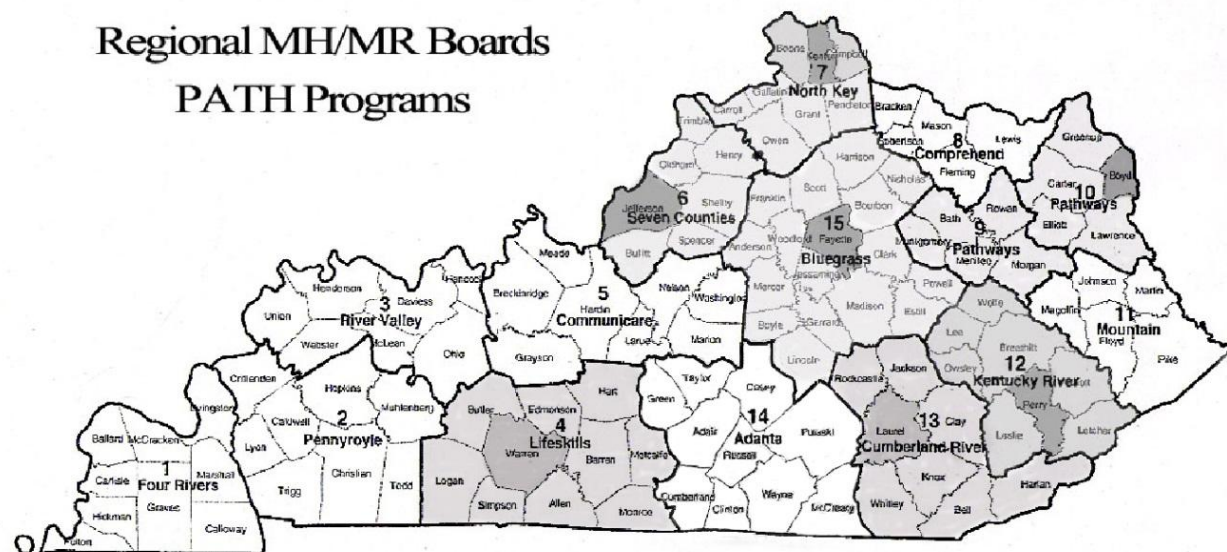


services through their Homeless Outreach Team. The program is located in Jefferson County, Kentucky.

Pathways, Inc., which provides outreach and case management in the Ashland / Boyd County area.

Kentucky River Community Care, which provides outreach, case management, housing support services, and support for six (6) emergency apartments for homeless persons with a mental illness located in Hazard / Perry County, but which also draws from Breathitt, Knott, Lee, Leslie, Letcher, Owsley, and Wolfe Counties in southeast Kentucky.

Cumberland River Regional MHR Board, which provides outreach, case management and housing support services in Laurel County.



Regions with PATH Programs are shaded in grey. Dark grey indicates a county specific program; medium grey indicates a region-wide or extended service area.

By combining PATH and other McKinney funds (that support specialized services) with state and federal funds (that support Community Support Services), KDBHDID and the Regional MH/MR Boards attempt to provide a statewide system of outreach, community support, and mental health services for persons with severe mental illness who are homeless. The role of the State PATH Coordinator is central to supporting local PATH providers throughout Kentucky. The Coordinator prepares the annual PATH application in collaboration with local providers, insures that annual data collection requirements are met, and insures that fund allocation and contracts are in place. Support is also provided through notification of relevant training, updates on homeless issues, and on-site technical assistance as needed.

The Department is also involved with other homeless initiatives including:

- KDBHDID, in collaboration with Lake Cumberland MHR Board, Inc., the Department of Corrections, the Department for Community Based Services, the Louisville Coalition for the Homeless, and Families and Children Place, administers a Homeless Prevention Project. This assists persons being discharged from state facilities in accessing housing and mainstream services, in an effort to limit discharges to homeless shelters. This project assists persons serving out of the prison system, persons being discharged from psychiatric institutions, and persons aging out of foster care.

- KDBHDID collaborates with the Specialized Housing Resources Department within KHC in the operation of local homeless planning boards (“Continuum of Care Committees”) in Kentucky’s area development districts (which correspond to the fourteen mental health regions). Regional Boards are encouraged to participate in this process for the benefit of individuals with severe mental illness who are homeless or may become homeless in their regions.
- KDBHDID provides state funds to the St. Johns’ Day Center in Louisville to hire an outreach worker. This staff person provides on-site assessment and links individuals with services at Seven Counties Services, the Regional Board for Louisville.
- CMHS Block Grant funds will continue to support a Rural Homeless Outreach program in the Mountain Regional Board area. The goal of this program is the identification of individuals with serious mental illness who are homeless and linkage with mainstream mental health services. Consultation and training to homeless service providers is also provided under this initiative.

#### **Criterion 4: Targeted Services to Rural and Homeless Populations**

##### **1) Outreach to Homeless: Children’s Mental Health**

*Narrative Question: Describe State’s outreach to and services for individuals who are Homeless*

The Kentucky Housing Corporation conducts a Point-In-Time Count of the Homeless every year to best monitor the homeless situation in Kentucky. The U.S. Department of Housing and Urban Development (HUD) requires such a count every other year, but KHC believes it best serves the people of Kentucky to conduct this count yearly. A summary of the results of the 2013 Count are reported in Table 1. The results of the Point-In-Time Count demonstrate the need for resources for housing and services for homeless persons in each community. The Count also helps determine how much federal funding will be awarded from HUD for homeless programs. In addition, the Count helps assess progress under Kentucky’s Ten-Year Plan to End Homelessness and provide important information for updating the plan. Beginning in 2014, the Point-In-Time Count will be called the K-Count. The 2014 K-Count will be held Wednesday, January 29, 2014.

The 2013 Point-In-Time Count located 5,245 homeless individuals. Of concern is the fact that 23% of the homeless were children under the age of 18 and 10% were young adults age 18-24. Families comprised only 3% of the homeless population, but they were 28% of the chronically homeless. This 2013 Count indicates a 21% decrease in individuals who are homeless compared to the last statewide Point-In-Time Count in 2010.

According to the Kentucky Department of Education (KDE), which provides the most accurate number of homeless children, there were 33,198 homeless children statewide in all grades during the 2010-2011 school year and 35,891 for the 2011-2012 school year (an 8% increase).

To determine if a child is homeless, Kentucky Department of Education uses the Department of Education/McKinney-Vento Education for Homeless Children and Youth definition of homelessness which is broader than the HUD definition. The HUD definition of homelessness excludes those living in substandard housing conditions, doubled-up with family or friends, or expecting eviction within seven days who have a community support

network to assist them. According to HUD, these individuals are precariously housed, not homeless. The Department of Education/McKinney-Vento Education for Homeless Children and Youth definition states that homeless students/people are those who lack a fixed, regular and adequate nighttime residence. This includes children and youth, ages three through 21 who are:

- Sharing housing due to loss of housing or economic hardship;
- Living in motels, hotels, dilapidated trailers or camping ground due to lack of alternative adequate housing;
- Living in emergency or transitional housing;
- Abandoned in hospitals;
- Awaiting foster care;
- Having a primary nighttime residence that is a public or private place not designed for, or ordinarily used as regular sleeping accommodations;
- Living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations; or
- Migratory students who live in housing described above.

According to the National Center on Family Homelessness report, America's Youngest Outcasts, children experiencing homelessness are compared to non-homeless children: 4x more often sick than other children; 4x as likely to have respiratory infections; 2x as likely to have ear infections; 5x more likely to have gastrointestinal problems; 4x more likely to have asthma; 2x more likely than other children to go hungry, yet they have high obesity rates due to nutritional deficiencies; and **3x more likely to have emotional and behavioral problems compared to non-homeless children.**

According to the National Center on Family Homelessness report, America's Youngest Outcasts, one in every 50 American children is homeless each year and do not have a safe place to sleep. The National Center on Family Homelessness 2009 report, America's Youngest Outcasts: State Report Card on Child Homelessness, ranked Kentucky 42nd. This ranking was based on the state's overall performance across four domains:

- 1) Extent of Child Homelessness (adjusted for population size)
- 2) Child Well-Being
- 3) Risk for Child Homelessness
- 4) State Policy and Planning Efforts

Almost 20 percent of homeless households interviewed in the 2010 Point-In-Time Count reported having children with them; national statistics put this number at closer to 50 percent.

### Special Populations

The 2013 Point-In-Time Count also reports on "special populations" such as veterans, individuals who are severely mentally ill, individuals experiencing chronic substance abuse, veterans, and victims of domestic violence (see table 2). Veterans comprise 11% of the homeless in Kentucky (male veterans 94%, female veterans 6%), individuals who are severely mentally ill are 17% of the homeless whereas domestic violence victims make up 15%. Individuals who experience chronic substance abuse are most likely to experience homelessness (27% of the homeless total).

**Table 1**

**2013 Commonwealth of Kentucky Point In Time Count**

	Total Homeless	Emergency Shelter				Unsheltered				Chronically Homeless			Transitional Housing			
		Total # of persons in Emerg. Shelter	Under age 18	18-24	Over age 24	Total # of persons Unsheltered	Under age 18	18-24	Over age 24	Total # of Persons Chronically Homeless	Persons in Families	# of Individuals (18 and over, alone)	Total # of Persons	Under age 18	18-24	Over age 24
KY	5,245	2,433	513	222	1,704	754	90	97	567	520	143	377	2,042	599	204	1,239
% of Total Homeless		46%	10%	4%	32%	14%	2%	2%	11%	1%	3%	7%	39%	11%	4%	24%
% of Category			21%	9%	70%		12%	13%	75%		28%	72%		29%	10%	61%

**Table 2**

<b>Special Populations</b>						
	<b>Total Veterans</b>	<b>Male Veterans</b>	<b>Females Veterans</b>	<b>Individuals Who Are Severely Mentally Ill</b>	<b>Victims of Domestic Violence</b>	<b>Individuals Experiencing Chronic Substance Abuse</b>
	595	562	33	880	773	1,398
% of Total Homeless	11%	11%	<1%	17%	15%	27%
% of Total Veterans		94%	6%			

## 2) Rural Area Services: Adult Mental Health

*Narrative Question: Describe how community-based services will be provided to individuals in rural areas.*

Using the definition of Standard Metropolitan Statistical Area, and information from the 2010 Census, Kentucky has 32 counties considered urban and 88 considered rural. Population distribution is shown in the chart below.

Regional MH/MR Boards	Adult Census 2010	Urban Adult Population	Rural Adult Population
1. Four Rivers	161,545	81,338	80,207
2. Pennyroyal	158,100	88,909	69,191
3. River Valley	161,977	108,431	53,546
4. LifeSkills	217,231	100,939	116,292
5. Communicare	200,640	78,127	122,513
6. Seven Counties	730,843	699,976	30,867
7. NorthKey	326,235	282,835	43,400
8. Comprehend	42,757	13,225	29,532
9/10. Pathways	170,601	87,533	83,068
11. Mountain	119,756	0	119,756
12. Kentucky River	89,550	0	89,550
13. Cumberland River	181,110	0	181,110
14. Adanta	160,202	19,047	141,155
15. Bluegrass	595,449	506,999	88,450
<b>Total</b>	<b>3,315,996</b>	<b>2,067,359</b>	<b>1,248,637</b>

Transportation barriers remain one of the greatest concerns among providers, consumers and family members. The Human Service Transportation Delivery Program pools existing public transportation funds including Medicaid non-emergency transportation. A total of 16 transportation regions statewide operate 24 hours a day/seven days a week with a single broker or broker/provider established in each region. Consumers access transportation services through a toll-free phone number. Ten of fourteen Regional Boards report engaging in initiatives to better coordinate transportation services in their regions. Region 10 (Pathways) has the most developed transportation initiative as they pay staff to transport individuals from almost any location in the Region to outpatient sites or to the crisis stabilization programs in Morehead and Ashland. Transportation remains, however, the number one barrier to accessing services in rural parts of the Commonwealth as reported by the Boards and their Regional Planning Commissions.

Rural communities often have fewer staff and resources to provide mental health services. It is important for rural mental health agencies to develop collaborative agreements with primary care physicians, senior citizens centers, church groups, and government agencies. Rural case managers have been resourceful in assisting persons with a severe mental illness in meeting their needs through the identification and development of local resources, and are critical linkages to formal and informal services and supports in rural Kentucky. Some changes in Kentucky law over the years have increased the types and numbers of mental health professionals who can be Qualified Mental Health Professionals and created licensure for professional counselors to provide mental health services. The KDBHDID will continue to work

with rural communities and other entities in addressing funding, training, and in bringing all stakeholders together at the state and local level to strategize best practices.

Several Regional MH/MR Boards now report delivering or accessing services from the telehealth network. Nine out of fourteen regions have telehealth equipment and utilize it for coordinating some services (i.e. case management assessments regarding state hospital discharge). Some of these uses include:

- Comprehend, Inc. uses the telehealth network for quarterly meetings with Eastern State Hospital and for trainings and other educational activities.
- Pathways, Inc. is developing telemedicine services and has sites in three counties.
- Kentucky River Community Care, Inc., has several sites equipped for video conferencing. Two sites are a part of the Appalachian Regional Healthcare network and one site is a part of the Centernet network. They convene business meetings, Olmstead meetings, case conferences, trainings and other events over these networks.
- Bluegrass Regional MH/MR Board uses Telehealth for discharge planning meetings between ESH and outpatient offices. Bluegrass also utilizes trainings from the University of Kentucky's TeleHealth network for continuing education of staff and general grand rounds.
- Lifeskills currently utilizes the telehealth network for discharge planning between WSH and outpatient offices. Specifically they use this technology to introduce hospital clients to their prospective case managers and outpatient therapists prior to discharge.
- Four Rivers currently utilizes the telehealth network for psychiatric screening and services as well as mental status assessments, case conferences, staff trainings and meetings.
- River Valley has a contract with the University of Louisville to provide psychiatric services via telehealth in a percentage of their outpatient clinics.

In May of 2009, the regulation regarding telehealth services was rewritten by Medicaid and submitted to CMS for approval. The original telehealth regulation approved only psychiatrists or advanced registered nurse practitioners as providers. In March of 2011, the telehealth amendment was approved by CMS. Medicaid now approves reimbursement for several other professionals (physicians, licensed psychologists, marriage and family therapists, professional counselors, licensed clinical social workers, psychiatric registered nurses, psychiatric medical residents) to provide the following services under telehealth:

- Consultations;
- Mental health evaluations and management;
- Individual and Group therapy;
- Pharmacological management; and
- Psychiatric/Psychological/Mental Health diagnostic interview examination.;

Regional Boards have begun to expand these reimbursable services into their array and it is hoped that more rural consumers will have better access to services and better continuity of care between providers. Prohibitive factors remain the extensive expense of the necessary equipment and the fact that not every Regional Board has this equipment at this time.

The DIVERTS (Direct Intervention: Vital Early Responsive Treatment System) project in the Western State Hospital catchment area, as well as the onset of reimbursement for telehealth services has spurred the increased utilization of this technology in that region of the state, in particular. The four Regional Boards that use Western State for inpatient care, have all

purchased telehealth equipment with the primary purpose of diverting as many individuals as possible from inpatient care, as well as insuring continuity of care upon discharge from the hospital. Staff from both the hospitals and the CMHCs involved in discharge planning use the technology to provide services as well as to discuss scheduling, clinic referrals, follow-up, and to allow inpatient psychiatrists to consult with local clinical practitioners in pre-screening admission.

## 2) Rural Area Services: Children’s Mental Health

*Narrative Question: Describes how community-based services will be provided to individuals in rural areas.*

Using the Rural-Urban Continuum Codes and the 2010 Census information, Kentucky has 35 (29%) counties considered metropolitan, 49 nonmetropolitan urban (41%), and 36 nonmetropolitan completely rural (30%). See table below. The three most common barriers to mental health services in rural areas are the isolation of families who have a child with an emotional disability, limited workforce and limited public transportation. Isolation can be partially attributed to the geographic distance between neighbors, but may be more closely associated with the heightened stigma associated with mental health services in rural areas and the difficulty of ensuring confidentiality and anonymity in a small community.

Rural-Urban Continuum Codes	Description of Rural-Urban Continuum Codes	# of KY Counties
1	Metro - Counties in metro areas of 1 million population or more	14
2	Metro - Counties in metro areas of 250,000 to 1 million population	11
3	Metro - Counties in metro areas of fewer than 250,000 population	10
4	Nonmetro - Urban population of 20,000 or more, adjacent to a metro area	2
5	Nonmetro - Urban population of 20,000 or more, not adjacent to a metro area	4
6	Nonmetro - Urban population of 2,500 to 19,999, adjacent to a metro area	19
7	Nonmetro - Urban population of 2,500 to 19,999, not adjacent to a metro area	24
8	Nonmetro - Completely rural or less than 2,500 urban population, adjacent to a metro area	11
9	Nonmetro - Completely rural or less than 2,500 urban population, not adjacent to a metro area	25

Data Source: USDA, Economic Research Service, May 2013

Limited public transportation contributes to problems with accessing services and also increases the cost of services. The Human Service Transportation Delivery (**HSTD**) Program provides non-emergency, non-ambulance medical transportation services to eligible Medicaid, Vocational Rehabilitation, and Department of the Blind recipients. HSTD services are coordinated by the Kentucky Transportation Cabinet, Office of Transportation Delivery. The state is divided into twelve transportation regions with a single delivery broker established in each region. Consumers access transportation services through a toll-free phone number. When no other source of funding is available to Kentucky IMPACT clients, wraparound funds may be used to pay transportation costs, or if appropriate, costs to repair or secure an automobile.

### Telehealth

The advantages of establishing a telehealth capability across rural areas are well known. Due to difficulties in recruiting qualified medical and clinical staff to work in more rural areas, telehealth can be used to extend staff coverage from a central site to outlying rural clinics and other service sites. Specialized services (e.g., therapists who are fluent in sign language, psychiatry, crisis services) can be effectively extended through the use of technology. The Kentucky Department for Medicaid Services reimburses providers for tele-psychiatry, psychotherapy, family therapy and group psycho-therapy when services are provided to DMS eligible members through real-time telecommunications and conducted by a legally authorized representative for a medically necessary service.

Another strategy to address rural access problems is the recruitment and development of family support staff, who are parents of children with severe emotional disabilities. These parents are responsible for facilitating a regional network of parent-to-parent support and advocacy, which provide informal connections between parents to supplement kinship networks. An additional problem is the difficulty of recruiting staff to work in the rural areas, which limits the capacity to expand and create alternative, non-traditional services.

### Opportunities for Family Leadership

Opportunities for Family Leadership (OFL) is a unit within DHBDID which offers a resource line for parents and caregivers to access education, resources and support. The toll free number for the resource line is (800)374-9146. OFL provides numerous services for families and youth and the systems that serve them, including:

- Training in advocacy, communication, cultural competency, collaboration and legal rights in schools;
- Awarding mini-grants for parent and youth support groups to develop local training events and provide community resource libraries. Over 250 training events are held each year by parent and youth groups.
- Providing technical assistance to ensure Standards of Practice for Family Liaisons and Kentucky Family Peer Support Specialists across the state are met and approving required trainings per the Standards of Practice;
- Awarding mini-grants for parent and youth support groups to develop local training and awareness events;
- Distributing reader friendly versions of Client Rights and Grievance Procedures, and supporting documents to parents, youth and others to ensure that these policies and procedures are understood by everyone; and
- Providing technical assistance to organizations and individuals with regard to children's behavioral health, developmental and intellectual disabilities and substance abuse services and supports. Resource information and training opportunities are among the many items provided on OFL's web site at <http://dbhdid.ky.gov/dbh/OFL.asp>.

While the three problems of isolation, transportation and workforce are common to rural areas, each rural community has its own unique problems because of cultural, geographic and social differences. Thus, the strategies to address them must be collaborative among local, regional and state level stakeholders.

One strategy to address rural access problems is the recruitment and development of family support staff, who are parents of children with severe emotional disabilities. These parents are responsible for facilitating a regional network of parent-to-parent support and advocacy, which provide informal connections between parents to supplement kinship networks. An additional



problem is the difficulty of recruiting staff to work in the rural areas, which limits the capacity to expand and create alternative, non-traditional services.

While the three problems of isolation, transportation and workforce are common to rural areas, each rural community has its own unique problems because of cultural, geographic and social differences. Thus, the strategies to address them must be collaborative among local, regional and state level stakeholders.

### **3) Older Adults**

*Narrative Question: Describes how community-based services are provided to older adults.*

According to the 2010 Census, Kentucky's population of persons 60 and older is approximately 829,193 persons, representing approximately 19.1% of the state's population. It is anticipated that this population will increase by 91.4% by the year 2030, due to the aging of the "baby boom" generation. With regards to persons 60 and older with mental health issues, community mental health centers serve approximately 6% on a National level.

Chronic depression is not a normal part of the aging process, but it does occur frequently among older adults. More than 15 percent experience depression at some point in their later years. Nearly 50 percent of people with Parkinson's Disease and 35 percent of those suffering from Alzheimer's Disease become chronically depressed. Diagnosis of mental health conditions can be more complicated with older adults. Many are not treated for their mental health problems due to lack of recognition of the problem, ageism, stigma, and lack of trained professionals who can identify and treat these mental health disorders.

There is a lack of flexibility in funding to provide the services that older adults need. Medicare is a funding source for most of these persons, but Medicare reimburses at 50 percent of an approved cost for mental health services. Medicare will reimburse for acute care, but not for services that might be defined as rehabilitative.

Kentucky is committed to addressing the need of expanded access to mental health treatment for older adults with serious mental illness. In 1999, Kentucky received a SAMHSA grant that eventually led to the development of a state level Mental Health and Aging Coalition. The state level coalition consists of representatives from KDBHDID, Department for Aging and Independent Living (DAIL), Area Agencies on Aging, Office of Vocational Rehabilitation, University of Kentucky, University of Louisville, CMHCs, consumers, caregivers, and other interested stakeholders. Coalition goals for SFY 2013/2014 are:

- To encourage every local coalition to include at least one adult consumer of behavioral health services or caregiver representative of an older adult consumer of behavioral health services, in their coalition;
- To establish Mental Health and Aging Coalitions in every region across the state through continued outreach and to establish a formalized alliance with DAIL;
- To explore the feasibility of participating in the advocacy planning technical assistance project from the Geriatric Mental Health Alliance of New York;
- To continue to explore ways to maximize relationships in order to develop name recognition and partner with other entities to advance mutual goals and objectives;
- To continue to increase awareness/knowledge of regional initiatives by hosting at least one statewide coalition meeting per year at a regional coalition annual meeting/conference; and

- To provide “Mental Health First Aid” “Train the Trainers” training to two people who agree to provide trainings for the local coalition.

There are currently ten (10) Mental Health and Aging Coalitions in Kentucky. Mental Health Block Grant funds are used to support the following activities through these coalitions:

- Regional training/conferences for professionals, caregivers and consumers;
- Public education and awareness activities;
- Traveling exhibit boards;
- Development and distribution of resource manuals;
- Health fairs and depression screenings;
- Suicide prevention projects;
- Anxiety reduction programs; and
- Mental Health First Aid training.

In Kentucky there are fifteen (15) Area Development Districts (Area Agencies on Aging), which focus on the needs of Older Adults. The Area Agencies on Aging are under the umbrella of the Department of Aging and Independent Living (DAIL). The KDBHDID collaborates with DAIL and the Regional Boards in a variety of ways, including:

- Staffing the statewide Mental Health and Aging Coalition;
- Participating in training events regarding mental health and aging;
- Staffing the Mental Health Planning and Advisory Council;
- Participating in numerous committees such as KinCare Subcommittee, Alzheimer’s Disease and Related Conditions Council, Grandparents Raising Grandchildren-Bluegrass chapter, and the Kentucky Elder Readiness Initiative; and
- Grant applications regarding older adults and mental health.

A staff person from the DBHDID serves as a designee for the Commissioner on the NASMHPD Older Person’s Division. This is a national group comprised of one designee from each state and territory, as well as a liaison from NASMHPD. This group strives to consistently provide resources and consultation to the state mental health authorities regarding the imperatives in the Surgeon General’s Report and the President’s New Freedom Commission Report regarding mental health needs throughout the life span. The Older Person’s Division keeps abreast of the national agenda in this arena and shares information with membership through monthly conference calls.

## **Criterion 5: Management Systems**

### **1) Resources for Providers: Adult and Children’s Mental Health**

*Narrative Question: Describes financial resources, staffing, and training for mental health services.*

This criterion addresses three critical components of the overall management of the systems of care that serves adults with SMI and children with SED. These components include Financial, Workforce and Training. Kentucky struggles to maintain and improve performance with serious financial constraints and workforce shortage issues. Thoughtful and collaborative planning is key to moving the system forward in the face of such challenges. Offered below is discussion about the current status of the three components for this Criterion.

#### **Component 1: Financial**

Regional Boards have been hard hit financially in the past year in several salient ways, including:

- Frozen Medicaid rates for key services, including Case Management;

- Increases in costs to provide health insurance for their employees;
- Increases in the percentage employers must pay towards retirement plans; and
- National economic crisis (increased access; increased transportation issues).

As described in Section I of this grant application, Regional Boards are required by statute and contract to provide a core array of services and are held accountable to selected performance indicators, but are given considerable autonomy in how funds are distributed based on regional priorities. Detailed block allocations for SFY 2014 are provided elsewhere in this document.

### **Component 2: Workforce**

KDBHDID contracts directly with each Regional Board to provide direct services and each Board employs the staff who deliver services. Thus, KDBHDID involvement in human resource development activities for the Regional Boards and their staff have traditionally been indirect, focusing on staff training, technical assistance and the establishment of minimum qualifications and core training requirements for providers.

The system has also been hard hit by an exodus of retirees in both central office and the Regional Boards. This exodus is occurring because enhanced pension benefits that have been available for several years ended on January 1, 2009. The Boards have experienced many recent changes in management. Half of the fourteen Chief Executive Officers for the Regional Boards have retired as well as many in other leadership positions.

### **Component 3: Training**

KDBHDID strives to provide access to on-going training and technical support for all Central Office staff as well as partner agencies and providers statewide. There is a full time Training Coordinator position within the Department to assist with these efforts. The Department seeks to utilize available technology to provide educational/training and consultation opportunities. One example is the TrainingFinder Real-time Affiliate Integrated Network (TRAIN). TRAIN is comprised of the national TrainingFinder.org site and participating TRAIN affiliates. TRAIN is a web-based system allowing anyone with internet capability to access the description and registration process for a number of trainings. KDBHDID is developing on-line modules through a software program called LECTORA. These presentations can provide basic information more efficiently as participants can proceed at their own pace in their own locations.

KDBHDID provides or sponsors and participates in a variety of other training initiatives. This includes many opportunities for central office staff, as well as contracted and private service providers to increase their knowledge and skill level in various best practices. Many offerings provide participants with needed continuing education units (CEUs) for professional board certification or licensure.

The Department provides scholarships (limited) for consumers, parents/family members, and Regional Board staff to attend training events. Funds are also used to provide Certified Psychiatric Rehabilitation Practitioner (CPRP) examinations from the US Psychiatric Rehabilitation Association (USPRA) for Regional Board staff, as well as to support technical assistance for the development and maintenance of adult and children's programming (e.g., Targeted Case Management, Therapeutic Foster Care). The table below details some available training events.

## Division of Behavioral Health Sponsored/Provided Training Events

<b><i>Trainings Relevant to Adult Services</i></b>			
<b>Type of Training</b>	<b>Intended Audience</b>	<b># of Participants Anticipated</b>	<b>Frequency/ Length of conference</b>
Case Management Certification Training—Level I (required for providers)	Mental Health Case Managers who work with Adults with SMI and their supervisors	Approximately 80	Online component available continuously plus a 1 day face-to-face training offered 4 times per year
<b>Adult Case Management Training—Level II</b>	Mental Health Case Managers who work with Adults with SMI and their supervisors	Approximately 80	4 per year 2 days each
Community Support Program (CSP) Directors Technical Assistance Meetings	CSP Directors	Approximately 25	Quarterly 1 Day
<b>Hearing Voices that are Distressing</b>	Behavioral health providers and administrators, consumers and family members	Maximum of 40	As requested 3 hours
Kentucky Peer Specialist Training	Consumers of behavioral health services	Varies depending on location across the state	At least 1 per year 5 days
Leadership Academy	Consumers of behavioral health services	Approximately 25	4 per year 2.5 days
SSI/SSDI Access, Outreach and Recovery (SOAR)	Case Managers, Social Service Workers, Homeless Service Providers	Approximately 30 per session	6-8 per year; 2 days
<b>Working with Adults with SMI who have Hearing Loss: Case Management Level II Training</b>	SMI Case Managers	Approximately 25 per session	1.5- 3 hours. Embedded in Case Management training and available by request

**BOLD** Denotes that Continuing Education Units (CEUs) are offered for these training sessions. The following offers additional detail about some of the major training events listed above.

## ***Description of Trainings Relevant to Adult Services***

### **Adult SMI Targeted Case Management Certification Training**

The adult certification program consists of an online training module and an online certification examination administered through TRAIN, and a one day mandatory face-to-face training. The face-to-face training is held four times per year, two in the fall and two in the spring. The curriculum for these trainings has been developed by a team of professionals, consumers and advocates. The faculty seeks to continually improve upon the content and delivery of the information deemed most relevant. This group is enthusiastic about follow-up training and support for case managers and it is hoped that staff retention will be affected by the work being done.

*There are two distinct Case Management/Service Coordination training programs designed separately for adult case managers and child service coordinators.*

### **Adult SMI Case Management Training—Level II**

This two-day training will be open for adult case managers and case management supervisors. This seminar will be offered during SFY 2011, as a statewide event open to all child and adult case managers.

### **Hearing Voices that are Distressing**

This is based on a training module developed by Patricia E. Deegan, Ph.D. This training consists of activities designed to simulate auditory hallucinations. The goal is to foster understanding and empathy in providers.

### **Kentucky Peer Specialist Training**

This five day, thirty hour training prepares participants to pursue employment as Kentucky Peer Specialists. The training is provided primarily by consumers using a curriculum developed from national peer support experts, Ike Powell and Larry Fricks.

### **Leadership Academy**

Since 2003, the Office of Consumer Services within KDBHDID has sponsored a Leadership Academy for adult consumers of mental health services. This training prepares consumers to assume a position of strong leadership in changing the system of care. The Leadership Academy provides two levels of education:

Level 1: Participants learn to take the initiative, develop projects, collaborate with others, participate in policy decisions, influence the budgets at the state and local levels, improve services, create new services, and educate the community.

Level 2: Prepares participants to present trainings in their communities. Topics include, Advance Directives, Consumer Rights, Leadership Academy, Recovery and Transitioning Skills.

### **SSI/SSDI Access, Outreach and Recovery (SOAR)**

The Department collaborates with Kentucky Interagency Council on Homelessness and the Kentucky Housing Corporation to provide these trainings in communities across the state. These trainings educate providers about the application process for social security benefits and how best to assist consumers.

### **Community Support Program (CSP) Directors TA Meetings**

These meeting are held quarterly and are open to all Regional Board Community Support Directors as well as other staff working in community programs serving adults with SMI.

<b>Trainings Relevant to Children's Services</b>			
<b>Type of Training</b>	<b>Intended Audience</b>	<b># of Participants Anticipated</b>	<b>Frequency/ Length of conference</b>
<b>Ages and Stages Questionnaire – Social Emotional</b>	Mental Health Practitioners and other clinicians who provide services to the birth to five population	60	As needed; 2 days
Behavioral Health Professionals (BHPs) Regional Forums	IMPACT Plus Sub providers, CMHC partners (LRCs) (Offered Regionally)	Varies depending on location	4 Hours As needed
<b>Behavior Institute, co-sponsor</b>	Educators, administrators, agency service providers, and families	Approximately 1200	Annually; 2.5 days
<b>Child Parent Psychotherapy Learning Collaborative</b>	Early Childhood Master's Level Clinicians	30	Learning Collaborative 18 months
<b>Child System of Care Summit</b>	Children's Targeted Case Management Providers and their Supervisors, Parents, Central Office Staff, Representatives from Collaborating Agencies	Approximately 200	Annually 2-3 Days
<b>Child Targeted Case Management/Service Coordination 101 Certification</b> (required for providers of TCM)	Prospective providers of Children's Targeted Case Management services (IMPACT and IMPACT Plus and their Supervisors)	Up to 50 per Session	Quarterly 2.5 Days
<b>DC:0-3R</b>	Mental Health Practitioners and other clinicians who treat disorders of infancy and early childhood	60	As needed; 2 days
Effects of Prenatal Drug Exposure/FASD	Behavioral Health service coordinators, clinicians, prevention specialists	15-20	As needed
Evaluation Webinars	Service Coordinators, LRCs, and LRC Assistants	15	Monthly 2 hours
Family Leadership Academy	Caregivers of children with behavioral health issues, young adults (16-25) with emotional disabilities	Up to 50 per Session	Biannually 3 Days

<b>Trainings Relevant to Children's Services</b>			
<b>Type of Training</b>	<b>Intended Audience</b>	<b># of Participants Anticipated</b>	<b>Frequency/ Length of conference</b>
Family Liaison Orientation	New Family Liaisons	The training is typically one-on-one with new Liaisons.	3-4 Hours As needed.
IMPACT Introduction to Deafness	IMPACT Service Coordinators	Approximately 25 per Session	1.0-1.5 hours embedded in Service Coordination 101 OR available by request 1-3 Hours
<b>IMPACT Plus Behavioral Health Professional (BHPs) Training 101</b>	IMPACT Plus BHPs and BHPs under Clinical Supervision (Offered Regionally)	Varies depending on location	Quarterly 1 Day
Introduction to Child Development of Children who are Deaf or Hard of Hearing	Providers of early intervention and children's services, Kentucky School for the Deaf staff, and others by request	Target 10-20 per Session	As requested and tailored to needs of group
Introduction to Evaluation Family Interviewer Training	Family Interviewers for RIACs receiving KY SEED funds	5	Annually; 1.5 days
Kentucky Family Peer Specialist Support Specialist Core Competency Training	Family Leadership Academy Graduates	Up to 30	5 Days Biannually
KY SEED Monthly Cohort Meeting and Technical Assistance	RIACs that provide ECMH services	Cohort 1 & 2; approximately 25 participants	Monthly; 2 hours
KYSEED New Cohort Orientation	Newly funded RIACs that will provide ECMH services.	4 regions, approximately 45 participants	Annually; 2.5 days
KY SEED Regional Interagency Council Technical Assistance Meetings	RIAC members, regional CMHC staff	Cohort 1 & 2; approximately 25 participants	As needed; 1 day
Lifelines Prevention Curriculum	6 <sup>th</sup> -12 <sup>th</sup> grade students (about 10,000 over the next 2 years)		
<b>Mental Health First Aid USA</b>	Any Family or Community Partner	25	As requested 2 Days

<b>Trainings Relevant to Children's Services</b>			
<b>Type of Training</b>	<b>Intended Audience</b>	<b># of Participants Anticipated</b>	<b>Frequency/ Length of conference</b>
<b>Motivational Interviewing</b>	IMPACT Program Staff from Regional Boards (Offered Regionally)	Up to 25 per Session	Provided for each Region 1 Time
<b>Parent –Infant Dyad Therapy</b>	Regional Perinatal Depression contacts, Early Childhood Mental Health Specialists	Up to 25 per Session	3-4 Times per Year 2 Days
<b>Parent Child Interaction Therapy</b>	Mental Health Practitioners and other clinicians who treat disorders of infancy and early childhood	60	As needed; 3 days
<b>School Law</b>	IMPACT Program Staff from Regional Boards & Family Members, Community Partners (Offered Regionally)	Up to 40 per Session	Annually 3 Hours
<b>Service Coordination 101</b>	IMPACT Service Coordinators, IMPACT Local Resource Coordinators, Supervisors of Service Coordinators, Department for Community Based Service (DCBS) staff providing Medicaid-funded Targeted Case Management, and their supervisors, IMPACT Plus Case Managers, IMPACT Plus supervisors of Case Managers, Behavioral Health Professionals/Behavioral Health Professionals under clinical supervision	60	4 Times per Year 2.5 days
<b>Seven Challenges</b>	Community Mental Health providers that are under the umbrella license Fidelity visit-same as above	15	1 day as needed Fidelity visits from Seven Challenges llc, 1 x per year
School-Based Suicide Prevention	School Administrator, Educators, Staff	40	As requested
Team Observation Measure	CMHC Kentucky IMPACT Staff	20-30	3 hours 2-4 times per year
Transition Aged Youth Launching Realized Dreams (TAYLRD)	Child and Adult Case Managers	60	As requested 1 Day
<b>Trauma-focused Cognitive Behavioral Therapy Learning Collaborative</b>	Master's Level Clinicians	25	1 Year Learning Collaborative



<b>Trainings Relevant to Children's Services</b>			
<b>Type of Training</b>	<b>Intended Audience</b>	<b># of Participants Anticipated</b>	<b>Frequency/ Length of conference</b>
<b>Trauma Informed System of Care Training</b>	Any Community Providers	50	As requested 3 Hours
<b>Trauma Informed System of Care Training for Trainers</b>	Trainers within various child serving agencies	25	1 day, plus follow-up sessions, 2 per year
Wraparound Refresher Training	Mental health staff, educators, child welfare staff, juvenile justice staff, court staff	50	As requested 1 Day
Youth/Parent Conference	Youth between the ages of 13 and 24 with emotional, behavioral, mental health, and substance use disabilities and their parents or caregivers.	100	2 Days Annually

**BOLD** Denotes that Continuing Education Units (CEUs) are offered for these training sessions. The following offers additional detail about some of the major training events listed above.

### **Description of Trainings Relevant to Children's Services**

#### Ages and Stages Questionnaire: Social Emotional

KY SEED hosted the ASQ and ASQ: SE Train the Train sessions for early intervention program staff, child development specialists, public health professionals, social workers, child care providers and early childhood mental health specialists. Participants were given an introduction to developmental screening, legal mandates, and the benefits of developmental screening; the methods of administering the questionnaires, tracking results, scoring the questionnaires, and communicating screening results to families; how to interpret ASQ-3 scores and how to make referral decisions based on those scores; and implementation issues.

#### Behavioral Health Professionals Regional Forums

Regional Forums are held to focus on issues related to training needs (some include trainings), resource development and collaboration within regions as well as information dissemination. This year, 1200 educators, school administrators, pupil service personnel, child-serving agency providers, and youth and families attended.

#### Behavior Institute (sponsor)

The Behavior Institute is a cutting edge two-day behavior conference sponsored by the Kentucky Council for Children with Behavior Disorders, the Kentucky Department of Education, Kentucky's System to Enhance Early Development through Kentucky Division of Behavioral Health, Kentucky Autism Training Center and the Central Kentucky Special Education Cooperative.

#### Child Parent Psychotherapy

Child Parent Psychotherapy is an intervention for children from birth-5 who have experienced at least one traumatic event and, as a result are experiencing behavior, attachment, or mental health issues. The goal of CPP is to support and strengthen the relationship between the child and his or her caregiver to help restore the child's sense of safety, attachment and appropriate affect and improving the child's cognitive, behavioral, and social functioning.

### Child System of Care Summit

This is an event planned to bring all child serving agencies together to discuss System of Care development across the state and across all agencies. Generally a theme around a specific topic (e.g., Co-occurring MH and SA among adolescents) emerges throughout the year and is the focus of the plenary session.

### Child Targeted Case Management/ Service Coordination (SC 101) Certification Training

The Department is responsible for certifying children's case managers and offers quarterly training in different areas of the state. The faculty consists of regional providers, parents and a Medicaid representative. The content of the training is skills-based. Supervisors are provided a manual to use with staff to cover additional areas of interest and on-line modules are being considered for the coming year. The training is continually evaluated and improvements to the content and delivery are made accordingly. Information about co-occurring mental health and substance abuse and information about deafness are currently being added to the curriculum. *There are two distinct Case Management/Service Coordination training programs designed separately for adult case managers and child service coordinators.*

### DC: 0-3R

KY SEED hosted two training sessions about the proper utilization of the DC:0-3R - Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood. This developmentally based system for diagnosing mental health and developmental disorders in infants and toddlers will assist mental health clinicians, counselors, physicians, nurses, early interventionists, early childhood educators, and researchers as they provide ECMH services. The DC:0-3R is an indispensable guide to evaluation and treatment planning with infants, toddlers, and their families. On-going mentoring regarding the utilization of the DC:0-3R is provided to service providers by the KY SEED clinical staff.

### Effects of Prenatal Drug Exposure/FASD

The Department's Substance Exposed Infants Workgroup and FASD Prevention Enhancement Site offer trainings quarterly recognizing children who may need an FASD assessment, providing services and supports for these children, and preparing the family and young adult for transition to adulthood.

### Family Leadership Academy

The Department has partnered with the statewide family advocacy organization, KPFC to create curriculum and offer quarterly week-long sessions for parents/caregivers of youth with SED.

### Family Liaison Orientation

A Kentucky Peer Support Specialist from the Opportunities for Family Leadership (OFL) meets with new Family Liaisons to conduct a 3-4 hour OFL 101 training. She supplies the Liaison's with books on diagnoses, advocacy and other topics they need to carry out their role.

### IMPACT Introduction to Deafness

This training can be adapted from 1-3 hours as an introduction to working with Deaf-member families. Focus is on understanding the cultural and linguistic implications of hearing loss, adapting services, and knowing the appropriate resources.

### IMPACT Plus Behavioral Health Professionals Training 101

Training is provided to BHPs and BHP under clinical supervision to provide information on the wraparound model, developing goals that focus on the strengths of the child and family as a way to address unmet needs. The sessions also include information on boundaries and ethics as well as documentation as outlined in the IMPACT Plus regulations.

### Introduction to Child Development with Children Who Are Deaf or Hard of Hearing

This workshop challenges providers to think about the psychosocial development of children with hearing loss and how best to provide wraparound services that meet the needs of the whole child.

#### Introduction to Evaluation - Family Interviewer Questions

These are trainings given to Family Interviewers as part of the KY SEED project.

#### Kentucky Family Peer Support Specialist Core Competency Training

The Department partnered with the statewide family advocacy organization, KPFC, in 2009 to provide this intensive, skills-based five (5) day training. Parents/caregivers must be a graduate of the Family Leadership Academy and complete an application process and to qualify for this training. The Department continues to work with Medicaid Services to make Specialists' services Medicaid billable.

#### KY SEED Monthly Cohort Meeting and Technical Assistance

RIACs that receive funding from KY SEED participate in monthly conference calls with KY SEED staff to discuss implementation issues including accomplishments, challenges, best practices or possible solutions, staff needs, budget execution and monitoring, and clinical information to enhance ECMH services. KY SEED staff provide technical assistance or identify resources to support the RIACs.

#### KY SEED New Cohort Orientation

KY SEED staff and other organizational partners conduct a 2 ½ day orientation session for newly funded RIACs. This session includes information about the concepts and philosophy of system of care and its history in KY, early childhood development, social marketing, evaluation, and cultural and linguistic competency. Practical information about implementation of this initiative is also provided including reporting requirements, budget administration, technical assistance, and community readiness.

#### KY SEED Regional Interagency Technical Assistance Meetings

Meeting/training held to orient new cohorts to the early childhood system of care grant initiative.

#### Lifeline Prevention Curriculum

The Lifelines Prevention Curriculum educates students on the facts about suicide and students' role in suicide prevention. It provides information on where to find suicide prevention resources in the school and community. Training materials are included for faculty and staff that provide accurate and practical information on identifying and referring students who might be at risk for suicide. *Lifelines: A Suicide Prevention Program* also includes a presentation for parents that answers questions about youth suicide and prevention, and it involves them in the school's suicide prevention activities.

#### Motivational Interviewing

These trainings are designed to help participants gain a greater understanding of adolescent development, Stages of Change Theory, and Motivational Interviewing and how they each relate to effectively working with teens and their families. The course includes experiential "real plays", brief lectures and videos in a six hour time frame.

#### Parent-Infant Dyad Therapy

This two-day training is skills-based and offered to the Regional Board staff who are designated as the Perinatal Depression "point persons" and the Early Childhood Mental Health Specialists.

#### Parent Child Interaction Therapy

KY SEED provides quality training and support to ECMH service providers which can improve the quality of mental health services provided to children and families. Parent-Child Interaction Therapy (PCIT) is a proven parent-child treatment program that assists parents of children with behavioral problems (aggression, non-compliance, defiance, and temper tantrums). This unique treatment program focuses on promoting positive

parent-child relationships and interactions while teaching parents effective child management skills. It is our goal to increase the number of trained and qualified mental health providers in rural and urban areas with the expertise to comprehensively respond to the special needs of children and families through the delivery of PCIT services.

#### School-Based Suicide Prevention

Participants leave this workshop with practical information on how to implement evidence-based universal and targeted suicide prevention programs, the issue of suicide contagion in Kentucky schools, and suicide postvention procedures.

#### School Law

The Department partners with Protection and Advocacy to offer a three-hour overview seminar that provides audience with basic knowledge of IDEA, NCLB, and KDE disciplinary actions protocol. Participants are provided with an array of resources for additional further study and tools for advocating in school meetings for their own or other children.

#### Service Coordination 101

Service Coordination 101 Certification Training is required in order to bill the Kentucky Medicaid Program or the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), Division of Behavioral Health for Targeted Case Management Services. Service Coordinators/Case Managers and their supervisors must complete this training within six months of employment. This three day training is offered four times during the calendar year and provides certification for Service Coordinators/Case Managers and their supervisors.

#### Seven Challenges

The Department carries an umbrella license for the Community Mental Health Agencies to use the Seven Challenges Model. The trainings that occur will be for providers who need to train agency staff as providers but will need to have one person in their agency designated as a “leader” and have attended the “leader training” that is only offered by Seven Challenges LLC. Seven Challenges LLC also requires that there is a once a year fidelity visit that all leaders and providers must attend in which not only is fidelity issues discussed and reviewed but also continued support and education/training is given to those in attendance around the Seven Challenges model and philosophy

#### Technical Assistance Meetings for IMPACT Local Resource Coordinators, Early Childhood Mental Health Specialists, Children’s Crisis Program Directors, Therapeutic Foster Care Providers, Children’s Services Directors, Family Liaisons, Kentucky Family Peer Support Specialists, State Family Advisory Council Members,

These meeting are held quarterly for 1-1½ days and are open to all Regional Board staff belonging to one of these peer groups.

#### Team Observation Measure Training

A training to teach Kentucky IMPACT staff how to implement the Team Observation measure, a wraparound fidelity instrument.

#### Trauma Informed System of Care Training

A cross-agency overview of trauma and trauma informed care.

#### Trauma Informed System of Care Training for Trainers

A cross-agency training to train child serving agency trainers on a “Trauma Informed System of Care Basics Training” so that they, in turn, can train their agencies on a general overview of trauma and trauma informed care.

#### Wraparound Refresher Training

This 1-day training will provide experienced team facilitators with knowledge about the principles and phases of Wraparound.

Youth/Parent Conference

An annual 2 ½ day conference that offers tracks for youth between the ages of 13-17 years old that have an emotional, behavioral, mental health, and/or substance use disability; young adults (transitional age: 18-25 years old) that have an emotional, behavioral, mental health, and/or substance use disability; and parents of these youth and young adults.

<b>Trainings Relevant for Both Adult and Children’s Services</b>			
<b>Type of Training</b>	<b>Intended Audience</b>	<b>Number of Participants Anticipated</b>	<b>Frequency/ Length of conference</b>
Access Options for Consumers with Hearing Loss	Each CMHC Region and other Providers Upon Request	Ranges from 5-125 per Session	As Requested; In Partnership with Hamilton Relay
Adapting Substance Abuse Treatment for Deaf or Hard of Hearing Consumers	Any provider currently or interested in serving consumers with hearing loss.	Target 8-25 per Session	As requested. Tailored to needs of audience.
<b>American Sign Language Interpreter Peer Supervision Groups on Mental Health Interpreting</b>	Certified, Licensed Interpreters and interns working in mental health settings across the state. Groups exist or are forming in Lexington/Danville, Louisville, Northern KY, and Bowling Green	Target 5-10 per Session	Every 4-6 weeks One Day
Applied Suicide Intervention Skills Training: Training for Trainers	CMHC Crisis Directors and Master’s Level Clinicians	25 across the state	
<b>Assessing and Managing Suicide Risk: Core Competencies for Mental Health</b>	CMHC Behavioral Health Clinicians	Target-30 per Session	As requested One Day
<b>Assessing and Managing Suicide Risk: Training for Trainers</b>	CMHC Behavioral Health Clinicians	20	
Barbara Stanley Suicide Safety Planning Training	CMHC Clinicians, Crisis Staff, Administrators	1,000-1,500 over next 2 years	

**Trainings Relevant for Both Adult and Children's Services**

<b>Type of Training</b>	<b>Intended Audience</b>	<b>Number of Participants Anticipated</b>	<b>Frequency/ Length of conference</b>
Collaborative Assessment and Management of Suicidality (CAMS)	CMHC Master's Level Clinicians and Crisis Staff, Psychiatrists, Crisis Directors, Administrators	250 Statewide	
<b>Cognitive Behavior Therapy for Consumers who are Deaf with Language and Learning Challenges</b>	Therapists, case managers, rehabilitation counselors for the deaf, and others.	40	As needed.
<b>Cognitive Behavior Therapy for Perinatal Depression</b>	Regional Perinatal Depression contacts, Early Childhood Mental Health Specialists	30-50 per Session	3 Times per Year 2 Days
Columbia Suicide Severity Rating Scale Training	Behavioral health care providers	1,000-1,500 statewide over two years	
<b>Crisis Intervention Team Training (CIT)</b>	Law Enforcement Officers	Approximately 180 Total	6 per year 5 Days (40 hours)
<b>Cultural Competency Training of Trainers</b>	Current and prospective providers of Cultural Competency Training at the KDBHDID operated or contracted facilities and Regional Board staff and KDBHDID central office staff	Varies depending on location across the state	As requested 2-3 Days
<b>Deaf and Hard of Hearing Providers' Symposia</b>	DHHS Specialists and other CMHC staff with consumers with hearing loss.	20	Quarterly
<b>Deafness 101</b>	Overview of Cultural and Linguistic Issues in Serving Deaf or Hard of Hearing Consumers for any interested providers of mental health, developmental disability, or addiction services	Varies depending on interest and location – available statewide. Target is 100.	As Requested by Any Provider or Educational Institution across the State. Goal is to have it offered at every CMHC and facility. 1.5 to 3 hours

**Trainings Relevant for Both Adult and Children's Services**

Type of Training	Intended Audience	Number of Participants Anticipated	Frequency/ Length of conference
<b>Deafness 102</b>	1.5 to 3 hour Overview of adapting clinical practices to be culturally and linguistically affirmative for those with hearing loss. Available to current or prospective providers	Varies depending on interest and location. Available statewide. Goal is 100.	As Requested by Any Provider or Educational Institution Across the State. Goal is to have it offered at every CMHC and facility. 1.5 to 3 hours
Department of Psychiatry Grand Rounds	Department staff	5-110	1 ½ - 2 Hours Bimonthly
<b>Emergency Services Training</b>	Behavioral health providers and administrators, community providers and leaders, local interest groups.	Available statewide	As needed
<b>Evidenced Based Care for the Client At-Risk for Suicide</b>	Behavioral health clinicians	Target-80	As requested One Day
<b>Kentucky Registry of Interpreters for the Deaf (RID)</b>	DHHS Interpreters from across the state	17-40	Annually
KDBHDID Orientation	Newly Hired Central Office Staff	Average 4-8	Quarterly and as needed 1 Day
Kentucky Behavioral Health Planning and Advisory Council Member Orientation	New and current members	15	Annually
<b>Kentucky School of Alcohol and Other Drug Studies</b>	Behavioral health providers and administrators, consumers and family members	Approximately 600	Annually 4.5 Days
<b>Law Enforcement Response to Individuals with Special Needs</b>	Police Officers, Deputies, School Resource Officers	25	5 Days 40 Hours

**Trainings Relevant for Both Adult and Children's Services**

<b>Type of Training</b>	<b>Intended Audience</b>	<b>Number of Participants Anticipated</b>	<b>Frequency/ Length of conference</b>
Lethal Means Restriction in Emergency Departments Training	Hospital Emergency Department nurses, doctors, case managers	1,000-1,500 over next 2 years	
Let's Talk Safety for Families: Access to Lethal Means	General Audience	New offering for suicide prevention	As requested 1.5 Hours
<b>Let's Talk Safety: Clinical Issues Associated with Access to Lethal Means</b>	Behavioral Health Clinicians	New offering for suicide prevention	As requested 1.5 Hours
Mental Health Interpreting Peer Supervision Groups	A supervision group for clinicians serving clients who are deaf or hard of hearing.	5-15	Monthly
Motivational Interviewing	Case managers, clinicians and other behavioral health staff	30-40	As needed 1-4 days
Question, Persuade, and Refer Training (QPR)	Behavioral health service providers, state operated or contracted facilities, consumers, local interest groups and central office staff	Varies depending on location across the state	Quarterly and as Requested 1.5 Hours
Therapists' Retreat for those Serving Consumers with Hearing Loss	Behavioral health service providers, state operated or contracted facilities, consumers, local interest groups and KDBHDID central office staff	Ranges from 4-25	4 per year
Transition Age Youth Launching Realized Dreams	Adult Case Managers and Children's Service Coordinators	60	1 Day As requested
Understanding Self-Harming Behavior	General audience as well as educators	New offering	As requested 2 Hours



<b>Trainings Relevant for Both Adult and Children's Services</b>			
<b>Type of Training</b>	<b>Intended Audience</b>	<b>Number of Participants Anticipated</b>	<b>Frequency/ Length of conference</b>
<b>Working with the Suicidal Client</b>	Behavioral health clinicians	Target-200	As requested 2 Hours
Workshops for the Deaf Community	Existing consumers and others who may be in need of mental health services.	10-55	Monthly and as needed

**BOLD** Denotes that Continuing Education Units (CEUs) are offered for these training sessions. The following offers additional detail about some of the major training events listed above.

### ***Trainings Related to Both Adult and Children's Services***

#### Applied Suicide Intervention Skills Training (ASIST) Training for Trainers

Applied Suicide Intervention Skills Training (ASIST) is a two-day intensive, interactive and practice-dominated course designed to help clinical, non-clinical caregivers and parents recognize and review risk, and intervene to prevent the immediate risk of suicide.

#### Assessing and Managing Suicide Risk: Training for Trainers

This one-day training focuses on competencies that are core to assessing and managing suicide risk. The program includes: pre-workshop reading materials; 6.5 hours of training, comprised of an engaging mix of lecture and exercises; a 110-page participant manual, including an extensive bibliography and other valuable resources; journaling throughout the day; and time for discussion.

#### Barbara Stanley Suicide Safety Planning Training

This training will teach behavioral health professional how to do effective safety planning with suicidal individuals.

#### Collaborative Assessment and Management of Suicidality (CAMS) Training

The Collaborative Assessment and Management of Suicidality (CAMS) identifies and targets Suicide as the primary focus of assessment and intervention.

#### Columbia Suicide Severity Rating Scale Training

This is a training is to teach behavioral health care providers how to use the Columbia Suicide Severity Rating Scale.

#### Crisis Intervention Team

In collaboration with National Alliance for the Mentally Ill (NAMI) and Kentucky CIT, KDBHDID provides training for law enforcement officers regarding how to better respond to encounters with individuals who may be experiencing a behavioral health crisis.

#### Cultural Competency

Training regarding cultural competency issues is part of the initial orientation package for each Department employee. The Regional Boards are also required to provide cultural competency training for all staff members. The Cabinet also offers training through the Office of Diversity and Equality. Cabinet trainings are offered once a month.

#### Cultural Competency Training for Trainers

Department trainers provide this 2-3 day training to trainers in state-run or contracted facilities and community mental health centers on an as-needed basis.

#### Deaf and Hard of Hearing Services Providers' Symposia

Offered quarterly, these trainings bring together DHHS specialists as well as other CMHC staff who have consumers with hearing loss. Due to the lack of training in contiguous states, we have had participants from Ohio and Indiana as well.

#### Department of Psychiatry Grand Rounds

The Department accesses via video-conference the Department of Psychiatry Grand Rounds presentations for both the University of Louisville and University of Kentucky Schools of Medicine. The Department facilitates access to these presentations by the state facilities and the Community Mental Health Centers, often offering CEUs to staff who participate.

#### DDCAT/DDMHT Training and Technical Assistance

Our Department continues to develop a treatment delivery system in which all publicly-funded Mental Health and Substance Abuse treatment facilities across the state are co-occurring diagnosis capable, as measured by the Dual Diagnosis Capability in Addiction Treatment (DDCAT) and DDMHT (Mental Health Treatment) Fidelity Instruments. Trainings and technical assistance is being offered to Department and CMHC to learn the following:

- To have an understanding of Addiction/Mental Health Only Services vs Dual Diagnosis Capability vs Dual Diagnosis Enhanced Programs;
- To comprehend the program requirements for achieving DDC and DDE;
- To become competent in conducting DDCAT/DDMHT assessments;
- To be able to utilize DDCAT/DDMHT results in strategic planning; and
- To recognize the potential statewide impact of utilizing the DDCAT/DDMHT.

#### Emergency Services Training

Each Regional Board is encouraged to educate emergency services personnel (the courts, peace officers, inpatient psychiatric facilities, Rape Crisis Centers, etc.) in their area, as to applicable statutes concerning involuntary hospitalization and how to access evaluation services on a 24-hour per day, seven days a week basis. In collaboration with the Kentucky Association of Regional Programs (KARP), suicide risk assessment training (QPR) at each local mental health center is provided.

#### Kentucky Registry of Interpreters for the Deaf Conference

Deaf and Hard of Hearing Services provides a mental health track at the Interpreters' Conference, 3 workshops.

#### Kentucky School of Alcohol and Other Drug Studies

The annual "Kentucky School" is the premier training event for Kentucky's substance abuse prevention specialists, substance abuse treatment providers, and persons in recovery. It has grown to include a wider audience and a broader focus to include mental health and professionals from a variety of disciplines including child welfare, corrections, and juvenile justice. There are intensive sessions on a variety of topics including Adolescent Substance Abuse and Co-Occurring Disorders.

### Law Enforcement Response to Individuals with Special Needs

This 40-hour training is offered biannually to law enforcement officers and school resource officers. The focus of the training is how to provide a sensitive, appropriate response to adults and youths with mental illness, diagnosed with an autism spectrum disorder, deaf, who have a substance-related disorder, or dementia.

### Mental Health Interpreting Peer Supervision Groups

Training provided in Northern Kentucky and Louisville areas (statewide as requested). This peer supervision group is the only ongoing training of its kind in the country.

### Motivational Interviewing

Motivational interviewing is non-judgmental, non-confrontational and non-adversarial way of engaging with clients. The approach attempts to increase the client's awareness of the potential problems caused, consequences experienced, and risks faced as a result of the behavior in question. Alternately, therapists help clients envision a better future, and become increasingly motivated to achieve it.

### Suicide Prevention Training

In keeping with the state suicide prevention plan, the Department offers a series of trainings related to suicide prevention, across the state, to train providers, educators, consumers, family members and the public about suicide prevention, awareness, intervention and evaluation. Specific suicide modules are listed in the training grid above.

### QPR Community Suicide Prevention Presentation.

QPR stands for Question, Persuade and Refer. This is a basic community oriented presentation designed to create greater awareness, recognition of warning signs and knowledge of what to do if someone you know is struggling with a potential suicidal crisis. This program is 90 minutes in length and includes PowerPoint, video, and group interaction. Each participant receives a booklet containing the basic program information.

### Transition Age Youth Launching Realized Dreams

A specialized training for providers who work with transition age youth focusing on best practices and resources for this population.

### Understanding Self-Harming Behavior

This workshop can be designed for either clinical audiences or school staff and family members. The school and family presentation is 2hrs and the clinical version is a 3hr presentation. Both workshop formats explore the issue of prevalence and understanding the phenomenon of self harm itself in the context of developmental issues associated with adolescents and young adulthood. In the school and family format there is a consideration of appropriate school protocol and what family members can do. For the clinical format, focus is directed to evidence-based treatment and working with a client who engages in this behavior. Approved CEU's can be provided for mental health providers.

### Working with the Suicidal Client

This is a clinical training appropriate for mental health providers, case managers or those working in the healthcare field. This workshop is flexible - 2hr, 3hr and full day lengths. The material can be utilized to earn approved CEUs. Specific content can be flexed to meet the needs a given group. Modules include: Prevalence; Risk & protective factors; Issues of provider competence; Understanding the suicidal mind; How to conduct a solid risk assessment; establishing a therapeutic connection; and what we know about effective treatment. The workshop presentation includes PowerPoint, video, group exercises and interactive dialogue; each participant receives a notebook with a generous number of resources.

### Workshops for the Deaf community

Most states focus on existing consumers; we are doing case finding as well as reducing stigma by presenting in diverse environments such as the KY Association for the Deaf, KY School for the Deaf's Family Learning Vacation, and with VR counselors in their regions ("Taking Care of Yourself in Tough Economic Times").

## **Criterion 5: Management Systems**

### **2) Emergency Service Provider Training – Adult Mental Health**

*Narrative Question: Describe training of providers of emergency health services regarding mental health*

Senate Bill 104, which was passed during the 2007 General Assembly, mandated KDBHDID with the development of a 40 hour Crisis Intervention Team (CIT) training curriculum to be utilized to train law enforcement officers to better respond to persons with mental illness. CIT training began in Memphis, Tennessee and is now known as "The Memphis Model." Kentucky's CIT training curriculum includes modules regarding children's mental health, suicide prevention, developmental disabilities, serious mental illness as well as substance use disorders. Included in this 40 hour training is a requirement for law enforcement officers to spend an entire day practicing skills taught during the week, while being critiqued from a panel of experts. The DBHDID currently contracts with a retired police lieutenant to organize and implement training of law enforcement officers across the state in the CIT model. This contract requires collaboration with the Department of Criminal Justice Training, which approves the curriculum and trainers for each course. Training events also require the collaboration of the local Regional Board as well as consumers of behavioral health services and their family members. During SFY 2011, five (5) additional CIT officers, in the Western part of the state, were certified as CIT instructors. Local CIT instructors were trained to provide the Memphis Model in their specific regional location and thus increase the number of officers receiving training. Several local trainings have occurred and this process is being supervised carefully, with excellent training being provided to more officers. To date, 1168 officers across Kentucky have been trained.

Goals for SFY 2014/2015 include:

1. **Continue to offer Specialized Training for Law Enforcement by means of a 40 hour Crisis Intervention Team (CIT) Training** currently being implemented by contract with a retired police lieutenant. State police officers as well as local police officers are trained using the Memphis Crisis Intervention Team model. Officers volunteer and are assigned by their supervisors for the training. CIT held their 4<sup>th</sup> annual CIT Conference for Law Enforcement in June of 2013, which provided additional opportunities to gain an understanding of mental health issues and their effects on individuals. Regions with CIT advisory committees nominate a CIT officer of the year and one is selected by NAMI and recognized at the annual NAMI Kentucky conference.
2. **Continue to increase the number of instructors and continue to increase the number of CIT trained officers across the state.** Several experienced CIT officers across the state have now been trained and qualify to be CIT instructors. Five (5) regions in Kentucky are utilizing local trainers to decrease costs and thereby increase the number of trainings available to local law enforcement agencies. Several local trainings occurred during SFY 2013 and are scheduled for SFY 2014. This process is being supervised closely by contract staff and DBHDID. To date 1168 law enforcement officers from agencies across Kentucky have been trained in the 40 hour Kentucky Law Enforcement Council (KLEC) certified CIT training class. This includes city police, county police, university campus police, sheriff departments and state police. In the statewide training, forty nine (49) CIT classes have been taught to date. To date officers

have been trained for 167 law enforcement agencies in Kentucky. Ten (10) regions currently have CIT Advisory Committees. The CIT Advisory Committees build upon the relationships between law enforcement, mental health professionals and mental health advocates, established in the 40 hour CIT class. However, these committees allow for long term and systemic improvements in services to persons with mental illness, developmental disabilities and substance use issues. Where there is a strong CIT Advisory Committee we have seen improvements in the “system” and in the response to those we serve.

3. **Continue to work on developing teams in rural eastern Kentucky mountain areas.** In April 2013, we offered the first CIT training in the Prestonsburg area. We continue to move this training into new areas and expect to have held training in every region by the end of SFY 2015.

The Division of Behavioral Health was awarded a two-year SAMSHA grant in June 2003 to develop regional behavioral health emergency disaster preparedness plans for each of the Regional MHMR Boards. As a continuation of that initiative, the Division continues to receive a small amount of funding (2005-2013) from the Kentucky Department for Public Health to help fund a statewide Mental Health/Mental Retardation Disaster Preparedness coordinator. This coordinator provides a behavioral health focus for Kentucky’s 14 regional ASPR (Assistant Secretary of Preparedness and Response) healthcare planning coalitions and ongoing interagency collaboration that have resulted in integrated and coordinated responses to emergencies and disasters. Regional CMHC plans continue to be updated annually and the Department continues to designate a program administrator to coordinate regional and statewide efforts.

The Regional CMHC’s will continue to participate in local/regional healthcare preparedness planning coalitions. CMHC staff shall assess, identify and monitor shelter needs for individuals with behavioral health, developmental, and intellectual disabilities during emergencies and disasters. CMHC staff shall assist in providing notification to behavioral health, developmental and intellectual disabilities populations and caregivers regarding response and recovery information.

The Program Coordinator continues to sit on the Kentucky Community Crisis Response Board (KCCRB) as the Commissioner Designee. The Kentucky Community Crisis Response Board provides assessments, crisis intervention, service collaboration, and system development following disasters. KCCRB, as the state lead disaster mental health agency, coordinates services, administers FEMA Crisis Counseling grants when necessary following a presidential Declaration, in collaboration with local and regional mental health providers. The KCCRB also provides multi-component crisis intervention services statewide, and is on call 24 hours a day, seven days a week. Regular incident responses include responding to crises with first responders, schools, businesses or community organizations, as invited.

## **Criterion 5: Management Systems**

### **2) Resources for Providers – Children’s Mental Health**

*Narrative Question: Describe training of providers of emergency health services regarding mental health.*

#### Crisis Intervention Team Training

Senate Bill 104, which was passed during the 2007 General Assembly, mandated KDBHDID with the development of a 40 hour Crisis Intervention Team (CIT) training curriculum to be utilized to train law enforcement officers to better respond to persons with mental illness. CIT

training began in Memphis, Tennessee and is now known as “The Memphis Model.” Kentucky’s CIT training curriculum includes modules regarding children’s mental health, suicide prevention, developmental disabilities, severe mental illness as well as substance use disorders. Included in this 40 hour training is a requirement for law enforcement officers to spend an entire day practicing skills taught during the week, while being critiqued from a panel of experts. KDBHDID currently contracts with a retired police lieutenant to organize and implement training of law enforcement officers across the state in the CIT model. This contract requires collaboration with the Kentucky Department of Criminal Justice Training, which approves the curriculum and trainers for each course. Training events also require the collaboration of the local Regional Board as well as consumers of behavioral health services and their family members. During SFY 2011, five (5) additional CIT officers, in the Western part of the state, were certified as CIT instructors. Local CIT instructors were trained to provide the Memphis Model in their specific regional location and thus increase the number of officers receiving training. Several local trainings have occurred and this process is being supervised carefully, with excellent training being provided to more officers. It is the goal of SFY 2014-2105 to continue statewide and local CIT trainings in order to increase the number of CIT officers in Kentucky. During SFY 2012, 287 officers were trained using the CIT model. To date, 1168 officers across Kentucky have been trained. In the Louisville Metro Area, 68 Louisville Metro Police Officers were trained during SFY 2012. The total officers in the Louisville Metro Area trained to date is 675, over 50% of their entire force of 1216 officers. The goal in the Louisville Metro Area is to have a least one (1) CIT officer on each shift.

Goals for SFY 2014/2015 include:

4. **Continue to offer Specialized Training for Law Enforcement by means of a 40 hour Crisis Intervention Team (CIT) Training** currently being implemented by contract with a retired police lieutenant. State police officers as well as local police officers are trained using the Memphis Crisis Intervention Team model. Officers volunteer and are assigned by their supervisors for the training. CIT held their 5<sup>th</sup> annual CIT Conference for Law Enforcement in June of 2013, which provided additional opportunities to gain an understanding of mental health issues and their effects on individuals. Regions with CIT advisory committees nominate a CIT officer of the year and one is selected by NAMI and recognized at the annual NAMI Kentucky conference.
5. **Continue to increase the number of instructors and continue to increase the number of CIT trained officers across the state.** Several experienced CIT officers across the state have now been trained and qualify to be CIT instructors. Five (5) regions in Kentucky are utilizing local trainers to decrease costs and thereby increase the number of trainings available to local law enforcement agencies. Several local trainings occurred during SFY 2012 and are scheduled for SFY 2013. This process is being supervised closely by contract staff and DBHDID. To date 1168 law enforcement officers from agencies across Kentucky have been trained in the 40 hour Kentucky Law Enforcement Council (KLEC) certified CIT training class. This includes city police, county police, university campus police, sheriff departments and state police. These totals exclude the Louisville Metro Police department (LMPD). The LMPD currently has over 600 trained CIT officers and also trains all new recruits in the full 40 hour CIT class. In the statewide training, thirty nine (39) CIT classes have been taught to date, with ten (10) scheduled for calendar year 2013. To date officers have been trained for 167 law enforcement agencies in Kentucky. Ten (10) regions currently have CIT Advisory Committees. The CIT Advisory Committees build upon the relationships between law enforcement, mental health professionals and mental health advocates, established in the 40 hour CIT class. However, these committees allow for long term and systemic improvements in services to persons with mental illness, developmental disabilities and

substance use issues. Where there is a strong CIT Advisory Committee we have seen improvements in the “system” and in the response to those we serve.

6. **Continue to work on developing teams in rural eastern Kentucky mountain areas.** In April 2013, we will be able to offer the first CIT training in the Prestonsburg area. We continue to move this training into new areas and expect to have held training in every region by the end of SFY 2015.

#### Emergency Disaster Preparedness

The Division of Behavioral Health was awarded a two-year SAMSHA grant in June 2003 to develop regional behavioral health emergency disaster preparedness plans for each of the Regional Boards. As a continuation of that initiative, the Division continues to receive a small amount of funding (2005-2013) from the Kentucky Department for Public Health to help fund a statewide Mental Health/Mental Retardation Disaster Preparedness coordinator. This coordinator provides a behavioral health focus for Kentucky’s 14 regional ASPR (Assistant Secretary of Preparedness and Response) healthcare planning coalitions and ongoing interagency collaboration that have resulted in integrated and coordinated responses to emergencies and disasters. Regional CMHC plans continue to be updated annually and the Department continues to designate a program administrator to coordinate regional and statewide efforts.

In July 2012 staff from the Division of Behavioral Health and the Kentucky Department for Public Health met for biannual planning purposes and agreed to collaborate in the following ways during emergencies and disasters.

- Designate staff to serve in the DPH’s Department Operation Center during Level 1 or Level 2 incidents.
- Designate DBHDID staff serving the DPH DOC to report Community Mental Health Center and Department facility assessments and on-going status to Emergency Support Function -8 (ESF-8) and to the Commonwealth Emergency Operations Center through the DOC.
- Designate DBHDID staff serving the DPH DOC to assist with identifying resources to secure services for individuals with behavioral health (mental and substance use) disorders and developmental/intellectual disabilities for shelter, day care, supervision, medication, transportation and housing.
- Develop a written plan/Continuity of Operations Plan (COOP) and train staff on implementation of the plan should it be needed during an event.
- Assist DPH in the development of statistical profiles of persons with functional and access needs by providing data on persons served by the agency.

The Regional CMHCs will continue to participate in local/regional healthcare preparedness planning coalitions. CMHC staff shall assess, identify and monitor shelter needs for individuals with behavioral health, developmental, and intellectual disabilities during emergencies and disasters. CMHC staff shall assist in providing notification to behavioral health, developmental and intellectual disabilities populations and caregivers regarding response and recovery information.

Each Regional Board Emergency Disaster Preparedness Coordinator, as well as the statewide coordinator, provides information and training materials for first responders in their Healthcare Planning Coalitions and as requested at other Public Health venues. This has included planning for special needs populations in sheltering and other disaster situations.

### Kentucky Community Crisis Response Board

The Program Coordinator continues to sit on the Kentucky Community Crisis Response Board (KCCRB) as the Commissioner Designee. The Kentucky Community Crisis Response Board provides assessments, crisis intervention, service collaboration, and system development following disasters. KCCRB, as the state lead disaster mental health agency, coordinates services, administers FEMA Crisis Counseling grants when necessary following a presidential Declaration, in collaboration with local and regional mental health providers. The KCCRB also provides multi-component crisis intervention services statewide, and is on call 24 hours a day, seven days a week. Regular incident responses include responding to crises with first responders, schools, businesses or community organizations, as invited.

The Kentucky Community Crisis Response Board (KCCRB) is recognized as the lead disaster behavioral health agency by the KDBHDID, Kentucky Division of Emergency Management (KyEM) and the American Red Cross (ARC). In a natural disaster or under national security conditions, many events will occur which will necessitate the coordination and delivery of crisis intervention and disaster behavioral health services. KCCRB credentials and maintains a statewide network of trained professional volunteer responders and deploys rapid response teams to crisis and disaster sites. Many of the KCCRB volunteers are Regional Board staff. Additionally, the regional mental health centers provide training for their staff to respond to their specific community needs in disaster.

Crisis intervention and disaster behavioral health services include the immediate and coordinated provision of consultation, assessment, risk assessment, referral, and psychological first aid to people affected by crisis or disaster including first responders.

### Mental Health First Aid

In 2010, KDBHDID was asked by the Department for Public Health to begin setting targets for our Healthy Kentucky 2020 objectives to submit to the Centers for Disease Control and Prevention. One of our objectives was to increase the number of individuals trained in Mental Health First Aid. The following is our state's plan for accomplishing the goal:

Objective 23.4: Increase the Number of Individuals Who Receive the Mental Health First Aid USA Training Course

Data Source: KDBHDID, Mental Health First Aid USA

Baseline: 200 Individuals Trained in Kentucky

HK 2020 Target: 8,000 Individuals Trained in Kentucky

Implementation Strategy:

- KDBHDID will collaborate with various health advocacy groups throughout the state to provide the training.
- KDBHDID will offer the course to staff at the regional community mental health centers.
- KDBHDID will collaborate with faith-based organizations and service organizations to provide trainings.
- Making the course available to first responders is a priority.

At this point, our state has eleven instructors trained in Mental Health First Aid USA and approximately 500 individuals have received the 2-day training. Youth Mental Health First Aid is an 8-hour course for individuals 16 and older. Kentucky currently has three certified Youth Mental Health First Aid USA instructors across the state, one in Frankfort at Kentucky



Partnership for Families and Children and two in Ashland. Instructors must provide the training at least three times per year to stay certified. Our goal at this point is to ensure that many more people receive the training so that we can reach our Healthy Kentucky 2020 goal.

## **Criterion 5: Management Systems**

### **3) Grant Expenditure Manner – Adult and Children’s Mental Health/Substance Abuse Prevention and Treatment**

*Narrative question: Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved.*

Per Section 1911 of the Title XIX Block Grants, the state will expend the grant funds only for the purposes of:

- Carrying out the plan submitted for the fiscal year;
- Evaluating programs and services carried out under the plan; and
- Planning, administering and educational activities related to providing services under the plan.

KDBHDID allocates mental health block grant funds to Regional Boards and to agencies that are either public or not-for-profit entities in accordance with Mental Health Block Grant requirements. No funds are used to satisfy any requirement for the expenditures of non-Federal funds. The funds are utilized by KDBHDID to provide direct services for adults with SMI and children with SED and to support statewide initiatives that promote the systems of care for these populations. A few Regional Boards also act as the fiscal management agent for the expenditure of a portion of the grant funds allocated for statewide activities. The Substance Abuse Prevention and Treatment funds are utilized by KDBHDID to provide services for persons at risk of having substance use and/or mental disorders, services for persons at risk of contracting communicable diseases, and services for persons in need of primary substance abuse prevention. A few Regional Boards also act as the fiscal management agent for the expenditure of a portion of the grant funds allocated for statewide activities.

## MENTAL HEALTH BLOCK GRANT ALLOCATIONS FOR STATE FISCAL YEAR 2014

### CONTRACTED TO THE REGIONS FOR SERVICES:

<u>Region</u>	<u>Adults</u>	<u>Children</u>	<u>Supported Employment Pilot Sites</u>	<u>SMI/SED Deaf &amp; HoH</u>	<u>TOTAL</u>
Four Rivers	135,139	67,210			227,777
Pennyroyal	169,967	74,379			249,804
RiverValley	186,882	79,685			275,678
LifeSkills	191,484	84,644			287,431
Communicare	163,047	98,653			275,084
Seven Counties	568,148	305,948		38,833	893,849
NorthKey	258,649	80,534			349,594
Comprehend	35,045	43,638			113,646
Pathways	212,421	224,295			483,581
Mountain	169,467	68,980			240,777
Kentucky River	85,096	34,518			109,822
Cumberland River	243,676	100,317			339,393
Adanta	135,747	73,084			195,474
Bluegrass	135,983	207,433		22,482	343,485
Supported Employment Sites			150,000		<u>150,000</u>
					<b>\$4,445,395</b>

### STATEWIDE PROJECTS:

<u>Regional Board</u>	<u>Program or Service</u>	<u>Amount</u>
LifeSkills	Statewide Case Management Training	20,000
LifeSkills	Children's Training Initiatives	20,000
LifeSkills	MH Training and TA, USPRA	20,000
LifeSkills	Recovery Initiative	20,000
LifeSkills	Peer Support Training	20,000
LifeSkills	Supported Employment Fidelity Initiative	21,000
Seven Counties	Office of Consumer Advocacy	53,000
Seven Counties	Mental Health and Aging	20,000
Bluegrass	SIAC Support	25,000
Bluegrass	Parent Advocacy Mini-Grants	20,000
Bluegrass	Opportunities for Family Leadership	30,362
Bluegrass	Suicide Prevention	15,000
Bluegrass	CIT	70,000
Bluegrass	Statewide Deaf & HOH	<u>46,787</u>
		<b>\$401,149</b>

**OTHER:**

Kentucky Housing Corporation	13,334
Department of Corrections	50,000
Behavioral Health Planning Council	15,000
University of Kentucky - Institute for Pharmaceutical Outcomes & Policy (IPOP)	100,000
State Travel	15,000
NAMI KY – Recovery Oriented Family Support	119,554
Eastern Kentucky University	147,224
Kentucky Partnership for Families & Children – Family Driven Youth Guided Training & Support	143,000
Office of Vocational Rehabilitation – Supported Employment Services	75,000
University of Kentucky - Dartmouth	95,000
NAMI of Lexington (Participation Station) – Recovery Oriented Training	150,190
Audit Reserve (Federal Cuts)	<u>1,458,269</u>
	<b>\$2,381,571</b>

**TOTAL SFY 14 MHBG ALLOCATIONS** **\$7,228,115**

## SUBSTANCE ABUSE BLOCK GRANT ALLOCATIONS FOR STATE FISCAL YEAR 2014

### CONTRACTED TO THE REGIONS FOR SERVICES:

	<u>Region</u>	<u>Treatment</u>	<u>Pregnant &amp; Postpartum</u>	<u>Prevention</u>	<u>TOTAL</u>
1	Four Rivers	423,960	72,896	147,187	644,043
2	Pennyroyal	431,518	75,305	223,626	730,449
3	RiverValley	426,673	79,297	212,653	718,623
4	LifeSkills	700,711	233,883	210,042	1,144,636
5	Communicare Seven Counties	530,128	188,746	242,397	961,271
6	NorthKey	3,082,835	1,145,316	332,538	4,560,689
7	Comprehend	498,924	630,729	212,993	1,342,646
8		93,241	15,010	100,000	208,251
10	Pathways	549,059	95,123	242,107	986,289
11	Mountain Kentucky	455,154	63,172	165,933	684,259
12	River Cumberland	379,274	90,494	230,109	699,877
13	River	654,456	178,790	193,390	1,026,636
14	Adanta	22,711	117,882	221,658	662,251
15	Bluegrass	1,603,352	445,727	451,717	<u>2,500,796</u>
					<b>\$16,870,716</b>

### STATEWIDE PROJECTS:

	<u>Region</u>	<u>Program or Service</u>	<u>Amount</u>
4	LifeSkills	NIATx Training Funds	35,000
4	LifeSkills	Prevention	10,000
4	LifeSkills	Treatment	10,000
4	LifeSkills	Kentucky Prevention Network	19,950
5	Communicare	Crisis Intervention	30,000
		Statewide Deaf & Hard of Hearing	20,000
15	Bluegrass		
15	Bluegrass	Suicide Prevention	<u>15,000</u>
			<b>\$139,950</b>

**MISCELLANEOUS FUNDED WITH SAPT BLOCK GRANT:**

	<u>Treatment</u>	<u>Pregnant &amp; Postpartum</u>	<u>Prevention</u>	<u>TOTAL</u>
REACH of Louisville Recovery Oriented Training (People Advocating Recovery)	91,300		365,321	91,300
KPFC Kentucky Housing Corp	15,000			15,000
Louisville Metro Health Dept	13,333			13,333
NAMI Lexington Eastern Kentucky University	500,000		449,628	500,000
UK - CDAR	24,000	60,000	71,003	801,036
	594,680			<u>725,683</u>
				<b>\$2,511,673</b>

**Other:**

Armed Services Treatment	80,000			80,000
Peer Services Initiative	60,000			60,000
Audit Reserve	131,254			<u>131,254</u>
				<b>\$271,254</b>

**TOTAL SFY 14 SABG ALLOCATIONS**

**\$19,793,593**

## II. Planning Steps

### **Step 1: Assess the strengths and needs of the service system to address the specific populations**

*Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the State, intermediate and local levels differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other State agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities as well as youth who are often underserved.*

*Note: Kentucky also addresses the 5 required Criterion for Adult and Children in this section of the application.*

The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) is Kentucky's designated State Mental Health Authority (SMHA) and Single State Agency for Substance Abuse Services (SSA), as well as the State Opioid Treatment Authority (SOTA). Per Kentucky Revised Statute (KRS) 194.030, DBHDID is identified as the primary state agency for developing and administering programs for the prevention, detection and treatment of:

- Mental Health (Adults and Children);
- Substance Abuse Prevention and Treatment Services; and
- Developmental and Intellectual Disabilities.

DBHDID is part of the Cabinet for Health and Family Services (CHFS), which was most recently reorganized in February 2011. CHFS is one of the largest agencies in state government, with nearly 8,000 full and part-time employees. Among other offices and councils, the following are also within the Cabinet:

- Office of the Secretary
- Office of Health Policy (including Certificate of Need and Health Policy Development)
- Office of Kentucky Health Benefit Exchange
- Office of Legal Services
- Office of the Inspector General (Licensing and Regulation Authority)
- Office of Communications and Administrative Review
- Office of the Ombudsman
- Office of Policy and Budget
- Office of Human Resource Management
- Office of the Health Benefit Exchange
- Office of Administration and Technology Services
- Department for Public Health (Local and State Public Health Programs)
- Department for Medicaid Services (Medicaid Authority)
- Department for Aging and Independent Living (Aging, Guardianship, Brain Injury Services)
- Department for Community-Based Services (Adult and Child Protection, Child Welfare)
- Department for Income Support (Disability Determinations, Child Support Enforcement)
- Department for Family Resource Centers and Volunteer Services
- Kentucky Commission on Community Volunteerism and Service
- Kentucky Commission for Children with Special Health Care Needs
- Governor's Office of Electronic Health Information

Within DBHDID, there are three Divisions, including: Administration and Financial Management; Developmental and Intellectual Disabilities; and Behavioral Health. The Division of Behavioral Health is a product of the merger of the Division of Substance Abuse and the Division of Mental Health in July 2004. With an increased focus on the treatment needs of individuals with co-occurring disorders (mental health and substance use) at the national, state and local level, the Division is aimed at ensuring an integrated, seamless service system.

DBHDID's Division of Behavioral Health is comprised of the Director's Office and four Branches. The Branches include:

- *Data Research Branch* – Consists of the Substance Abuse Prevention Program, which targets the prevention of the abuse of alcohol, tobacco and other drugs in Kentucky, as well as the Driving Under the Influence (DUI) Program;
- *Program Development Branch* – Responsible for creating and planning program infrastructure based on assessment of need, promising practices, and stakeholder participation and also functions as the Children, Youth and Family Services Branch;
- *Program Support Branch* – Provides expert support through training, consultation and customer relations and also functions as the Adult Mental Health Branch; and
- *Provider Services Branch* – Provides administrative oversight and promotion of quality assurance with networks of service providers and contractors and also functions as the Substance Abuse Treatment Branch.

A Recovery Services Coordinator, who serves within the Director's Office, is responsible for coordinating consumer and family member support services across the state, and guiding Kentucky towards full implementation of a recovery-oriented behavioral health system. The Coordinator is also committed to identifying disparities, in service provision, with regard to race, ethnicity, age and sexual orientation.

An Executive Administrative Order was executed by the Cabinet for Health and Family Services, effective December 16, 2010, establishing a new Branch within the DBHDID's Division of Administration and Financial Management. The new Outcome Transformation and Education Branch was created to allow the Department to continue to meet quality standards while moving the Department forward with transformation of services to more appropriately meet the needs of individuals with mental/emotional disorders, substance use disorder and those with intellectual and developmental disabilities.

The Substance Abuse Prevention Program of the Division of Behavioral Health is responsible for completing the Annual Synar Report. The Office of Alcoholic Beverage Control enforces the Synar Regulation and conducts the annual Synar survey.

Adult Mental Health Inpatient Facilities

For over 180 years, Kentucky has operated psychiatric facilities that provide evaluation and treatment. Kentucky's state hospitals for adults are displayed in the table below.

State Hospital	Location	Operation	SFY 2005 ADC*	SFY 2012 ADC	SFY 2013 ADC
Western State Hospital	Hopkinsville	State operated	144	108	119
Central State Hospital	Louisville	State operated	108	65	59
Eastern State Hospital	Lexington	Contracted	162	127	127

Appalachian Regional Hospital (ARH) -Hazard Psychiatric Center	Hazard	Contracted	82	81	88
*ADC= Average Daily Census		TOTAL	496	381	393

Census at state hospitals had declined over the past decade as efforts were made to place persons in appropriate community programs. However, fluctuating factors, such as the closing of many psychiatric units within local community primary care hospitals and the implementation of Medicaid managed care in Kentucky has affected state hospital census in recent years.

### Nursing Homes

The Department operates two facilities that provide a nursing level of care for persons with psychiatric disabilities who also need a nursing level of care for a co-morbid condition, or because they are medically fragile. The facilities primarily serve persons who are discharged from state hospitals, or who are at risk of hospitalization in a state facility. They are:

- WSH Nursing Facility, located on the campus of Western State Hospital in Hopkinsville, which had an average daily census of 102 in SFY 2013; and
- Glasgow Nursing Facility in Glasgow, which had an average daily census of 84 in SFY 2013.

Newly constructed facilities to replace Eastern State Hospital (the second oldest psychiatric facility in the country, erected in 1817) and the Glasgow Nursing Facility are scheduled to open in September 2013. DBHDID will operate the Glasgow facility and has contracted with the University of Kentucky Medical Center to operate Eastern State Hospital.

### Specialized Personal Care Homes

To provide a less restrictive alternative for people in state hospitals who qualify for a transitional placement from a hospital level of care, specialized personal care homes for adults with serious mental illness (SMI) were developed in three of the four hospital districts (admissions are not restricted to residents of regions or districts). These homes, which are licensed in Kentucky as "Personal Care", (combination of room, board, and some supervision and oversight) are operated by Regional Boards. The focus of the rehabilitative programming within these facilities is the teaching of skills that will enable residents to be integrated into the community.

The two remaining facilities are:

- Bluegrass Personal Care Home, a forty (40) bed facility located on the campus of Eastern State Hospital in Lexington; and
- Caney Creek Rehabilitation Complex, an eighty (80) bed facility located in Pippa Passes in southeastern Kentucky.

During SFY 2008 and 2009 the Center for Rehabilitation and Recovery (CRR), a thirty-eight (38) bed unit located on the campus of Central State Hospital outside Louisville, began gradually moving some individuals from the CRR facility to smaller scattered-site living situations within the community, while continuing to provide necessary supports to maintain their independent living status. In June 2011, a contract was established between the DBHDID and Seven Counties Services, Inc., (one of the Regional Boards) to operate the



Center for Rehabilitation and Recovery, with the goal of moving all residents into permanent, community-based housing by the end of SFY 2013. In August of 2013, the last resident moved to the community. CRR continues to operate as a Supported Housing program in the community in lieu of a personal care home and has been renamed Housing First/Champions Trace. This, in essence, creates a less restrictive living environment for adults with SMI. This contract mandates that community housing for this population must follow supportive housing principles, utilizing SAMSHA's Permanent Supportive Housing Toolkit. This contract is a performance based contract, based on an evidence based practice and requiring positive outcomes from several performance indicators. (i.e. Occupancy Standards; Data Reporting; Outcome/Functioning; Person Centered Planning; Staff Training; Psychiatric Inpatient Admissions; Successful Transition; and Fidelity to the Supported Housing Model.) Housing First staff is now serving forty-one (41) consumers in the community with services designed to support continued successful community living.

During SFY 2013, a contract was established between the DBHDID and Kentucky River Community Care (one of the Regional Boards) to operate Caney Creek Rehabilitation Complex, with the goal of moving all residents into permanent, community-based housing. This contract is also performance based and mandates that community housing for this population must follow supportive housing principles, utilizing SAMSHA's Permanent Supportive Housing Toolkit. In addition, Caney Creek staff must utilize Assertive Community Treatment (ACT) as a method for meeting the needs of those residents who end up living in the community. This creates another less restrictive living environment for adults with SMI. This is the first year of the contract with Caney Creek and because they have eighty (80) beds as opposed to CRRs thirty-eight (38) beds, the timeline is extended. The goal for SFYs 2014 and 2015 is to continue to monitor and support these programs. As of August 2013, eighteen (18) individuals are residing in the community. The DBHDID will also work with the other specialized personal care home, during SFYs 2014 and 2015, to develop supported housing plans as appropriate, assuring that plans are person centered and individualized by regional strengths and needs.

In August 2013, the Cabinet for Health and Family Services entered into a settlement agreement with Kentucky Protection and Advocacy to develop and implement services to allow 600 individuals with SMI, who are residing in or at risk of entry into Personal Care Homes, to live in the community. By October 2014, the Cabinet will provide assistance to 100 individuals, by October 2015, to 200 additional individuals, and by October 2016, to 300 additional individuals. To operationalize this, DBHDID will reallocate funding from state psychiatric facilities to the 14 Regional Boards to provide the intensive community services needed. These funds, combined with Block Grant funds, will provide the following services:

- Assertive Community Treatment (ACT) is an outreach-oriented service delivery model for people with SMI, which delivers comprehensive community-based treatment, rehabilitation and support services to consumers in their homes, at work and in community settings using a 24-hour a day, 7 day a week team approach.
- Supported Housing provides an array of activities and services to assist individuals with SMI to choose, get and keep regular housing in the community. These activities may include accessing subsidies, locating suitable housing, negotiating leases, acquiring household items, moving the individual into the residence, and teaching housing related living skills.
- Supported Employment (SE) is an approach to vocational rehabilitation for people with SMI that emphasizes helping them obtain competitive work in the community and providing the supports necessary to ensure their success in the workplace.
- Peer Support is social and emotional support that is provided by persons having a mental health condition to others sharing a similar mental health condition in order to bring about a desired social or personal change. The support that is given and

received is developed around principles of respect, shared responsibility and mutual agreement of what is helpful.

The Cabinet is also working toward coverage of these services under Medicaid during SFY 15, and the eventual expansion of these services beyond the 600 served under the settlement agreement.

### Forensic Psychiatric Services

Kentucky Correctional Psychiatric Center is an inpatient psychiatric hospital, located within a correctional system complex, but operated by DBHDID. It primarily provides court-ordered inpatient evaluation and treatment to restore competency to persons charged with a felony offense. When inpatient evaluation is unnecessary, the Center facilitates outpatient competency evaluations through contracts for professional services with Regional Boards. The facility's average daily census in SFY 2012 was approximately 60 people.

Although Kentucky has operated a variety of psychiatric facilities for adults, for over 165 years, the state does not operate any inpatient facilities for children and youth under eighteen years of age.

There are currently 712 (up from 672 last year and from 633 in the previous year) available child psychiatric beds in Kentucky. The average daily census for the 712 beds is 549 and the average length of stay for patients is 25 days. The 712 beds are located in 13 hospitals that are geographically located in 8 of the 14 regions. Other residential care for children includes Psychiatric Residential Treatment Facilities (PRTFs), Private Child Care (PCCs) facilities, Therapeutic Foster Care (TFC). These services are provided by an array of privately operated organizations and most are collectively represented by the Children's Alliance. The Children's Alliance works with state agencies to promote collaboration and create effective public policy for at-risk children and families. The Office of Inspector General, within the Cabinet, is the regulatory agency for licensing all health care facilities, day cares, long-term care facilities, and child adoption/child-placing agencies in the Commonwealth. The child welfare and juvenile justice agencies are the only state agencies authorized to take custody of children. Neither licensing, nor "care, custody and control" of children are a function of the Department for Behavioral Health, Developmental and Intellectual Disabilities.

### Residential Substance Abuse Treatment

Genesis House (Formerly VOLTA): A short term residential treatment facility for individuals with substance use disorders is currently located on the grounds of Western State Hospital in Hopkinsville, Kentucky. During the past couple of years, Genesis House has transitioned from being a strictly state-run facility to being contracted through one of the Regional Boards (Pennyroyal Center). The name was changed to Genesis and they currently accept individuals with co-occurring disorders.

SCHWARTZ CENTER: A short term residential facility (less than thirty (30) days) for individuals with substance use disorders, in Lexington, Kentucky and provided through Bluegrass MH/MR Board, Inc. Also provides some outpatient substance abuse treatment. Currently located on the grounds of Eastern State Hospital, but plans to relocate when the new hospital facility opens in September 2013.

INDEPENDENCE HOUSE: A long term residential substance abuse treatment facility for women who are pregnant. Also provides case management services. Located in Corbin, Kentucky.

**CHRYSALIS HOUSE:** A residential facility for substance dependent expectant mothers located in Lexington, Kentucky. Consists of three (3) residential facilities, a forty (40) unit apartment complex, eighteen (18) scatter-site apartments, a multipurpose community center and two (2) playgrounds. Provides a variety of treatment and skill building services.

**LIGHTHOUSE:** An adolescent Recovery Center for drug treatment and alcohol rehabilitation located in Louisville, Kentucky. Provides long term substance abuse treatment for adolescents.

#### Community Programs

Kentucky is divided into fourteen geographic regions for the purposes of planning and providing publicly funded community mental health, substance abuse and prevention services. Together, they serve all 120 Kentucky counties. For each region, a Regional Mental Health and Mental Retardation Board has been established pursuant to KRS 210.370-210.480 (<http://www.lrc.ky.gov/KRS/210-00/370.PDF>) as the planning authority for behavioral health programs in the region. County and municipal governments do not provide community behavioral health services. A Regional Board is:

- An independent, non-profit organization;
- Overseen by a volunteer board of directors that broadly represents stakeholders (including consumers and family members) and counties in the region; and
- Licensed by the Cabinet for Health and Family Services as a “Community Mental Health Center.”



*Outpatient services are provided primarily through a network of Regional Boards also called “Community Mental Health Centers or Comprehensive Care Centers.”*

*Note of Clarification: Regions 9 & 10 were originally two different Boards but merged some years ago and are now counted as one region, thus there are a total of 14 Boards but they are represented with numbers one through fifteen.*

Kentucky Revised Statute 210.410 authorizes the Secretary of the CHFS to make state grants and other funding allocations to Regional Boards to provide, at a minimum, the following behavioral health services:

- Inpatient Services;

- Outpatient Services;
- Partial Hospitalization or Psychosocial Rehabilitation Services;
- Emergency Services;
- Consultation and Education Services; and
- Services for Individuals with an Intellectual Disability.

Behavioral health services, including mental health services for adults and children, substance abuse services for adults and adolescents, and services for individuals with co-occurring disorders are provided in county level clinics. Services may not be denied to any individual based on age, race, ethnicity or ability to pay. In addition to the clinics, there are fourteen (14) Regional Prevention Centers established to provide technical assistance and training on evidence-based prevention strategies.

### **Implementation of Managed Care in Kentucky**

Kentucky entered the arena of Medicaid managed care in November 2011. At that time Kentucky Medicaid entered into contracts with three managed care organizations (MCOs) to provide services to approximately 540,000 Medicaid enrollees in seven of the eight Medicaid regions of the Commonwealth. Behavioral health was included along with physical health in an effort to provide a more integrated service continuum to those it serves. Under this new arrangement, three MCOs were selected: Wellcare, Kentucky Spirit / Cenpatico, and Coventry / MHNet. Contracts were enacted for a 30-month period (through June 30, 2014).

In the region that was not initially included, which encompasses 16 counties across three (3) CMHC regions, physical health for Medicaid recipients had already been operating under managed care for nearly a decade. This region, which includes the state's largest metropolitan area (Louisville), was served by the *Passport Health Plan*. As of January 1, 2013, the Louisville managed care region now has integrated physical and behavioral health care through the introduction of two new MCOs (Humana CareSource / Beacon and Passport / Beacon). Beacon will serve as the Managed Behavioral Health Organization (MBHO) for both Humana and Passport. Wellcare and MHNet also provide MBHO services in the Louisville Medicaid region.

Note: Per the Kentucky Spirit web site at

<http://www.kentuckyspirithealth.com/2013/08/07/exiting-ky-medicaid-program-for-members/>

Kentucky Spirit Health Plan stopped coverage for service to members effective July 6, 2013. On June 29, 2013, the Department for Medicaid Services (DMS) sent letters to all members with information about this change. This letter contained the new health plan assigned to the member and the contact number... To help ensure that our members are supported during the change to other health plans, Kentucky Spirit continues to do the following activities for a reasonable period of time following July 5, 2013: Maintain member services call center staff; Maintain provider services call center staff; Process and pay claims with dates of service up to and including July 5, 2013; Maintain provider relations staff to address provider issues; and Prepare and provide continuity of care forms to the new health plan for all medically fragile members.

In partnership with the Department for Medicaid Services (DMS), the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) has had a significant role in oversight of the managed care rollout, with a focus on the effects on the public behavioral health system. DBHDID meets with each MCO about every six weeks to review data, discuss interface with DBHDID programs (especially continuity of care issues), and formulary and payment issues.

### **Medicaid Expansion in Kentucky**

Calling it “the single-most important decision in our lifetime for improving the health of Kentuckians,” Governor Steve Beshear announced in May 2013 that Kentucky will take advantage of the Medicaid Expansion provision of the Affordable Care Act and seek to expand Medicaid coverage under the Patient Protection and Affordable Care Act anticipated to extend coverage to 300,000 adults earning up to 133 percent of the federal poverty level. This number would nearly cut in half the number of individuals who currently lack health coverage—estimated at 640,000 (17.5% of the state’s population under 65). The Governor made the decision after reviewing both internal and external reports completed by outside research groups including the University of Louisville and Price Waterhouse Coopers. The research shows expanding Medicaid would create 17,000 new jobs and adds \$15.6 billion to the state’s economy between 2014 and 2021. There is opposition to this decision within the Kentucky legislature, and the state’s representatives in Congress -U.S. Senate Republican leader Mitch McConnell and Republican Senator Rand Paul, are both strong opponents of the law and have continuously called for it to be repealed.

In Kentucky, Medicaid or Kentucky Children’s Health Insurance Program (KCHIP) benefits currently are available to:

- Adults if they have disability, serve as the caretaker relative for a child who is eligible for Medicaid and on average has income below 43 percent of (FPL), or are pregnant; and
- Children with family income up to 200 percent of FPL.

Expansion will allow more than 308,000 Kentuckians to access reliable, quality health care. The new threshold of 138 percent of FPL means a single person with no children earning less than \$15,856 per year is eligible to sign up for Medicaid. A family of four with an annual income of less than \$32,499 is also eligible.

Most of the Kentuckians who will be eligible are the working poor. This includes people who work at minimum wage jobs for fewer than 40 hours per week; individuals who are self-employed; or single parents whose children are covered through KCHIP.

A new state website houses information about the expansion, including a white paper written by the Cabinet for Health and Family Services and letters from supporters. Also available is county-by-county data displaying how many citizens will be newly eligible for Medicaid, and how much county jails spent on medical care last year. Visit [governor.ky.gov/healthierky](http://governor.ky.gov/healthierky).

The following is a comprehensive description of the Mental Health services arena in Kentucky and is organized in the federally mandated Criterion 1-5 format for Adults and Children.

## **Criterion 1: Comprehensive Community Based Mental Health Services**

### **1) Establishment of System of Care: Adult Mental Health**

*Narrative Question: Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental illness and substance abuse disorders.*

The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (KDBHDID) administers a recovery oriented, comprehensive, community-based system of mental health care for adults with serious mental illness and their families through contracts with Kentucky's Regional Boards, also known as Community Mental Health Centers (CMHCs). KDBHDID works with the Kentucky Department for Medicaid so that basic services, like outpatient and rehabilitation services, are available and have similar requirements for Medicaid and non-Medicaid eligible consumers.

The KDBHDID contracts with the fourteen private, not-for-profit Regional Boards to provide services to citizens in all 120 counties of the state. Regional Boards are required to specifically describe their current system of care for adults, and to state their plans for development regarding key system components, within the annual Plan & Budget process. These components include:

- Consumer and Family Support
- Emergency Services
- Mental Health Treatment Services, including Co-occurring Treatment for Mental Health and Substance Abuse and Mental Health Services for Deaf and Hard of Hearing
- Case Management Services
- Rehabilitation Services
- Housing Options
- Physical Health Interface
- Continuity of Care

KDBHDID is committed to working collaboratively with Regional Boards to continuously enhance continuity of care, service effectiveness and accountability.

### **1) Establishment of System of Care: Children's Mental Health**

*Narrative Question: Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental illness and substance abuse disorders.*

The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (KDBHDID) administers a comprehensive, community-based system of behavioral health care for children with severe emotional disabilities (SED), and their families. With guidance from SAMHSA's *Leading Change: A Plan for SAMHSA's Roles and Actions 2011–2014*, the department strives to further promote system of care principles and objectives, while at the same time ensuring autonomy at the regional level for service planning and decision making.

KDBHDID contracts with fourteen private, not-for-profit Regional Mental Health/Intellectual Disabilities Boards (Regional Boards) to provide services to citizens in all 120 counties of the state. Regional Boards, in the annual Plan & Budget process, are required to specifically describe their current children's system of care and to state their plans for development regarding key system components, including:

- Family and Youth Involvement and Support
- Clinical Services
- Integration of Services
- Best Practices
- Data and Outcomes
- Planning for Underserved Populations
- Staff Training and Development and
- Promotion of Wellbeing/Prevention of Behavioral Disorders

KDBHDID is committed to working collaboratively with Regional Boards to continuously enhance service access and capacity, youth and family involvement, evidence-based clinical care, seamless transitions between levels of care, integrated care, and positive outcomes for youth and families. Current activities regarding each of these components are discussed throughout this grant application.

Within the Division of Behavioral Health, there is a Children, Youth and Family Services Branch with twenty staff dedicated to the development and implementation of a strong and progressive behavioral health services delivery system and a coordinated system of care for Kentucky's children, youth and families.

## 2) Available Services: Adult Mental Health

*Narrative Question: Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:*

- *Health, mental health, and rehabilitation services;*
- *Employment services;*
- *Housing services;*
- *Educational services;*
- *Substance abuse services;*
- *Medical and dental services;*
- *Support services;*
- *Services provided by local school systems under the Individuals with Disabilities Education Act;*
- *Case management services;*
- *Services for persons with co-occurring (substance abuse/mental health) disorders; and*
- *Other activities leading to reduction of hospitalization.*

## HEALTH, MENTAL HEALTH, AND REHABILITATION SERVICES

### HEALTH

The interface between the physical healthcare system and the mental health system is of growing importance to providers of behavioral health services. It is well known that a significant amount of behavioral health services are provided in the physical healthcare arena. Continuity of care across these systems is critical if individuals are going to recover and succeed in establishing chosen roles in the community.

Kentucky is a relatively unhealthy state and struggles with poor health outcomes overall. To maintain focus on improving access to dental and physical health services, a representative of the Department for Public Health was appointed to the Kentucky Mental Health Services Planning Council. That representative has been attending planning council meetings since SFY 2003 and contributing valuable suggestions for collaboration between the physical health and mental health system. Additionally, meetings between the Commissioners of KDBHDID and the Department for Public Health produced an agreement to establish a formal liaison between the Departments for the purpose of improving collaboration and developing strategies for better integration of physical healthcare service with mental healthcare services.

In April 2010, the Governor announced the creation of a Health Information Exchange (HIE) where hospitals and clinics will be able to exchange health information electronically regarding Medicaid clients. Today the Kentucky Health Information Exchange (KHIE) has grown to include 385 participation agreements representing over 860 healthcare locations

around the state. One hundred, eighty-seven (187) of those locations are live and exchange data on KHIE daily. The core components of the KHIE include: a master patient/person index; record locator service; security; provider/user authentication; logging and audits; clinical messages and alerts. The system supports e-prescribing, patient demographics, lab order entry and results, radiology and transcription reports, historical patient diagnoses, medications, procedures, dates of services, hospital stays, and access to the statewide immunization registry, ability to communicate reportable diseases and a provider portal.

In December 2012 Kentucky was selected as one of three states in the nation to receive awards from the Office of the National Coordinator for Health Information Technology for demonstrating strong partnerships between federally sponsored programs, local organizations and state agencies. This collaboration has led to the successful implementation and meaningful use of electronic health records throughout the state. "We're proud of the work being done to improve care of people throughout the state and are thrilled the effort is receiving national recognition," said Polly Mullins-Bentley, Acting Executive Director of Governor's Office of Electronic Health Information. "Current technologies make it easy and safe for doctors, nurses, pharmacists and others to communicate with each other on their patients' behalf. It results in fewer errors and means health care providers and their staff can spend more time actually talking with their patients. That's what we're working toward." "On behalf of ONC, we commend the hard work and dedication of KHIE in facilitating and expanding the secure electronic movement and use of health information in the state of Kentucky," said Peter Banks, ONC Project Officer for Kentucky. "These efforts will increase the quality and coordination of care for all residents in the state."

Kentucky was showcased for achieving the nation's first successful transmission of a secure continuity of care document to the Kentucky Cancer Registry. The collaborative efforts between the Centers for Disease Control and Prevention, Kentucky Cancer Registry, KHIE and the Kentucky REC, enabled the transmission of vital health statistics that will help population health experts study the prevalence and incidence rates of chronic disease across the state. The teams were also recognized for pioneer work in assisting behavioral health facilities. As one of only five states in the nation to receive Substance Abuse and Mental Health Services Administration funding for Health IT implementation, Kentucky is now on path to facilitate the integration of primary and behavioral health care, helping mental health and substance abuse facilities implement electronic health records and transmit data. "Adoption of health information has been remarkable all across the state," said Mullins-Bentley. "This is attributable to our partnership with the Department of Medicaid Services and the state's regional extension centers, whom have been integral in securing early adoption among the provider community." Together, the Kentucky Regional Extension Center and KHIE have helped providers in Kentucky secure more than \$115 million in Meaningful Use incentive dollars.

The Division of Behavioral Health was awarded a two-year SAMSHA grant in June 2003 to develop regional behavioral health emergency disaster preparedness plans for each of the Regional MHMR Boards. As a continuation of that initiative, the Division continues to receive a small amount of funding (2005-2013) from the Kentucky Department for Public Health to help fund a statewide Mental Health/Mental Retardation Disaster Preparedness Coordinator. This Coordinator provides a behavioral health focus for Kentucky's fourteen (14) regional ASPR (Assistant Secretary of Preparedness and Response) healthcare planning coalitions and ongoing interagency collaboration that have resulted in integrated and coordinated responses to emergencies and disasters. Regional CMHC plans continue to be updated annually and the Department continues to designate a program administrator to coordinate regional and statewide efforts.



In July 2012 staff from the Division of Behavioral Health and the Kentucky Department for Public Health (DPH) met for biannual planning purposes and agreed to collaborate in the following ways during emergencies and disasters.

- Designate staff to serve in the DPH's Department Operation Center (DPH DOC) during Level 1 or Level 2 incidents.
- Designate DBHDID staff serving the DPH DOC to report Community Mental Health Center and Department facility assessments and on-going status to Emergency Support Function -8 (ESF-8) and to the Commonwealth Emergency Operations Center through the DOC.
- Designate DBHDID staff serving the DPH DOC to assist with identifying resources to secure services for individuals with behavioral health (mental and substance use) disorders and developmental/intellectual disabilities for shelter, day care, supervision, medication, transportation and housing.
- Develop a written plan/Continuity of Operations Plan (COOP) and train staff on implementation of the plan should it be needed during an event.
- Assist DPH in the development of statistical profiles of persons with functional and access needs by providing data on persons served by the agency.

The Regional CMHC's will continue to participate in local/regional healthcare preparedness planning coalitions. CMHC staff shall assess, identify and monitor shelter needs for individuals with behavioral health, developmental, and intellectual disabilities during emergencies and disasters. CMHC staff shall assist in providing notification to behavioral health, developmental and intellectual disabilities populations and caregivers regarding response and recovery information.

The Program Coordinator continues to sit on the Kentucky Community Crisis Response Board (KCCRB) as the Commissioner Designee. The Kentucky Community Crisis Response Board provides assessments, crisis intervention, service collaboration, and system development following disasters. KCCRB, as the state lead disaster mental health agency, coordinates services, administers FEMA Crisis Counseling grants when necessary following a presidential Declaration, in collaboration with local and regional mental health providers. The KCCRB also provides multi-component crisis intervention services statewide, and is on call 24 hours a day, seven days a week. Regular incident responses include responding to crises with first responders, schools, businesses or community organizations, as invited.

During SFY 2013, DBHDID formed a group to study Medicaid Health Homes. This initial group included representatives from the DBHDID, the Department for Medicaid Services, Kentucky Association of Regional Programs, Kentucky Primary Care Association, CMHCs, and two (one urban and one rural) Federally Qualified Health Centers. This group went to Missouri to study a successful Medicaid health homes initiative. In December 2012, DBHDID, with the support of this group, responded to a Request for Applications (RFA) regarding State Integration and Medicaid Health Homes, a National Council Learning Community, from the National Council for Behavioral Health. The application was awarded in January 2013. The Learning Community brings state leaders together in a group learning model that accelerates change and helps participants tackle confounding problems of integration and Medicaid Health Homes for persons with disabilities. The six (6) month Learning Community covers policy development, clinical models, and implementation strategies. At the end of the Learning Community, group members will have developed a strategic plan for implementing health integration/Medicaid Health Homes for special populations in Kentucky.

## **MEDICAL/DENTAL**

Regional Boards are required to assess the physical health of each consumer they serve during the intake process and at least annually thereafter. Clinicians and case managers work closely with community primary care physicians, local health departments, and other health care providers to address the overall health needs of adults. The Department has assisted several regions in improving tools used to assess physical health concerns and continue to encourage further assessment and integration of physical and mental health care.

During SFY 2010, two Regional Boards received funding to assist with integrating physical and behavioral health services. One region located in rural Western Kentucky (Pennyroyal) received a SAMHSA grant for \$500,000 per year for four (4) years. This area serves individuals with primary needs related to poverty, unemployment, obesity, tobacco use, etc. This grant is targeting adults with SMI with numerous primary care needs in eight (8) counties in Western Kentucky. Another region (NorthKey) located in Northern Kentucky received several smaller grants from the Health Foundation of Greater Cincinnati focusing on integrated care. A \$206,366 grant received in 2007 allowed for the beginning of integration. Five (5) behavioral health clinicians were placed into five (5) separate primary care clinics. A \$155,000 grant received during SFY 2010 allowed for the provision of primary care services in more primary care clinics and seeks to address health disparities experienced by individual with SMI.

Physical health services are available through Medicaid or local “free” clinics that provide indigent health care. A number of Regional Boards have chosen to “partner” with local health providers in developing/constructing clinics with shared space for both mental and physical health. These partnerships have been very successful in better identifying both mental health and physical health problems experienced by members of their community.

For dental care, access to low or no cost services are provided by the dental schools at the University of Louisville and the University of Kentucky (in Lexington). They serve individuals in the clinics located in Lexington and Louisville. The University of Kentucky also provides mobile dental services which reach out to uninsured families in Eastern Kentucky (those who do not make enough money to pay for dental care but who make too much money to qualify for Medicaid assistance). There are four dental vans from the University of Kentucky. Several faith based organizations have provided the financial support needed to start these services and to keep them operating. In addition, some faith based groups have opened free clinics in church buildings, which are staffed by volunteer dentists who come to the region from all over the state for weeklong mission trips. And yet others hold dental events in Wal-Mart parking lots, handing out free samples of toothpaste, dental floss and toothbrushes to anyone who wants them. Still, case managers and clinicians that have knowledge of local resources and well-developed relationships with local providers tend to lead to better access to dental services. There are, in many communities, those dentists who will serve individuals in need who have no ability to pay. However, overall access to dental care is generally considered poor.

## **MENTAL HEALTH**

Suicide prevention is a critical consideration for Kentucky’s system of care. While suicidality is often recognized among vulnerable youth, research consistently indicates youth are not the most vulnerable group. In October 2004, out of concern for deaths by suicide and the impact for a growing number of survivors, a suicide prevention coordinator was hired within the KDBHDID. After gathering together key stakeholders, the KY Suicide Prevention Group (KSPG) emerged as the collaborative group to develop a state suicide prevention plan that guides the state’s response to suicide within the Commonwealth. Key elements of this plan

are awareness, intervention and evaluation. The state suicide prevention plan is currently in the process of being updated.

As a result prevention efforts over 240 trained gatekeepers conduct QPR (Question, Persuade and Refer) awareness trainings throughout the state, nine local coalitions have been established, school-based prevention programs have been introduced to multiple school districts, over 800 clinical trainings have been conducted and statewide media campaigns involving the production of a Kentucky specific video chronicling the impact of suicide on Kentucky citizens have raised the level of awareness throughout the Commonwealth.

The grid below demonstrates the availability of the wide array of services for adults with severe mental illness in each of the fourteen mental health boards. The grid is updated annually based on required Plan and Budget submissions by the Regional Boards.

**Regional Availability of Community Support Services SFY 2013**

	1	2	3	4	5	6	7	8	10	11	12	13	14	15
<b>Services</b>														
<b>Consumer and Family Support</b>														
Training and Advocacy	X	X		X	X	X	X	X	X	X	X			X
Consumer Support Group	X			X	X	X	X	X	X	X	X		X	X
Social Club Drop In	X		X				X		X			X		X
Local NAMI of Kentucky	X	X	X	X	X	X		X	X	X	X	X	X	X
Consumer Conferences			X		X	X		X	X	X	X		X	X
Peer Support	X			X	X	X			X	X	X		X	X
<b>Emergency Services</b>														
Emergency-Help Line	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Walk-In Crisis Services (8-5 M-F)	X	X		X	X	X	X	X	X	X	X	X	X	X
Mobile Crisis Services	X	X					X	X	X	X	X			X
Residential Crisis Stabilization	X		X	X	X	X		X	X	X	X	X	X	X
<b>Mental Health Treatment</b>														
Medication Management	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Community Medication Support	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Outpatient Therapy	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Intensive Outpatient		X			X	X	X	X	X					
Specialized Co-occurring Disorder Services		X				X	X	X	X	X	X	X		X
<b>Case Management Services</b>														
Case Management	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Wraparound Funds	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Specialized Intensive Case		X			X	X			X					X
Assertive Community Treatment		X		X				X	X	X	X			X
Continuity of Care and Specialized Initiatives						X		X	X		X			X
Homeless Outreach	X	X	X	X		X	X	X	X		X		X	X
Payee Services		X	X	X		X	X	X			X	X	X	X
<b>Rehabilitation Services</b>														
Therapeutic Rehabilitation		X	X	X		X		X	X	X	X	X	X	X
Supported Employment	X	X	X		X	X	X	X	X	X		X		X
Educational Services								X	X					X
Other Community Support				X		X					X			X
<b>Housing Options</b>														

Supported Housing Program		X	X	X	X	X	X		X		X	X		X
Residential Support		X		X		X		X	X					X
Housing Development	X	X					X	X			X	X	X	X

**MENTAL HEALTH TREATMENT**

Each regional board provides a full array of outpatient services including, but not limited to, individual psychotherapy, group psychotherapy, psychiatric evaluations, walk-in emergency appointments, psychopharmacology, medication education and peer support groups. Every effort is made to place these outpatient clinics within close geographic proximity for consumers in order assure easy access to needed services. Budget constraints have forced some regions to scale back availability of mental health treatment in less populous, rural counties. Additional areas of focus include:

- Recognizing the need to provide assertive outreach so fewer appointments are missed although most regions do report having a system for following up with missed appointments;
- Assuring medication continuity within the agency when level of care changes;
- Addressing shortages of professional staff, especially prescribers, increasing waiting periods for appointments;
- Assuring continuity of care between Regional Boards and inpatient settings or other community providers, thereby ensuring quality, holistic care;
- Screening adequately for substance use disorders/co-occurring disorders; and
- Providing opportunities for staff training in co-occurring mental health and substance use disorders (screening, assessment and treatment).

**SUBSTANCE ABUSE TREATMENT AND PREVENTION OVERVIEW**

Services provided primarily through contracts with community-based service providers (14 Regional Mental Health and Mental Retardation Boards and their subcontractors, local government agencies and other community-based organizations) include:

- Prevention programming in communities offered through 14 Regional Prevention Centers;
- Juvenile diversion programs; DUI assessment and education programs;
- Consultation with businesses on the development of a drug-free work place and employee assistance programs;
- Social setting detoxification centers, residential treatment centers, outpatient treatment services;
- Specialized treatment services for pregnant women, adolescents and intravenous drug users; and
- Opiate replacement therapy to opiate dependent persons who are high-risk for HIV disease due to their intravenous drug use.

Training, consultation and client evaluations are made available, within budget limitations, to criminal justice agencies and other agencies within the Cabinet for Health and Family Services for clients with alcohol and other drug problems.

The Division of Behavioral Health provides alcohol and other drug abuse prevention and treatment services pursuant to KRS Chapter 222 (Alcohol and Drug Education, Treatment and Rehabilitation). The provision of alcohol intoxication fees is pursuant to KRS 431.100.

Other statutes affecting the Division of Behavioral Health services include: KRS 189A (DUI assessment, education and treatment) and KRS 218A.410 (drug forfeiture).

Effective prevention and treatment of alcohol and other drug abuse will have a major impact on the health and well being of every Kentuckian. From peer pressure of youth to use alcohol and drugs to the risks of being involved in a drunk driving accident, all Kentuckians are at risk for alcohol and other drug related problems. The Division of Behavioral Health has the statewide responsibility for providing leadership and program direction for the implementation of primary prevention, early identification (intervention) and treatment for persons who are alcohol or drug dependent.

### An Assessment of the Strengths and Needs of the Prevention Service System to Address Individuals in Need of Primary Substance Abuse Services.

#### **Strengths:**

- Kentucky has a well-developed system of prevention, at the state, regional and county levels. Regional Prevention Centers have been in place for 20 years and the local Kentucky Agency for Substance Abuse Policy (KY-ASAP) boards have been functioning for over 10 years. One hundred and thirteen of Kentucky's 120 counties have established KY- ASAP Boards.
- Our prevention workforce includes approximately 80 Certified Prevention Specialists serving Kentucky's 120 counties. Regional Prevention Center Staff are required by statute to obtain Certified Prevention Specialist status within 3 years of being hired. (Kentucky has one of the highest percentages of ICPS exam pass rates of any state in the United States.)
- Kentucky was recently awarded a SEOW PFS Grant. This grant will permit the SEOW to continue to update the state epi profile as well as create new work products that will help guide future planning efforts. The State Staff has a very close working relationship with the SEOW.
- Kentucky's Prevention Enhancement Site Network, created in 1998 during Kentucky's first SIG Grant continues to offer high quality training and technical assistance to local coalitions and Regional Prevention Centers on implementing Environmental Strategies and best practices in Alcohol, Tobacco and Other Drug (ATOD) abuse prevention. The system consists of five sites, each with a particular area of expertise: alcohol, tobacco, marijuana, Fetal Alcohol Spectrum Disorder and faith-based initiatives. The PES system serves Regional Prevention Centers, local prevention planning boards, faith-based groups and other local stakeholders. PES services are provided to prevention groups in Kentucky free of charge. Working within the Strategic Prevention Framework process, the Prevention Enhancement Sites are instrumental in increasing the effectiveness of local community efforts to decrease the availability of alcohol, tobacco and other drugs. A key focus of the PES sites is helping communities implement local policies such as clean indoor air ordinances, mandatory responsible beverage service and keg registration ordinances
- Kentucky has the highest number of Drug Free Community Grantees per capita than any other state in the United States (32). This exceptionally high number, given our population of 4.3 , million reflects the high quality of technical assistance that our Regional Prevention Centers are providing local coalitions who apply for DFC funding.

- The Kentucky Prevention Network (KPN) seeks to promote collaboration among prevention professionals, volunteers, community members and others in the interest of healthy lifestyles. KPN meets quarterly and sponsors an annual prevention conference that brings together prevention specialists from around the state. Conference attendance has increased considerably since the conferences began in 2006.

## Weaknesses

- Clearly, gaps in resources remain and the need for strengthening the capacity remains. There has been significant turnover in the RPC system over the last four years which means that a number of new staff were not operational during the SPF Grant and were not able to benefit from the state level trainings provided. For instance, as part of a survey conducted with prevention specialists and community coalition members from across the state (N=58) indicated the following gaps and training needs:
  - Only 31% of all participants believed they were proficient in using the SPF process to address substance abuse in their region/community; and, only 23% were comfortable with their skill level in terms of helping coalitions use the SPF process;
  - Prevention specialists indicated that, on average, only 40% of the counties in their region were using the SPF process effectively;
  - 63% of participants desired additional training on sustainability theory (and 68% wanted additional training on practical application);
  - 41% desired additional training on implementation theory (and 46% wanted additional training on practical application);
  - 74% desired additional training on knowledge and skills related to program evaluation (including instrument design, data analysis and portrayal).
- Some of our longest standing DFC coalitions have come to the end of their 10 year funding cycle and are in the process of either disbanding or have scaled down their activities due to reduced or lack of funding. The diminished capacity of these cornerstones in our local prevention system has changed the readiness profile in some regions in the state.
- Reduction of state funding has reduced the scope of activities of our KY-ASAP Local Boards.
- Due to the absence of research in the area of effective prescription prevention drug strategies we do not really know if the strategies that our target regions are implementing through the PFS II initiative are effective. Quantitative data is needed on the efficacy of community drug drops, permanent prescription drug drop boxes and lock boxes.
- Reaching the LGBTQ and Military community continue to be a challenge due to a scarcity of data and a difficulty in establishing venues in which to administer prevention services to these at risk populations.

### How the Regional Prevention Centers Provide Primary Prevention Services to Children, Youth and Adults.

It is the belief of the Kentucky Prevention System that in order for prevention to be truly effective it must begin and remain rooted in the community in which it serves. Therefore the primary focus of the Regional Prevention Centers (RPCs) is to build/strengthen and help sustain local coalitions. Regional Prevention Centers are the state conduit to local communities. Regional Prevention centers coordinate prevention efforts through their longstanding partnerships with law enforcement, school systems, the health departments, County Judge Executives businesses and other community partners. The RPCs enhance these efforts through high caliber training and technical assistance on the Strategic Prevention Framework planning process. In addition, as part of their annual work plan, each RPC creates a county specific work plan for every county in their region. The work plan follows the five steps of the SPF.

The services that RPCs provide to communities are aimed at building capacity to ensure that coalitions have the necessary expertise to plan effectively and implement evidence based prevention strategies.

### How the Regional Prevention Centers Address the Needs of Diverse Racial, Ethnic and Sexual Gender Minorities.

The Regional Prevention Centers serve these at risk populations by first assessing needs of these populations through available data in the needs assessment section of their county work plan. Once these needs have been determined the RPC's identify the community leaders of these populations (to the extent that they are visible) and work with them to integrate the needs of their racial, ethnic, or gender minority group into the community strategic plan. Cultural competence is a required part of the SPF planning process. Cultural competence training is a required part of all Certified Prevention Specialist Training. Workshops on cultural competence and serving at risk populations are offered annually through The Kentucky School of Alcohol and Other Drug School, Prevention Academy and the Kentucky Prevention Network.

### **CO-OCCURRING DISORDERS**

In 2009, the Division of Mental Health and Substance Abuse was renamed the Division of Behavioral Health. Formal steps have been taken by the KDBHDID towards the integration of mental health and substance abuse services across the Commonwealth. Currently, one staff position within the Division of Behavioral Health is dedicated solely to the development, implementation and monitoring of integrated mental health and substance abuse services across the Commonwealth.

Additional steps have been taken by the Division including:

- Evidence-Based Practice "Seed" Grant to Kentucky River Community Care with Mental Health Block Grant Funding (\$25,000) – involvement of Dr. Mee-Lee in region specific consultation and statewide training event
- NIMH / SAMHSA Evidence-Based Practice Planning Grant – Case Study of Integrated Treatment Implementation in Bluegrass Region
- "One Time" training events – Mental Health Institute, Kentucky School, etc. focused on providing mental health training to substance abuse staff and vice versa (substance abuse training to mental health staff)
- Motivational Interviewing training

- Ongoing research on co-occurring financing policy (existing barriers with Kentucky Department of Medicaid Services, study of Michigan system, technical assistance from national consultant)
- Use of “implementation drivers” format to examine implementation of integrated treatment for adolescents (under RWJF Reclaiming Future grant)

Technical assistance was received from the Co-Occurring Center for Excellence (COCE) and from a Dual Diagnosis Capability in Addiction Treatment (DDCAT)/ Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) national trainer during SFY 09. A core team of integration specialists were trained to use the DDCAT/DDCMHT tools. Pilot sites were identified at four (4) Regional MH/MR Boards. These sites agreed to have their adult outpatient programs reviewed for co-occurring capabilities. During SFY 2010, four (4) baseline DDCMHT/DDCAT reviews were completed and three (3) follow-up assessments were done. In 2011 the Division moved on to the assessment of co-occurring capabilities in programs in the ten (10) remaining Regional Boards of the states fourteen (14) Regional Boards. All programs were offered the opportunity to use the data from their DDCAT/DDCMHT reviews to make changes using the Network for Improvement of Addiction Treatment (NIATx) process improvement model to raise any scores below the score of three (3), which is co-occurring capable. Each center formed a change team and submitted an implementation plan. During 2011-2012 all teams participated in monthly coaching calls with the Division co-occurring program administrator and a contracted NIATx coach. In May 2012 the participating programs presented their NIATx change projects in a meeting in Frankfort and received a \$6,000 incentive made possible by a Transformation Transfer Initiative (TTI) grant. At the final presentation meeting the teams were joined by Heather Gotham, co-creator of the DDCMHT, who worked with them to understand how to use the review data to become co-occurring capable in all seven (7) dimensions of the DDCMHT/DDCAT indexes.

In the current plan and budget applications for 2013 the Regional Boards are encouraged to complete a DDCAT assessment on at least one substance use disorders program and have a score of three (3), co-occurring capable, or adopt an action plans to raise their score to co-occurring capable.

Fourteen (14) CMHCs have participated in DDCMHT/DDCAT reviews and two (2) Kentucky programs have been added to the National Focus on Recovery (FIT) treatment locator map. Two (2) DBHDID employees attended the International Reciprocity and Credentialing (IC&RC) conference on co-occurring disorders in Minneapolis in 2012. One (1) DBH employee participated in the CADC licensure workgroup crafting the bill to create a credential for recovery peer support specialists to work with individuals in recovery from addiction. That bill has been introduced in the current legislative session.

Plans/ goals for Co-occurring Disorders for SFY 2014/2015:

- To continue evaluating the capacity of state programs for providing co-occurring treatment in programs receiving behavioral health block grant funding. The current CMHC plan and budget applications require Regional Boards to become co-occurring capable and to use evidence based practices in their substance use and mental health programs;
- To require the Regional Boards report their use of validated screening and assessment tools as well as how they are applying the American Society of Addiction Medication – Patient Placement Criteria (ASAM-PPC) criteria. The ongoing DDCAT/DDCMHT review provide a means of mapping progress toward co-occurring capability;
- Continue using the DDCAT/DDCHMHT at the program level;
- Continue to support and facilitate new peer led mutual support groups;
- Continue to require the use of evidence based treatment practices;



- Support employment of registered peer support specialists for recovery; and
- Support co-occurring training for providers. Jeff Georgi will present on “co-mingling” disorders and treating specific co-occurring psychiatric disorders at the Kentucky School of Alcohol and other Drug Studies in July 2013.

## **CONSUMER AND FAMILY SUPPORT**

Since the mid-1980s, the DBHDID has been committed to consumer and family involvement in program development and service delivery as a strategy for strengthening informal community supports. This focus has empowered consumers and family members to become more active in assisting Department staff in developing policies, monitoring and providing technical assistance to local programs, and evaluating requests for funding. The Division of Behavioral Health was directed by leadership to convene a workgroup in SFY 2009 with the goal of redesigning the consumer affairs function within the Division. A workgroup was convened that consisted of several adult branch staff members, including the consumer liaison, a representative from the substance use treatment branch, and an adult consumer. A framework for a redesign of the consumer affairs office was developed. Statewide consumer input was gathered at several points along the way, including informal meetings with the Division Director and during two (2) Olmstead/Consumer Advisory Committee meetings.

During SFY 2010, the Division of Behavioral Health began working to implement these recommendations. Department leadership agreed to hire a full time “Recovery Services Coordinator”, who is a self-identified consumer of behavioral health services and who is a part of the management team. Department staff as well as consumers gave input on the job description for this individual. In February of 2011, a Recovery Services Coordinator was hired.

The Department currently provides funds for a variety of statewide and local consumer and family support initiatives. These initiatives are focused on goals related to advocacy, discrimination reduction, wellness and recovery programs, peer support, education and training, and operating support. During SFY 2010, Division staff used consumer recommendations to rewrite contracts to be awarded to statewide consumer and family groups. These two contracts were renamed, appropriately, as the Recovery Oriented Training and Technical Assistance contract and the Recovery Oriented Family Support Services contract. These two (2) contracts were awarded during SFY 2011, as prescribed by the Request for Proposal (RFP) process monitored by the Finance Cabinet. A Department liaison was designated to monitor these contracts.

The Recovery Oriented Family Support Services contract was awarded to NAMI Kentucky and included requirements for organizing and providing a series of recovery oriented trainings and support activities for family members, utilizing established training modalities and implementation of other support groups that are established as best or promising practices. In addition, NAMI Kentucky must provide at least one “train the trainer” session per year for individuals who will provide the family support group training. This contract also required the provision of leadership in advocacy activities including collaboration with other organizations in supporting improved and evidence based practices such as supported employment, stigma reduction and mental health recovery. New to this contract was the provision of educational symposiums to regional areas across the state, based on needs and requests of local population and the development of a comprehensive needs assessment. NAMI must assure at least monthly contact with training/support staff across the state in an effort to enhance community integration and inclusion and ensure coordination of family support services and other outreach. During SFY 2011, a statewide “train the trainer” training for Family to Family Teachers and Family Support Group Facilitators was held. NAMI

provided 18 Family to Family 12 week classes with 225 individuals graduating. NAMI provided monthly family and consumer support groups. NAMI conducted monthly conference calls with Family to Family teachers and support group facilitators to enhance community integration, inclusion and outreach. NAMI Kentucky partnered with DBHDID to host five (5) "Community Conversations" across the state to educate and gather input on the 1915 (i) state plan amendment. NAMI Kentucky, as the family advocacy team leader, partnered with DBHDID to assist with a Individual Placement and Supports (IPS) Supported employment pilot project in four (4) regions in the state, and provided seven (7) educational symposiums to seven (7) different regions in the state. In addition, a listserv was created by NAMI Kentucky to promote mental health and community integration with statewide providers, consumers and family members.

Goals for NAMI Kentucky for SFY 2014/2015 include:

- Working on growing and strengthening NAMI affiliates by making personal visits to their community and having community meetings to enhance community integration, inclusion, outreach and increased efforts in stigma reduction;
- Focusing on educating the local education system and business community on mental illness and resources; and
- Increase the number of trainers for NAMI signature programs.

The Recovery Oriented Training and Technical Assistance contract required the development of a Technical Assistance Center and the provision of recovery oriented trainings across the state. Contractors gathered stakeholders from across the state, including consumers, family members and providers, and developed consensus for the formation of Kentucky System Transformation, Advocacy, Recovery and Support (KY STARS), a training and technical assistance center focusing on recovery oriented mental health services. During SFY 2012, KY STARS provided education to consumers in state psychiatric hospitals, consumers in treatment at local CMHCs, staff of two state psychiatric hospitals and regional CMHCs, and to Kentucky Peer Specialists and Leadership Academy graduates. KY STARS also provided technical assistance to consumers of peer run programs, staff of local CMHCs, and staff of state psychiatric hospitals. In addition, KY STARS worked to expand the number of peer to peer support groups available across the state and worked to train peers as facilitators of activities that are considered best practices.

KY STARS developed, conducted and analyzed a Comprehensive Needs Assessment of all mental health services in Kentucky during SFY 2011-2012. The Assessment polled over 300 consumers, provider and family members from across the state and looked at major issues in the mental health system, including service gaps, consumer inclusion and cultural competence. The data was broken down by geographical region and has guided KY STARS activities toward the mission of infusing recovery oriented care into all aspects of the Kentucky mental health system.

The KY STARS Training and Technical Assistance Center is located at Participation Station, Inc. This is one of Kentucky's first Peer Operated Centers. KY STARS has provided Participation Station with significant assistance in SFY 2012 with adopting and implementing the SAMHSA Toolkit for Consumer Operated Services. Participation Station is using the Fidelity Assessment Common Ingredients Tool (FACIT) to guide programming and evaluation for the program and has selected the Peer Outcomes Protocol (POP) to measure individual outcomes for the participants in the program.

In SFY 2012, KY STARS worked to develop and facilitate support groups for individuals with co-occurring substance use and mental disorders. Double Trouble in Recovery (DTR) groups, an evidence based practice, are traditional twelve (12) step programs geared toward

the special needs of individuals who are also dealing with a psychiatric diagnosis. KY STARS helped initiate and support the development of four (4) new DTR groups, one of which is held in one of the state psychiatric hospitals.

The Recovery Oriented Training and Technical Assistance contract requires the provision of Leadership Academy across the state. The **Leadership Academy** is a three (3) day educational program for persons with a mental illness who have a desire and interest in developing and improving their leadership and advocacy skills. Lessons are geared to address local and state concerns and provide students with practical and useful communication skills. The Leadership Academy consists of two training levels. Level One Training is the general skills training. Level II training is a Train-the-Trainers format, where graduates are able to return to their regions and teach groups. Graduates of the leadership academy are able:

- To identify and assess community issues and needs,
- To create, develop and participate in group action plans,
- To organize local advocacy groups into a respected and effective voice on mental health issues, and
- To participate on boards, councils and commissions.

Since April of 2007, Leadership Academy graduates have attended and participated on Eastern State Hospital's Recovery Mall Leadership Council, by attending monthly meetings. These graduates assist the attendees at the Council meetings in learning recovery skills and in learning how to conduct effective meetings. These meetings benefit both the residents at Eastern State Hospital who are working on their own recovery, as well as the Leadership graduates who are utilizing their newly learned skills.

During SFY 2013, one (1) Leadership Academy training was held, in Bardstown, Kentucky. Instructors for these trainings are Kentucky Peer Specialists. The goal for SYF 2014/2015 is to continue to provide at least two (2) Leadership Academy trainings per year. As a result of the Leadership Academy Training in Bardstown, Kentucky, the group of consumers trained became so inspired that they negotiated with their local NAMI affiliate and CMHC, and with technical assistance from KY STARS, opened a peer operated center in their area.

During SFY 2012, KY STARS provided training and technical assistance to staff at Western State Hospital to assist with the successful implementation of a Recovery Mall as part of the services offered to inpatient mental health consumers. This program was modeled after the Recovery Mall at Eastern State Hospital and Appalachian Regional Hospital psychiatric facilities. The treatment mall model has now been adopted by three (3) of Kentucky's four (4) state psychiatric hospitals. Feedback from consumers has been very encouraging and many comment that they became more engaged in their recovery.

KY STARS presented a state-wide conference for consumers of mental health services during SFY 2012. This conference was attended by almost four hundred (400) consumers from across the state. Peter Ashenden, from Optum Health was the keynote speaker. He is a national leader in mental health peer support and proved to be an inspiration toward expansion of peer support services in Kentucky.

In regards to peer support services in the state, KY STARS also held a preconference plenary for a selected group of Kentucky Peer Specialists from various geographical areas of the state. Cherene Allen-Caraco, a Certified Peer Specialist from Charlotte, NC presented a full day workshop entitled "Organizational Recovery" in which she taught Kentucky Peer Specialists how to interface with the public mental health system, Community Mental Health Centers, and other provider entities to fully integrate peer support into existing systems.

During SFY 2013, KY STARS presented a state-wide conference for consumers of mental health services as well. Approximately two hundred, fifty (250) attended. Steve Harrington from the International Association of Peer Support was the keynote speaker as well as the speaker for the preconference the day before.

In order to further the cause of expanded peer support services in Kentucky, KY STARS developed a functional website to share programs, recruit new Kentucky Peer Specialists and educate the public.

**Kentucky Peer Specialist Training** is a five day intensive training program for persons with a mental illness who have a desire to learn more about the recovery process and learn how to help others move forward in their own recovery process. The training program was modeled after the Georgia and South Carolina models of Peer Support.

While Kentucky Peer Specialist services are still not a billable service under Medicaid, DBHDID continues to train consumers for this service. During SFY 2012 three (3) peer support trainings were conducted. During SFY 2013 four (4) trainings were held. The manner in which we present these classes has been improved in the following ways:

- Upgrading the curriculum by adopting the second edition of the Georgia training model from the Appalachian Consulting Group which was copyrighted in 2011;
- Improving our delivery model to accomplish greater efficiency and economy. Previously we brought trainers and students from across the state to a single training location and paid everyone's (up to 28 people) travel, food and lodging for up to six days. It was expensive. We now depend upon community mental health centers to team with us by providing the location so that we can train our students regionally. Students are able to travel back and forth from their homes to the training. Thus we are expanding our reach and we are responsible only for the meals and lodging for the trainers; and
- Expanding our training corps so that we have competent trainers in several regions of the state to facilitate additional trainings, and deliver coaching and continuing education programs.

During SFY 2013, DBHDID began to work toward establishing a Kentucky Peer Support Organization. DBHDID is exploring joining the International Association of Peer Specialists. The Department also began utilizing electronic newsletters on a quarterly basis to improve contacts and disseminate information.

During SFY 2013, DBHDID developed a new curriculum for peer support persons who are interested in serving people experiencing substance use disorders. This is an urgent need since 60% of those with mental health problems also experience substance use disorders and 80% of those with substance use disorders also experience mental health problems.

Three (3) **Peer Operated Programs** are working on the process of establishing fidelity to the SAMHSA Consumer Operated System of Care Model. Participation Station in Lexington, Kentucky, (Bluegrass Regional MH/MR Board, Inc. region) and the Personal Involvement Empowering Recovery (PIER) program in Northern Kentucky (NorthKey Community Care region) are working on fidelity. There is also a new Participation Station in Bardstown, Kentucky. (Communicare, Inc. region) This new program began in March 2013. All three (3) of these programs are completely operated by consumers.

The goals for SFY 2014/2015 are to continue to provide credentialing for peers in Kentucky, both for Kentucky Peer Specialists and persons experiencing substance use disorders. Also,

DBHDID hopes to offer peer support as a Medicaid billable service. In addition, DBHDID hopes to foster Consumer Operated programs in all regions through issuing an RFA (Request for Applications) to develop four (4) new programs using Mental Health Block Grant funding. During SFY 2013 an RFA was issued and awarded to four (4) regions. Those regions are currently working on establishing their programs with fidelity to the Consumer Operated Programs model.

KDBHDID and the Regional Boards use a number of strategies to support consumer and family involvement. Block Grant funding supports various consumer involvement activities, including:

- Encouraging increased collaboration between Regional Boards and advocacy organizations;
- Sponsoring or co-sponsoring recovery oriented events in the regions;
- Recovery oriented training and technical assistance from consumers and family members to state psychiatric hospitals and providers;
- Consumer support groups on a regional basis;
- Wellness Action and Recovery Plan (WRAP) trainings for consumers; and
- Reimbursement for consumer and family members to attend state and regional meetings, conferences, and other gatherings.

The DBHDID and the Regional Boards encourage consumer and family member participation in planning, monitoring, and service delivery. To improve on existing weaknesses and build on existing strengths, plans are to:

- Continue to involve consumers and family members in the Behavioral Health Block Grant planning process;
- Design programs, trainings, and outcome measures that incorporate recovery principles;
- Implement Supported Employment training to encourage hiring of consumers;
- Encourage the growth of consumer run services by encouraging processes that establish fidelity to the SAMHSA model of Consumer Operated System of Care;
- Continue to encourage statewide consumer participation at all planning events; and
- Make Recovery Model training available in all regions.

While the DBHDID and the Regional Boards have come a long way in fostering consumer and family member participation in planning, monitoring, and service delivery, many challenges remain, including:

- Lack of dedicated funding for consumer run services;
- Few programs that fully incorporate recovery principles;
- Limited number of consumer run services that can serve as “mentor” programs; and
- Persistent transportation barriers for individuals to attend meetings and other events.

## **EMERGENCY SERVICES**

Since 1995, the DBHDID has made a concerted effort to develop a statewide network of Crisis Stabilization Programs (CSU). These programs, which primarily serve individuals with SMI, can be home-based interventions or residential units and are a major factor in Kentucky’s stabilization of 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;
- Overnight Crisis Beds;
- 23 Hour Observation Beds in Hospitals; and
- After Hours Face to Face Crisis Evaluations.

Regional Boards have flexibility in how they choose to provide emergency services based upon the unique needs and population within their region. As such, the ideal array is not available in every region. For example, 12 of the 14 regions offer residential Crisis Stabilization Units or overnight beds. This flexibility does enable the regions to expand crisis services to meet their unique needs and one region has set aside one (1) bed in their facility to serve the crisis needs of adults with Developmental and Intellectual Disabilities. This has become a need in other areas and the Adult Crisis Directors group shares information and specific protocols when an individual is admitted to a Crisis Stabilization Unit (CSU).

The fourteen Regional Boards report, through their annual Plan and Budget submissions, that:

- All fourteen regions have a 24 hour Crisis and Information line;
- All fourteen regions have qualified mental health professionals on call for emergency evaluations for involuntary psychiatric hospitalization 24 hours a day, seven (7) days a week;
- All regions respond within three (3) hours to a request for involuntary hospitalization evaluation;
- Crisis Stabilization Units are available in eleven (11) regions and an additional region can offer overnight crisis respite beds;
- All regions provide walk-in crisis services in at least one (1) clinic in the region during business hours;
- Training is provided to law enforcement related to accessing emergency psychiatric care in every region; and
- Mobile Crisis Services are available in eight (8) regions.

A growing trend is the centralization of staff that performs various types of emergency evaluations, such as involuntary hospitalization certifications, jail triage emergency evaluations and walk in emergency evaluations. In the past all clinical staff was expected to do these as part of their work. By centralizing this as the sole duty of a few staff, it allows for specialization of screening, risk assessment, forensics, etc. for some staff, while at the same time allowing those who are providing psychotherapy to devote their schedules to the consumers they serve, without disruption. One region has developed a central triage center where all crisis calls, emergency evaluations and involuntary hospitalizations are screened and triaged by qualified mental health professionals who are empowered to arrange for an array of emergency services from expedited appointments to hospitalization at the point of contact. This center will be moving in the upcoming year from the hospital grounds and will be co-located with the regions substance abuse treatment staff which will provide an overlap of treatment options for Individuals with co-occurring disorders. Substance abuse treatment options, especially detoxification services, continue to be a gap in the service array that may improve if treatment becomes a Medicaid billable service in the general benefit package for the Commonwealth.

The goals for SFY 2014/2015 include:

DBHDID is refocusing Emergency Services as the public mental health safety net and expecting the regions to screen, triage and stabilize anyone presenting in crisis. Regions will either offer the full array of crisis services or have a memorandum of understanding with an adjoining region to provide that service and give that consumer in need a warm hand-off to that level of care. Regional boards in three (3) urban areas have begun working with their local hospital programs (University of Louisville, University of Kentucky and St. Mary's) to discuss and jointly plan for high utilizers of emergency services that present at the ER.

Continue to advocate for third-party payor reimbursement for the services based on the importance of the Adult Crisis Stabilization Programs in preventing inpatient hospitalizations. One managed care organization in the state has negotiated a rate for Over-night crisis stabilization.

Continue to look at technology and assessment protocols to strengthen the Jail Triage program. This programming is currently running very stable and anecdotal feedback from the jails always seems highly positive. Our jail triage funding held steady from recent years and we must continue to innovate to protect the gratifying success of the program and continued cooperation from the jail staff.

DBHDID will continue to provide a 40-hour course for law enforcement, considered Mental Health 101 by the Kentucky Department for Criminal Justice Training (DOCJT) twice annually. This course serves as an elective for any law enforcement officer in the state who wants to better understand not only persons with mental illness but also those with developmental disabilities, substance use issues, brain injuries, co-occurring disorders and persons from the Deaf or Hard of Hearing community. A consumer of behavioral health services participates as an instructor in this training.

The Department will continue to build a working relationship with the Kentucky Department of Veterans Affairs, as well as the Veterans Administration, to explore further opportunities to enhance the current systems' response to veterans with Post Traumatic Stress Disorder, as well as other disorders, and their families. November 2012, the Department hired a program administrator to focus at least one-third of their time strengthening this collaboration with Veterans and their families.

### **REHABILITATION SERVICES (Includes Educational and Employment Services)**

The DBHDID incorporates the philosophy of "psychiatric rehabilitation" (outcomes improve when skills are taught in a social setting) and "recovery" (outcomes and satisfaction improve when consumers develop new meaning and purpose in life and grow beyond the catastrophic effects of mental illness) to assist the development of Community Support Services. As psychiatric rehabilitation technology has evolved, KDBHDID has promoted rehabilitation and recovery models through training, education, technical assistance, and targeted funding opportunities.

The DBHDID promotes the use of psychiatric rehabilitation technology by regional programs. The Psychiatric Rehabilitation model developed by the Center for Psychiatric Rehabilitation at Boston University was selected as the exemplary model as it has been extensively documented, validated, and replicated in hundreds of different settings for over two decades. This model also addresses the four major components of Community Support Services identified by KDBHDID with a focus on improving the lives of persons with psychiatric disabilities by enhancing their use of skills and/or environmental supports to live, learn, work, and socialize in the community and role of their choice.

Currently the DBHDID, Kentucky Medicaid, the Regional Boards, and other providers have not adopted a specific model of practice. Some programs have independently adopted a specific model but, without system support, have had difficulty implementing and maintaining a commitment to training and outcome measurement. The Psychiatric Rehabilitation model

offers a method that would specifically address improvement in skills, functioning, social environment, and role attainment with a proven process, intervention, and technology base.

The DBHDID supports the provision of three key rehabilitative services at the regional level: **therapeutic rehabilitation**, **supported employment**, and **supported education**. While they each rely on psychiatric rehabilitation technology, they are supported in very different ways.

KDBHDID supports rehabilitation services through the Regional Boards in a variety of ways:

- The Division of Behavioral Health designates a statewide community support program coordinator;
- KDBHDID offers technical assistance and training for Community Support Program Directors who coordinate services for the state's **therapeutic rehabilitation programs** (TRP). **Therapeutic rehabilitation programs** are goal directed services aimed at improving skills in living, working and socializing in communities of one's choice. Technical assistance is provided to regional programs in how to incorporate psychiatric rehabilitation technology into daily programming;
- KDBHDID has an interagency agreement with the Office of Vocational Rehabilitation that uses CMHS Block Grant funds to leverage **supported employment** services for adults with severe mental illness. In SFY 2010, the Department secured funds from the Johnson & Johnson Dartmouth Community Mental Health Program. This program provides funding and technical assistance for **supported employment** to State Mental Health Authorities (as of SFY 2013, seven (7) of fourteen (14) CMHCs are offering supported employment with "good fidelity" to the Dartmouth model); and
- Improving access to **educational services** through sites that provide Community Support Services remains a priority. According to the Kentucky Adult Literacy Survey, over 340,000 people lack the literacy skills necessary to compete in the workforce. Lack of literacy skills act as a hindrance to the personal advancement of another 656,000 Kentuckians. The lack of available educational services can seriously hinder persons with a severe mental illness in accessing and maintaining employment, and can negatively impact their quality of life. Providing access to educational support services has been a priority for Community Support Program Directors in community mental health settings.

Plan and Budget submissions for SFY 2013 reveal that access to rehabilitation services is available in all 120 of Kentucky's counties in the following manner:

- All fourteen (14) regions have traditionally provided access to therapeutic rehabilitation program services. However, as of SFY 2013 only ten (10) of fourteen (14) regions provide access to therapeutic rehabilitation services;
- Eleven (11) regions provide access to long term supports through supported employment services for adults with severe mental illness (seven (7) through the Dartmouth model); and
- Three (3) regions have specific educational support available in their programs.

Although adult rehabilitation services are available, access to services is inconsistent and often inadequate to meet the need. Only a fraction of adults with SMI in the state participate in rehabilitation programs offered through the Regional Boards.

Most regions have adopted Illness Management and Recovery, as adapted from the evidence-based practice model articulated by SAMHSA, and have restructured their



Therapeutic Rehabilitation services model to deliver this service, utilizing both professional staff and Peer Specialists.

The delivery of quality, timely rehabilitation services is challenged by a number of factors including:

- The current billing system that limits therapeutic rehabilitation as a site based service limiting community skills taught in the natural community;
- Kentucky Medicaid rates for therapeutic rehabilitation are quite low and significantly below the reimbursement rate for outpatient treatment services;
- Funding sources other than Medicaid do not reimburse for therapeutic rehabilitation services or else have challenging processes of reimbursement, so consumers without Medicaid have difficulty accessing this service;
- Therapeutic Rehabilitation Program services are inconsistent and have not adopted a specific model of practice with stated values, principles, practice guidelines, and expected outcomes of service;
- Certified Peer Specialist services is not yet a reimbursable service in Kentucky;
- Supported employment is not reimbursed by Medicaid and there is limited funding for the long term employment supports needed by adults with a severe mental illness;
- There has been difficulty gaining authorization for Therapeutic Rehabilitation Program services from Managed Care Organizations;
- Supported education is not reimbursed by Medicaid and is actually interpreted by some centers as being discouraged due to the possible interpretation of duplicity of services; and
- Difficulties with transportation, especially for consumers who do not receive Medicaid.

## **SUPPORT SERVICES**

### ***Criminal Justice System/Behavioral Health Interface***

Since the implementation of a multi-faceted legislative initiative in 1994, Kentucky has eliminated the use of jails during acute psychiatric crises and the involuntary hospitalization process. Instead, consumers are evaluated in emergency rooms or other safe, secure locations by staff of Regional Boards. These efforts have:

- Increased understanding of mental illness by emergency responders such as ambulance drivers, paramedics, and peace officers;
- Improved access to evaluation and treatment;
- Improved communication among local peace officers, judges, mental health professionals, other community resources and the general public; and
- Reduced the stigma and trauma of involuntary hospitalization.

KDBHDID has intensified efforts to build an integrated service system for individuals with severe mental illness who are involved in the criminal justice system, by collaboration between KDBHDID, the Kentucky Department of Corrections, and other stakeholders in our communities' "safety net" to serve persons with mental illness.

Regional Boards provide training to a number of entities in the criminal justice system in order to assure that persons with serious mental illness are diverted into treatment whenever possible rather than being arrested and booked into jail. In Jefferson County, Louisville Metropolitan area, the Crisis Intervention Team (CIT) within the Police Department has been in place for over seven (7) years and has successfully diverted thousands of individuals into care. During SFY 2012, 68 Louisville Metro Officers were trained in CIT. This made a total number of Louisville Metro Officers trained to date, 675, or over 50% of their 1216 total officer force. Their goal is to make sure at least one (1) CIT trained officer is on each shift. CIT

trainings in Jefferson County are not funded by mental health block grant or state mental health monies.

Jefferson County's circuit and district courts also have mental health diversion programs which work with regional board to operate post-booking interventions to divert many consumers into treatment and aftercare rather than long-term incarceration. Female clients with trauma history are represented at rates higher than the national average in therapeutic courts in Jefferson County. This led to a BJA expansion grant. Thru the technical knowledge gained, assessment protocols and more formal treatment modalities to address co-occurring issues were implemented. This region plans for continued expansion of mental health court programs to include Circuit court and a track for Assertive Community treatment. Programming continues to include: Illness Management and Recovery (IMR), Integrated Dual Diagnosis Treatment (IDDT), trauma informed and gender specific groups (including the Hands Off program to address the link between trauma and theft behavior). Cognitive Behavior Therapy (CBT) programming will focus on criminogenic factors that impact recidivism.

In SFY 2002, as the result of a series of investigative reports published in the Louisville Courier Journal related to suicides in local jails, the legislature appropriated \$550,000 to KDBHDID to develop a training curriculum for jail staff to address this issue. During SFY 2003, KDBHDID developed, implemented and monitored this training curriculum on suicide prevention and recognizing the signs and symptoms of mental illness. Regional board staff were trained in a "model curriculum" and then expected to train the staff in their local jails. In addition to this training, Regional Boards were encouraged to improve their working relationships with the local jails to assure mental health needs were being met for inmates housed in these facilities.

The relationship between Regional Boards and local jails has continued through the delivery of the mental health and suicide prevention triage assessments the Boards have been providing. Funding was also included to provide consultation to the jails on an as needed basis to improve jail personnel's response to inmates with behavioral health needs. Regional Boards report entering into formal agreements with their local jails in thirty-one (31) counties across the Commonwealth.

With the passage of Senate Bill 104 in 2007, the Kentucky Legislative Session established a statewide curriculum for training of law enforcement officers in the Crisis Intervention Team (CIT) Memphis model. The goal for SFY 2014/2015 is to continue to expand CIT trainings throughout the state. As of this year, over 1168 officers (including sheriff's departments, local police departments, state police officers, etc.) have been trained as members of Crisis Intervention Teams. Ten (10) regions to date have CIT advisory committees, which also involve mental health professionals, advocates and consumers alongside local law enforcement officers to enhance community collaboration.

KDBHDID has also partnered with the Kentucky Department of Corrections (DOC) on a re-entry project, partially funded by block grant funds. This program allows for strategic planning and case management for inmates with mental illness who are exiting Kentucky prisons and returning to their communities. The Boundary Spanner project employees a re-entry case manager who works to form a bridge of services between the prison system and the individual's home community. This enables the connection to behavioral health services to be planned and provided a "warm hand off" to the community mental health center. This program has been challenged by the passage of HB 463, which qualifies some offenders to be paroled or released early under mandatory release supervision conditions. This has created a demand for assistance in applying for Social Security benefits and behavioral health services months before the previously anticipated release dates. Other projects that

the Department is involved in include a Diversion Program being led by the Kentucky Department of Public Advocacy, which places a social worker in public defenders' offices across the state to develop diversion alternatives for persons with behavioral health issues.

KDBHDID's Community Mental Health Centers (CMHC's) contract language changed for SFY 2012 to allow for individuals within the Department of Corrections Correctional Psychiatric Treatment Unit (CPTU), an all male unit within one prison and the Psychiatric Care Unit (PCU), an all female unit within another prison, who are serving out of or being paroled from one of the two (2) units, to be served as a priority population by the Regional Boards. This will allow high risk individuals who are serving out of or being released from the CPTU and PCU to be seen within fourteen (14) days of release at a CMHC for mental health and medication management services. By having this population be seen as a priority population, the hope is that recidivism will reduce for this group of individuals. KDBHDID's Adult Services Branch and the Department of Corrections Mental Health Division are working collaboratively to develop a Memorandum of Understanding to include data sharing and collection mechanisms, and to gather information to help facilitate a smooth transition for all parties.

KDBHDID has been actively participating on the Governor's Reentry Taskforce, helping to develop recommendations for legislation in order to reduce many of the negative outcomes that are associated with incarceration and help to improve the reentry process for individuals with behavioral health issues. Goals for SFY 2014/2015 are to continue to collaborate with state and local entities in order to improve overall outcomes for individuals with behavioral health issues who are involved in the criminal justice system as well as improve access to substance abuse treatment services.

### ***Services to Persons who are Deaf and Hard of Hearing***

Effective behavioral health and substance abuse treatment begins with communication. If an individual is not provided language access, s/he is essentially blocked from the recovery services available to those proficient in spoken English. This fact is a common barrier for individuals who are Deaf, Hard of Hearing, or Deaf-Blind and need to access the CMHC system and state facilities. The Kentucky Deaf and Hard of Hearing Services (DHHS) staff strives to create an environment where individuals have linguistically accessible and culturally affirmative services. Through training, technical assistance, collaboration with community partners, funding assistance, program development, and policy review, DHHS aims to address unmet needs for the population. The program functions with one (1) full-time staff member. Lack of sufficient numbers of human resources necessitates creativity and collaboration in developing and implementing effective mental health services. Developing a network of skilled direct service professionals is key. Only two (2) regions have specialized staff dedicated to Deaf and Hard of Hearing Services: Bluegrass Mental Health / Mental Retardation Board has two (2) full-time therapists and one (1) part-time case manager. Seven Counties Services has two (2) full-time and one .2 FTE therapists. Most consumers in the CMHC system must still access services through an interpreter and with clinicians who have limited experience with the biopsychosocial effects of hearing loss. Training of clinical staff, interpreters, and peer specialists emphasize the importance of direct communication and lived experience.

Priorities for DHHS for SFY 2014/2015 include the following:

- Obtaining an Eastern Kentucky and a Western Kentucky Regional Coordinator to address the unmet needs in rural areas.
- Establishing a department-wide team to address quality assurance for all programs and services reaching individuals who are Deaf or Hard of Hearing in the Community Mental Health Centers and state facilities.

- Rolling out updated Standards of Care for Deaf and Hard of Hearing Services to be integrated into all Community Mental Health Center and state facility policies and procedures.

In addition, the following objectives for DHHS are noted for SFY 2014/2015:

- Support for four (4) interpreters to attend the Alabama Mental Health Interpreter Training then return to their state hospital regions to provide specific training and outreach to providers, consumers, and fellow interpreters on Best Practices in mental health interpreting. By the end of SFY 2015, at least fifteen (15) Kentucky interpreters will have this specialized training. Graduates will also continue to present a mental health track at the Kentucky Registry of Interpreters for the Deaf Spring Conference.
- Recruit, hire, train, and supervise up to eight (8) AmeriCorps volunteers each year in order to develop the workforce of individuals skilled in providing Deaf Mental Health Care and to address unmet service needs statewide.
- Conduct Communication Assessments for individuals who are Deaf with language dysfluency in order to provide recommendations for effective communication in evaluation and treatment. Work in collaboration with the Administrative Office of the Courts and the Office of Vocational Rehabilitation as well as university American Sign Language professors to develop a standardized protocol, process, and usage plan statewide.
- Address the need for children's services through collaboration with the Children's Branch, Kentucky School for the Deaf Statewide Outreach Center, and the parent group Hands & Voices. Participate in statewide outreach events and the Family Learning Vacation each year.
- Continue to reimburse for qualified mental health interpreters in Community Mental Health Centers and to develop partnerships with providers statewide.

The staff within the **Deaf and Hard of Hearing Services** program have been working to positively affect the quality of mental health services for this population. During SFY 2011, over thirty-three (33) training events were held, reaching over five hundred (500) people. During SFY 2011, work with Project SAFE (Safety and Accessibility for Everyone) led to a statewide look at Trauma Informed Care in Deaf Services and several workshops for shelters. A module regarding the needs of Deaf or Hard of Hearing citizens was added to the Department of Criminal Justice Training (DOCJT) "Special Needs" class that is now presented twice a year. In addition, a tri-state conference on adapting substance abuse treatment was presented with national expert Deb Guthman both live and utilizing the Deaf Off Drugs and Alcohol technology for remote participants. Training in SFY 2012 shifted to focus on intensive training for direct service providers and taking our approaches to a regional and national scale. Over thirty-five (35) trainings were held. Highlights included reaching parents of mainstreamed children through outreach events, working with the Child Advocacy Centers to address trauma in children, and collaborating with the KY System to Enhance Early Development (KYSEED) to present workshops statewide for case managers. In addition, technology was used to reach individuals in Developmental Disability / Intellectual Disability programs and those efforts continue in earnest today.

#### *Addressing Unmet Needs for Direct Service*

Data collected from the CMHCs indicates that those who are Deaf or Hard of Hearing with SMI, SED, or DD/ID designations continue to be under-served in terms of case management, service coordination, or wraparound services. The Eastern Kentucky and Western Kentucky Regional Coordinators will work to address these needs. Their role will also include case finding since under-reporting and under-utilization of services are suspected.

#### Eastern Kentucky

CMHC	ALL SMI	SMI with CM	ALL SED	SED with CM	ALL DD/ID	DD/ID with CM
Pathways	83	21	9	3	18	7
Mtn	170	28	18	6	9	3
Kentucky River	0	0	0	0	0	0
CRCC	320	31	27	3	19	10
Adanta	0	0	0	0	0	0
TOTAL	573	80	54	12	46	20

#### Western Kentucky

CMHC	ALL SMI	SMI with CM	ALL SED	SED with CM	ALL DD/ID	DD/ID with CM
Four Rivers	45	6	8	0	36	21
Pennyroyal	0	0	0	0	0	0
River Valley	51	13	0	0	2	2
Lifeskills	10	2	8	5	1	1

#### **Case Management Services**

Case management is an essential Community Support Service because it coordinates an individual's service array, making maximum use of available formal and informal supports. Case management has been available through Regional Boards since 1985 and was first covered by Kentucky Medicaid in 1991. Priority is given to adults with severe mental illness who have the greatest difficulties accessing resources and those with more intense service needs. Kentucky embraces a strengths based model advocated by the University of Kansas (Dr. Charles Rapp) blended with the psychiatric rehabilitation model endorsed by Boston University (Dr. William A. Anthony). Kentucky's Case Managers have caseloads of 25-30 individuals, with a maximum caseload of 35.

During SFY 2008, an Advisory Committee was formed, consisting of key CMHC and KDBHDID staff. The Case management certification training curriculum was updated through the input from this Committee and was placed in an online format. Face-to-face Level I Case Management certification training requirements were decreased from 2 ½ days to 1

day. Newly hired case managers are now able to begin certification training immediately upon hire, by utilizing the information module online. The certification exam was also placed in an online format. Designated Department staff monitors exam status and issues certificates upon completion of all the required elements.

So far in SFY 2013, approximately 45 case managers received Level I Case Management training. Level II Case Management training is scheduled for later in the fiscal year involving advanced documentation and goal setting.

During SFY 2012, three (3) Level II Case Management trainings were held at different geographical venues across the state regarding Motivational Interviewing. DBHDID held one training at Jenny Wiley State Park in the eastern part of the state, one training at Pennyriple State Park in the western part of the state and one training in Lexington, Kentucky in the central part of the state. Approximately eighty two (82) case managers were trained in Motivational Interviewing techniques.

KDBHDID supports case management through the Regional Boards in a variety of ways:

- The Division of Behavioral Health designates a statewide coordinator of case management services;
- KDBHDID requires and provides certification training for all case managers within six months of employment.
- The KDBHDID provides additional training opportunities for case managers and case management supervisors; and
- Adaptations of evidence-based practices such as Assertive Community Treatment are occurring as pilot projects in a few regions in the state and are being studied for possible expansion and implementation in other regions.

Case management services are available in all 120 of Kentucky's counties. Currently, case managers provide support to approximately 8,933 individuals with severe mental illness in a variety of ways. Plan and Budget submissions from the regions show that:

- Seven (7) regions report having an Assertive Community Treatment Team, although fidelity to the evidence-based practice is low;
- Eight (8) regions report having mobile outreach teams;
- Five (5) regions provide specialized intensive case management for forensic clients and;
- Five (5) regions provide continuity of care case management for special populations.

During SFY 2014/2015, the focus will be on maintaining stakeholder relationships, through the Advisory Committee, and continuing to respond to the needs of providers as well as monitoring the needs of consumers. There will be continued training opportunities for case managers, offered by the DBHDID, designed to enhance the effectiveness of working with adults with SMI.

### ***Community Medication Support Program (CMSP)***

KDBHDID supports the Community Medication Support Program (CMSP), a drug replacement program that provides low cost medications to the population who are living below poverty level and who do not otherwise qualify for federal or state assistance. This program is the result of a unique collaborative effort by the state operated/contracted psychiatric hospitals, the Regional Boards, KDBHDID, and local pharmacies. The goal of the program is to assist adults with SMI (and children with SED) who have no other means of purchasing prescribed psychotropic medication. Prescriptions are filled at local pharmacies, and then the medications are replaced to the pharmacies by our state operated/contracted hospitals. The program is available in all regions. Eligibility for the CMSP is based on age

(18+), income (federal HHS poverty guidelines and no third party payer sources), and KDBHDID criteria of SMI (diagnosis, disability and duration). During SFY 2011, KDBHDID partnered with the Kentucky Prescription Assistance Program (KPAP) administered by the Department of Public Health (DPH) in an effort to support a program for those indigent persons receiving services through Regional Boards to obtain free or reduced pharmaceuticals, including any pharmaceuticals needed for physical health. The goals of this partnership are to significantly increase access to the Pharmaceutical Companies Prescription Assistance Programs (PAPs); mobilize communities to assist their neighbors in obtaining free and reduced cost prescription drugs; expand collaboration with existing organizations who provide services to the underserved and uninsured, reducing duplication of effort; and promote integration between the primary healthcare system and mental healthcare system to provide a continuum of care for those individuals being served. Since its inception in 2008, KPAP has obtained \$90M in free medications overall. In SFY 2014, there will be a .5 FTE employed by each of the Regional Boards and a staff person within the Division of Behavioral Health that will be ensure maximum benefit of this program and systematic operational protocol.

### ***Housing Services***

The KDBHDID Housing Coordinator works with consumers, Regional Boards, the Kentucky Housing Corporation (KHC), the Kentucky Interagency Council on Homelessness, other state agencies and non-profit organizations to develop housing options, foster collaboration among housing and homeless programs, and support local efforts through:

- Technical assistance with other agencies and housing services providers;
- Planning and coordination with other agencies;
- Presentations related to housing; and
- Special training events.

Additionally, KDBHDID collaborates with KHC in these key initiatives:

- The Supportive Housing Specialist position, which is jointly funded by the KHC and KDBHDID, works to further integrate the housing needs of persons with mental illness into the state housing finance agency's programs.
- Technical assistance and consultation in developing housing projects is provided to local nonprofits by the Specialist.
- For SFY 2014, KDBHDID will continue to provide \$386,000 in funding to KHC to develop affordable housing options for persons with psychiatric disabilities through the application of funds by Kentucky Housing Corporation in their administration of the Olmstead Housing Initiative. These funds are used for rental assistance and moving expenses; and for SFY 2014, the development of supportive housing units.
- Providing SSI/SSDI Outreach, Access, and Recovery (SOAR) technical assistance and support to case managers, re-entry coordinators and other social services workers throughout the state to give them the knowledge and information needed to successfully assist disabled persons in accessing SSI/SSDI, as a first step toward gaining housing and independence.
- Promoting expansion of local SOAR initiatives by Regional Boards and non-profits across the state.

Regional Boards use a variety of strategies to develop housing options for individuals with severe mental illnesses. Some focus on actual housing development by employing regional housing developers; others focus on housing access by administering their own Section 8 set-aside programs or through collaborative arrangements with local public housing

agencies. Information from Plan and Budget submissions from the Regional Boards for SFY 2013 reveals that:

- There are currently 711 units in 61 projects operated by the Regional Boards;
- Many regions also operate a Tenant Based Rental Assistance program or access other assistance, providing over 100 vouchers across the state;
- Nine (9) regions operate housing projects that provide residential support;
- Eight (8) regions have organized formal supported housing programs;
- Seven (7) regions are involved in housing development;
- Eight (8) regions report having developed a regional housing plan; and
- Twelve (12) regions provide specialized housing training to agency staff.

Goals for SFY 2014:

- Continue to provide training and support to the Regional Boards through implementation of SAMHSA Supportive Housing Toolkit;
- Increase access and availability of housing options for priority populations through the application of the Olmstead Housing Initiative funds and other KHC programs, promotion of the "Housing First" model. Our Housing Specialist is on the Advisory Committee for a Housing First program in Louisville through the Phoenix Health Center. DBHDID continues to support this model through Department efforts and through the Interagency Council on Homelessness. The Center for Rehabilitation and Recovery has actually changed their name to Housing First; and
- Collaborate with Regional Boards and non-profits in establishing local SOAR initiatives.

Goals for SFY 2015:

- Provide technical assistance and support toward promoting fidelity to the Supportive Housing EBP. DBHDID will be providing additional training and assistance to two of our Specialized Personal Care Homes as they move from a PCH model to a Supportive Housing model;
- Continue to work with housing partners in increasing access for the priority populations through "Housing First";
- Continue to promote establishing local SOAR initiatives, and monitor and support existing initiatives.

## **REDUCTION IN INPATIENT PSYCHIATRIC CARE**

### **CONTINUITY OF CARE**

The Department believes that addressing the issue of continuity of care through a well-planned aftercare process is the key to ensuring a successful transition from the hospital to the community. Providing appropriate aftercare following a state hospital stay is critical to reducing readmission rates. The Department requires a Regional Board to provide an outpatient appointment within two weeks of a discharge. KDBHDID also requires the provision of case management services to adults with severe mental illness who are discharged from a state psychiatric facility, are determined by hospital staff to be in need of case management service, and agree to receive this service. As of SFY 2013, DBHDID also requires an outpatient appointment within two weeks of discharge from the treatment units of the Kentucky State Reformatory, a prison in LaGrange, Kentucky that houses two separate mental health treatment units.

The fourteen Regional Boards and the state operated/contracted psychiatric hospitals must work closely together to assure continuity of care. Contracts with all parties address continuity issues such as medications, discharge plans, case management and outpatient



referrals. Some Regional Boards function as a single portal of entry for some of the hospitals. Due to the uniqueness of the providers and each individual they serve regular continuity of care meetings between the respective hospital and local Regional Boards is initiated by KDBHDID staff. The agenda for each meeting includes the following topics:

- Aftercare performance;
- Community Medications Support Program;
- Olmstead planning;
- Continuity of care systems issues;
- Consumer issues;
- KDBHDID Performance Indicators; and
- Other issues requested as they may arise among participants.

During SFY 2005, KDBHDID worked with each of the state operated/contracted psychiatric hospitals and their assigned Regional Boards to develop a Memorandum of Agreement (MOA) between the two entities. In order to assure a seamless system of care, the need to develop these MOAs was identified to strengthen the relationships between the hospitals and the Boards. The MOAs include the contractual responsibilities each entity has to the KDBHDID, but also defines and clarifies roles and responsibilities the hospital and Regional Boards have to assure quality continuity of care to patients that they both serve.

KDBHDID strategies to reduce unnecessary psychiatric inpatient utilization include the development of residential crisis stabilization programs, responsive emergency services, assurance of continuity of care and the continued development of other community support services as effective alternatives for adults with serious mental illness who are in crisis.

KDBHDID has responsibility for the monitoring of the Kentucky **Olmstead Initiative** in each of the four state operated/contracted psychiatric hospital regions. Transition teams comprised of the representatives from the hospital, the Regional Board, KDBHDID staff, and other appropriate stakeholders meet on a frequent basis to review transition plans that assure a smooth and timely discharge to the community for identified patients. Funds were appropriated during the 2002 legislative session and in subsequent biennial budgets to pay for individualized and specialized wraparound services to assure the community tenure for each of these individuals.

Continuity of care is a major priority for the Department. A number of challenges are presented to KDBHDID and the Regional Boards. These include:

- Private psychiatric beds have been closing or are being converted to acute care beds which generate more revenue;
- The loss of private psychiatric beds in local private hospitals has placed a strain on state operated psychiatric hospital by increasing admissions;
- While crisis stabilization programs have existed in all fourteen (14) regions since SFY 2004, confidence in their appropriateness as alternatives to hospitalization remains low among many psychiatrists and utilization remains relatively low in some programs;
- Supervised residential options are sparse throughout Kentucky, thwarting efforts to discharge individuals with complex service needs; and
- The unavailability of adequate funding for community-based services as alternatives to hospitalization remains a barrier to good continuity of care.

Budget cuts in SFY 2009 resulted in one region reducing staff in their crisis stabilization unit and subsequently reducing the level of care for that program. One other region closed its community-based crisis stabilization unit and moved it to the grounds of the state psychiatric

facility in order to be more cost efficient. Budget issues in SFY 2012 resulted in one region closing their crisis stabilization unit. Plans for SFY 2014/2015 are to continue to support appropriate utilization of regional crisis stabilization units as a diversion to inpatient care.

A crisis services/emergency services workgroup has been formed by DBHDID during SFY 2013. This workgroup consists of DBHDID staff responsible for crisis services in adult and children's areas, as well as an outside consultant. Goals for this workgroup include a redesign of data gathering methods as well as more detailed review methods for each crisis unit.

A project entitled **DIVERTS** (Direct Intervention: Very Early Treatment System) was implemented in the Western State Hospital Catchment area during SFY 2007, as a partnership between KDBHDID, the four respective Community Mental Health Centers (CMHC) and the National Alliance of the Mentally Ill (NAMI). The goal was to reduce psychiatric hospitalizations. Approximately two million dollars that had originally been budgeted to the psychiatric hospital in Western Kentucky was instead allocated across the four Boards serving that hospital "catchment" area. The aim of this project was to reduce admissions to the hospital. Regions have been creative in addressing the issue of lowering hospitalization rates by providing specialized case management and other support services. Results have been good. One of the four regions reduced hospitalizations by 49% in SFY 2007 and by 5% in SFY 2008. Further reductions in hospitalizations have occurred in each fiscal year. The goal for SFY 2014/2015 is to continue the trend of reducing psychiatric hospitalizations.

An expansion entitled **DIVERTS II** is being finalized for SFY 2014/2015. This project reallocates over four (4) million dollars from psychiatric facilities to the remaining CMHCs to be used to relocate adults with SMI from residential personal care homes to homes in the community. Details continue to be established but services utilized will include four (4) evidence based practices, **Assertive Community Treatment (ACT)**, **Supported Employment (SE)**, **Supported Housing**, and **Peer Support**.

### **Geographic Area Definition – Children's Mental Health**

*Narrative Question: Establishes defined geographic area for the provision of the services of such system.*

Kentucky is divided into fourteen geographic regions for the purposes of planning and providing publicly funded community mental health, substance abuse prevention, and substance abuse treatment services. Together, the Regional Boards serve all 120 Kentucky counties. For each region, a Regional Board has been established pursuant to KRS 210.370-210.480 as the planning authority for community mental health programs in the region. County and municipal governments do not provide community mental health services. A Regional Board is:

- An independent non-profit organization;
- Overseen by a volunteer board of directors that broadly represents stakeholders and counties in the region; and
- Licensed by the Cabinet for Health and Family Services as a "Community Mental Health Center."



Originally, the Regional Boards were totally aligned with the Area Development Districts but in recent years Pathways serves two Development Districts, FIVCO and Gateway.

The Department for Community Based Services has nine (9) regional districts. The Department for Juvenile Justice and the Administrative Office of the Courts follow judicial districts. For public health services, seventy-four (74) counties are served by 15 district health departments and forty-six (46) counties are served by a health department in their county. There are 174 school districts across the state.

## 2) Available Resources Children’s Mental Health

*Narrative Question: Describe available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:*

- Health, mental health, and rehabilitation services;
- Employment services;
- Housing services;
- Educational services;
- Substance abuse services;
- Medical and dental services;
- Support services;
- Services provided by local school systems under the Individuals with Disabilities Education Act;
- Case management services;
- Services for persons with co-occurring (substance abuse/mental health) disorders; and
- Other activities leading to reduction of hospitalization.

## **HEALTH, MENTAL HEALTH AND REHABILITATION SERVICES**

### **Health**

The interface between the physical healthcare system and the behavioral healthcare system is of growing importance to providers of behavioral health services. It is well known that a

significant amount of behavioral health services are provided in the physical healthcare arena. Continuity of care across these systems is critical if children and families are to get the most beneficial services possible.

Regional Boards are required to conduct a physical health screening of all clients served. Department staff has assisted several regions in improving tools used to assess physical health concerns and continues to encourage further assessment and integration of physical and behavioral healthcare.

Per contract obligation, the five managed care organizations (MCOs) providing Medicaid services submit data to KDBHDID on a regular basis. The following 4 of the 13 reports provide information about physical health of children and adolescents:

- Behavioral Health Pregnant and Postpartum  
This report identifies the utilization of behavioral health services provided to pregnant and postpartum members. The postpartum period covers sixty (60) days after the date of delivery. All claims activity paid or denied during the reporting period is to be reported.
- EPSDT for Behavioral Health Population  
This report identifies the utilization of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services by the behavioral health populations. All claims activity paid or denied during the reporting period is to be reported. All provider types billing for mental health or substance abuse services are to be reported.
- Behavioral Health Annual Wellness  
This report associates wellness checks provided to behavioral health populations by procedure code. All claims activity paid during the reporting period is to be reported.
- Behavioral Health and Chronic Physical Health  
This report identifies the chronic physical health issues associated with children and adults who also are defined as one of the four major behavioral health populations. All claims activity paid or denied during the reporting period is to be reported. All provider types billing for mental health and substance abuse services are to be reported.

These reports are reviewed by department staff. Department staff then meets with each MCO approximately every six to eight weeks for planning and technical assistance.

#### Mental Health and Rehabilitation Services

All Regional Boards have a designated Children's Services Director. These Directors, along with other leaders, seek to ensure that the mental health service needs of children and families in their service region are assessed, addressed and evaluated in a structured, yet flexible manner. Such services are designed to meet the holistic needs of children with SED, as well as those of the general population of children served in their region.

A review of the information from the SFY 2014 Annual Plan and Budget applications reveals that Regional Boards continually strive to address barriers and meet the clinical service needs of children and families. Some examples of this include:

- Nine regions can get a child in for an initial intake appointment for a non-emergency in the same week that they contact the center;
- Eight regions provide walk-in crisis services for children and their family members during the evenings and weekends after clinics have closed;
- All regions offer off-site therapy services at the home of the child and throughout the community;
- The CMHCs employ 359 Service Coordinators to provide targeted case management to children and adolescents with SED;
- Eight of the fourteen regions offer specialized summer programs;

- Thirteen regions employ at least one designated Early Childhood Mental Health Specialist who provides therapeutic services for children birth to five years of age and education and consultation to others working with this population. In addition, the regions report employing 352 additional staff who have experience serving children birth through five and their families;
- Three regions have a Youth Representative on the Regional Interagency Council; and
- Six regions have a Parent Representative on the Center's Board of Directors.

Kentucky's Medicaid State Plan includes the Rehabilitation Option for behavioral health, including statewide coverage for therapeutic rehabilitation and targeted case management for children with SED. Eight of the Regional Boards operate day treatment programs and three Regional Boards operate partial hospitalization programs. There are additional Day Treatment programs, across the state, that are operated by the school districts and several private hospitals operate partial programs. Two Regional Boards also operate residential substance abuse programs for adolescents that offer integrated mental health services.

The Regional Boards rely heavily on their Kentucky IMPACT programs that offer targeted case management services, utilizing wraparound, to ensure that children with SED receive needed services and supports. Over \$5 million in state general funds is allocated to the Regional Interagency Councils that govern these Kentucky IMPACT programs. These funds are used to support program operation, including employment of Family Liaisons and flexible funds to meet the needs of youth and families. Kentucky IMPACT is available to children with SED regardless of whether they are Medicaid recipients. Most of the Kentucky IMPACT programs offer therapeutic aide services whereby a child is assigned an aide that will act as a mentor and skills-building coach. Many of the children, receiving IMPACT services, work to improve organizational skills, impulse control skills, social skills and coping skills. Services may occur on or off site to allow for "real life" learning experiences. The majority of IMPACT services occur in the home, school or community. Some IMPACT programs also offer after-school and/or extended summer programs where children may receive individual and group therapeutic services, as well as mentoring services. The table below represents an overview of the Available Services Array for Children provided by each of the fourteen Regional Boards across the state.

Children's Array of Services: Availability by Region from Plan & Budget Application for SFY14

Children and Youth Services Array/Number of Counties														
Regions	1	2	3	4	5	6	7	8	10	11	12	13	14	15
<b>Services</b>														
Clinical Services (Individual, Collateral, Family - provided by a Child Clinician at least 50% of time spent serving children and families)	9	8	6	10	8	7	8	5	10	5	8	8	10	17
Psychiatric Services (provided by a Child Psychiatrist-with at least one year of specialized child training)	9	2	6	8	8	7	8	2		5	8	8	8	17
Early Childhood Specialist	9		5	1	8	7	8	5	10	5	3	1	9	17
Other Early Childhood Clinician (who has received training and is supervised by the ECMH Specialist)				10	8	7	8	5	10	5	5	8		4
Paid Full-time Family Liaison			6	10		7		5	5		1			4
Paid Part-time Family Liaison					8		8							
Paid Full-time Kentucky Family Peer Support Specialist			6		1	1	8		5					
Paid Part-time Kentucky Family Peer Support Specialist							8					1	1	
Service Coordination for Children Age 0-5	9	4	6	10	8	7	8	5	10	5	8	8	10	17
Therapeutic Child Support Services		8		6		7	8		10	5	2	8	10	
School-Based Services	9	7	6	10	8	7	8	5	10	5	8	8	10	17
Intensive In-Home Services				10	8	1			5			8	4	17
After School Program		4			4				1			8		
Specialized Summer Program				7	8	1	3	1	10	5	8	8	9	
Respite Care		5		6	8	1		5	10					
Day Treatment Program					2	1	8			5		1		
Treatment Foster Home(s)		5		7				5		5				
Partial Hospitalization Program	1		1				8							
Crisis Services (M=Mobile, U=Unit, O=Other)	O	M	O	U	U	U M	M	U	U	U	U	U	2U	M

## **EMPLOYMENT**

Youth served in the Kentucky IMPACT programs across the state are given an opportunity to practice skill sets to prepare them for employment. Such vocational skills training may include writing resumes, job interviewing, and assistance retaining employment.

Supported Employment services are a needed service for transition age youth and are being addressed through several targeted initiatives, including the Johnson & Johnson/Dartmouth Supported Employment grant and the Kentucky Partners for Youth Transition trainings.

### **Kentucky Partners for Youth Transition**

The Department began coordinating an interagency workgroup in January 2008 to work collaboratively to promote and utilize best practices across all communities and systems that touch the lives of young adults (14-25 years old) with behavioral health concerns called Kentucky Partners for Youth Transition. Independent Living skills, employment skills and housing supports are important goals for the partners. The partnership includes seventeen agencies and advocacy organizations as well as youth/young adults and family members. The Partnership hopes through its efforts:

- Youth with serious behavioral health concerns will have earlier, faster and easier access to the developmentally appropriate care that they need.
- That the folks who work with youth will have the specialized skills necessary to adequately support youth through their transition age years – focusing on positive youth development and the transition domains of education, employment, living situation, and the life in the community.
- That youth will feel supported through the care they receive and that they will travel seamlessly through this care.

Successes around employment, housing and independent living from the Partnership and individual agencies that have/are taking place include the following:

- Kentucky's child welfare department, Department for Community Based Services, has made transition planning a priority and they have several initiatives occurring currently to better identify supports for youth prior to leaving care.
- Workgroup members are becoming educated on asset development and are sharing training and grant opportunities with young adults.
- The Kentucky Office of Vocational Rehabilitation is focusing on Asset Development by training staff on the FDIC Money Smart Curriculum to use with the young adults they work with. This will assist these young adults in becoming financially stable and increase their independent living skills, which will increase their opportunity to secure stable housing.
- The Partnership developed a best practice curriculum that can be used across disciplines and teaches the current best practices for working with transitioning youth. The six hour training for case managers/service coordinators is called Transition Age Youth Launching Realized Dreams (TAYLRD). The training has been held five times around the state to approximately 290 participants.

At their February 2013 quarterly meeting, the Partners engaged in a priority setting exercise to determine goals for the coming year. The top three priorities were improving access to resources, staff training and youth empowerment.

## **HOUSING**

Regional Boards strive to offer community based programs for children with SED that will allow them to remain in their own homes and communities, rather than in residential settings. They collaborate with the Departments for Community Based Services (DCBS-child welfare agency) and Juvenile Justice to maintain children in their own homes and communities whenever possible and when in the best interest of the child.

KDHBDID does not assume custody of children within the state, nor do it operate a children's psychiatric hospital or any other residential program for children. The Regional Boards, under contract with the Department, do offer a limited amount of residential care. Therapeutic foster care is offered in four of the fourteen regions, with a total of 72 foster homes. There are also a few Boards that offer overnight respite services on a limited basis. There are ten residential crisis stabilization units for children across the state, with a total of 96 beds. Ten Regional Boards offer mobile crisis stabilization services and may contract for overnight beds with a variety of providers (e.g., 23 hour acute hospital beds, private crisis stabilization residential program beds and private child care beds). Collectively, the five regions without a unit report availability of an additional 10 beds.

The Department for Community Based Services (DCBS-child welfare agency), within the Cabinet for Health and Family Services, is responsible for investigating child dependency, abuse and neglect and making recommendations to the courts. When deemed necessary, the Department for Juvenile Justice (DJJ), within the Justice Cabinet, also may assume custody of children. The Department collaborates with these two state agencies to ensure that the behavioral health needs of children are appropriately identified and addressed. DCBS and DJJ contract with Regional Boards and private providers to meet the residential needs of children in their custody.

#### Child Hospitalization Data

KDBHDID and Regional Board program staff, particularly emergency services staff, monitor children's psychiatric hospitalization rates. The Office of Health Policy within the Cabinet for Health and Family Services collects hospital utilization data and reports on it annually. In calendar year 2012, Kentucky experienced its first full year of managed care of Medicaid. There were 694 psychiatric beds within 13 hospitals available for youth aged birth to 17 years. 192 of these beds are for youth between the ages of 0-12 years old and 546 of these beds are for youth between the ages of 13-17 years old. The hospitals experienced 9,694 admissions, 165,045 inpatient days, and an average length of stay of 17.31 days for the year. On an average day, 451 children were utilizing these psychiatric beds (occupancy – 65%); *(Comparatively, in 2006, there were 633 beds; 7,705 admissions; 195,533 inpatient days; and the average length of stay was 25 days. In 2004, there were 612 beds, 8,536 admissions, 187,892 inpatient days and the average length of stay was 21.6 days.)*. 43% of the children's psychiatric beds are located in the state's largest city, Louisville; there are no beds in far western Kentucky nor in the four far eastern CMHC regions of the state.



Psychiatric Inpatient Utilization - Statewide - Children 0-17 Years of Age						
Year	Licensed Beds	# of Psy Beds	Admissions	Inpatient Days	ADC	ALOS
2012	1,285	694	9,694	165,045	451	17.31
2011	1,217	738	8,977	207,364	568	23.5
2010	1,220	735	8,532	215,193	590	25.23
2009	1,167	726	8,192	212,983	584	26.75
2008	1,183	712	7,949	200,754	549	25.23
2007	1,160	672	7,581	201,332	552	26.37
2006	1,118	633	7,705	195,533	536	25
2005	1,102	613	7,729	185,943	509	25.9
2004	1,102	612	8,536	187,892	513	21.6

**EDUCATIONAL SERVICES (INCLUDING SERVICES PROVIDED BY LOCAL SCHOOL SYSTEMS UNDER IDEA)**

DHBDID staff collaborates extensively with state and local educational agencies in support of IDEA and other initiatives focused on simplifying access to and coordinating services for children and youth with emotional and behavioral needs.

Currently, there are numerous school-based mental health initiatives across the state. Various models for school-based and off-site service provision continue to be studied and assessed for feasibility and effectiveness. KDHBID has sponsored several training seminars featuring national presenters to educate personnel of the Regional Boards and school districts. These have been well attended and partnerships between school districts and Regional Boards continue to grow statewide.

**KyCID**

The Department is most involved with promoting an integrated, multi-tiered approach that includes mental health promotion, early intervention, and intensive interventions utilizing a model of Positive Behavior Interventions and Supports (PBIS). The PBIS model encourages the involvement of mental health staff and parents at every level of intervention and support (universal/primary, targeted/secondary, and intensive/tertiary.)

KDE created the Kentucky Center for Instructional Discipline (KyCID) in late 2004. Goals of the program include:

- Enhance schools' ability to achieve proficiency by 2014;
- Involve families, schools, community, and related agencies to understand and support the model;
- Promote healthy school climate and effective school leadership;
- Support creation of local and regional capacity to implement and sustain the PBIS model; and
- Utilize ongoing data collection for decision-making on multiple levels.

Staff from KDHBID and the Kentucky Partnership for Families and Children (KPFC) serves on the KyCID steering committee to ensure that mental health and family involvement is supported at all levels of training and implementation. For additional information, please see [www.kycid.org](http://www.kycid.org).

#### Kentucky Interagency Transition Council for Persons with Disabilities

Chaired by the Division of Exceptional Children within KDE, the Kentucky Interagency Transition Council for Persons with Disabilities is made up of over 22 state agencies, including DHBDID. Their mission is to facilitate the work of state, regional and local agencies as they assist young persons with disabilities (all types) in moving from school to community living and employment. The Department's participation on the Council has offered a valuable forum for sharing of program information and resources as well as data to better address the needs of young people served by the various agencies.

#### Kentucky Educational Collaborative for State Agency Children

The Kentucky Educational Collaborative for State Agency Children (KECSAC) was established through legislation in 1992. KECSAC is a statewide collaborative that works with state agencies, school districts and local programs to ensure that state agency children receive a quality education comparable to all Kentucky students. "State Agency Children" are those children in the custody or supervision of the Commonwealth and who are being served in programs funded and/or operated by DJJ, DCBS, or KDBHDID in the state of Kentucky. KECSAC Advisory Group members include representatives from the following six agencies:

- Kentucky Department of Education
- Department of Juvenile Justice
- Department for Community Based Services
- Department for Behavioral Health, Developmental & Intellectual Disabilities
- Eastern Kentucky University and the College of Education
- Local Education Agencies

KECSAC is the responsible entity for assuring that the benefits of the Kentucky Education Reform Act are extended to children in the custody of state agencies, in day treatment programs, and schools on the campuses of residential programs. KECSAC links the schools, family and children's services, community mental health, juvenile justice, private providers, and institutions of higher learning. The Department's participation on KECSAC has enhanced communication between treatment and education providers and prompted more opportunities for cross-disciplinary training.

#### **SUBSTANCE ABUSE TREATMENT AND PREVENTION OVERVIEW**

Substance use among children and adolescents, and their caregivers, is often identified by Regional Board clinicians as a contributing factor to the poor mental health and overall wellbeing of clients they serve. While funding sources for substance abuse treatment services are quite limited for youth, the use and abuse of nicotine, alcohol, inhalants, prescription and illegal drugs is addressed in the treatment provided. Clinicians and case managers utilize education (prevention and intervention), treatment and referral mechanisms available through school districts, law enforcement agencies, private providers and Regional Board Prevention programs.

Regional Boards serve youth with substance abuse disorders in their outpatient programs, as well as in the IMPACT (targeted case management) program. Several Regional Boards have specialized inpatient and intensive outpatient substance abuse programs for youth.

One Regional Board in southeastern Kentucky is a Robert Wood Johnson Reclaiming Futures site and expansion of the model statewide is underway. Department staff are

available to provide technical assistance and coaching to the regions that plan to submit a proposal to the RF national program office to become an official Reclaiming Futures site. The goals of Reclaiming Futures include:

- Assess teens in the juvenile justice system that are using drugs and alcohol or are at risk for use;
- Provide increased drug and alcohol treatment for youth and streamline community resources and services; and
- Help at-risk youth become more responsible for their actions by linking them with community services and leadership activities.

Services provided primarily through contracts with community-based service providers (14 Regional Mental Health and Mental Retardation Boards and their subcontractors, local government agencies and other community-based organizations) include:

- Prevention programming in communities offered through 14 Regional Prevention Centers;
- Juvenile diversion programs; DUI assessment and education programs;
- Consultation with businesses on the development of a drug-free work place and employee assistance programs;
- Social setting detoxification centers, residential treatment centers, outpatient treatment services;
- Specialized treatment services for pregnant women, adolescents and intravenous drug users; and
- Opiate replacement therapy to opiate dependent persons who are high-risk for HIV disease due to their intravenous drug use.

Training, consultation and client evaluations are made available, within budget limitations, to criminal justice agencies and other agencies within the Cabinet for Health and Family Services for clients with alcohol and other drug problems.

The Division of Behavioral Health provides alcohol and other drug abuse prevention and treatment services pursuant to KRS Chapter 222 (Alcohol and Drug Education, Treatment and Rehabilitation). The provision of alcohol intoxication fees is pursuant to KRS 431.100. Other statutes affecting the Division of Behavioral Health services include: KRS 189A (DUI assessment, education and treatment) and KRS 218A.410 (drug forfeiture).

Effective prevention and treatment of alcohol and other drug abuse will have a major impact on the health and well-being of every Kentuckian. From peer pressure of youth to use alcohol and drugs to the risks of being involved in a drunk driving accident, all Kentuckians are at risk for alcohol and other drug related problems. The Division of Behavioral Health has the statewide responsibility for providing leadership and program direction for the implementation of primary prevention, early identification (intervention) and treatment for persons who are alcohol or drug dependent.

## **MEDICAL, DENTAL AND VISION CARE**

### **Medical Care**

Kentucky implemented managed care of its Medicaid program in the highest populated area of the state (Louisville/Jefferson County and 15 surrounding counties) in 1997. Passport Health Plan has been awarded the contract to oversee medical and dental care in that region since that time. On November 1, 2011, Kentucky Department for Medicaid Services

expanded managed care into the remaining 104 counties of the state. Three private companies were awarded contracts (Kentucky Spirit Health Plan, Coventry Cares of Kentucky, and WellCare of Kentucky) to provide care. On January 1, 2013, four private companies were awarded contracts for managed care in Louisville and the surrounding area (Passport Health Plan, Humana-Care Source, WellCare of Kentucky and Coventry Cares of Kentucky). Eleven of Kentucky's fourteen community mental health centers had little to no experience with doing business with managed care organizations and three were familiar with the requirements of Passport Health Plan. The agencies have restructured their organizations and processes to comply with the pre-authorization and billing requirements of the five managed care organizations.

Regional Boards are required to complete physical health screenings for all new clients and to update this information at least annually. Data is now being collected through the IMPACT Outcomes Management System on health concerns among children, with SED, served by Kentucky IMPACT (a targeted case management for children with SED), and the most commonly reported concerns include allergies and asthma. The prevalence of and risk for obesity and diabetes are also high among Kentucky's youth.

According to the Centers for Disease Control, thirty-five percent of low-income children between two and five years of age in Kentucky are overweight or at risk for becoming overweight. According to the Youth Risk Behavior Survey (2009), 61% of public high school students did not participate in sufficient moderate physical activity. Over 33% are overweight or obese (at or above the 85<sup>th</sup> percentile for body mass index). Almost 15% of high school students are seriously overweight, and an additional 15% are heavy enough to be considered "at risk" of becoming overweight adults. Obesity among Kentuckians is epidemic and Kentucky's children are among the most obese in the nation. A statewide plan to address this epidemic is a public/private partnership, The Partnership for a Fit Kentucky, which supports the Kentucky Department for Public Health's CDC Obesity Prevention Grant. The focus is on promoting nutrition and physically active communities. This website is a clearinghouse of the Partnership for a Fit Kentucky's initiatives. The intent is to link resources, network programs, provide tools that work, and strengthen partnerships in order to develop cutting edge initiatives. More information about this initiative can be found on the web site [www.fitky.org](http://www.fitky.org).

There are School-Based Health Centers in a handful of schools (9 of 174 school districts) across the state; the Kentucky School-Based Health Center Collaborative is advocating for legislation and funding to sustain such Centers. Schools and community health organizations across the country have concluded that providing medical services in the school building is one of the most effective approaches to reducing health problems and healthcare costs.

### Oral Health

Kentucky Department for Medicaid Managed Care has contracted with managed care organizations to provide dental care to Medicaid members.

Kentucky has one of the worst oral health profiles for children of any U.S. state; the state lacks dental providers in poor and rural areas, and many of its providers historically have not accepted Medicaid. A 2005 report produced by the nonprofit group Kentucky Youth Advocates revealed that half of the state's children between ages two and four had cavities and that only a third of those children covered by Medicaid had used dental services in the past year.

The Kentucky Oral Health Coalition, is a statewide group of dental providers, public health professionals, advocates, educators, and others working together to improve the oral health of all people in Kentucky. The coalition began in March 2012 and is staff by a well-known Kentucky children's advocacy organization, Kentucky Youth Advocates. This coalition is

currently working to increase oral health literacy; increase school based oral health care; and increase the number of dentists accepting Medicaid. Learn more about the Kentucky Oral Health Coalition at [www.kyoralthcoalition.org](http://www.kyoralthcoalition.org). Kentucky Youth Advocates reports that poor oral health stems from multiple factors including lack of access to care, lack of importance placed on oral health, lack of oral health knowledge, lack of money to pay for care, and many others.

The Kentucky Department for Public Health's Oral Health Program believes that children learn best when they are healthy, and dental health is a key component of overall health. The Oral Health Program provides the following initiatives to help children maintain good dental care: a fluoride varnish program, a sealant program, a community water fluoridation program, a rural school fluoridation program, a fluoride supplement program, oral health education and Healthy Smiles Kentucky. The [Healthy Smiles Kentucky](#) initiative was created by Governor Steve Beshear to improve the dental health of Kentucky's children, particularly in Appalachia. Healthy Smiles Kentucky is made possible by a combination of federal grant funds and state general funds. The main components of the initiative are: the ABCD training program; community oral health coalitions; and the Smiling Schools program.

The University of Kentucky College of Dentistry in coordination with other agencies provides a myriad of dental services for children:

- Inpatient and outpatient specialized dental services for children at the University of Kentucky Children's Hospital and the UK Medical Center. This includes the provision of services for dental patients with special needs. (physical, medical and other special needs);
- Primary dental services at an indigent care clinic serving north Lexington and a clinic in south Lexington;
- Seal Kentucky - a mobile dental sealant program providing on-site dental screening and preventive dental sealant services at eastern Kentucky elementary schools;
- East Kentucky Mobile Dental Program - provides dental prevention and treatment services on-site at elementary schools in central and eastern Kentucky;
- Western Kentucky Mobile Program - provides dental prevention and treatment services on-site at nine elementary schools in three western Kentucky counties;
- "Ronald McDonald" Mobile Dental Program - in partnership with Ronald McDonald Foundation provide on-site services at underserved preschools and elementary schools in Fayette and surrounding counties; and
- School-Based Dental Clinics in Rural Kentucky.

The pediatric dentistry program at the University of Louisville School of Dentistry provides services to patients between 6 months and 14 years of age. Special needs patients of any age are accepted. The program focuses on preventive dentistry such as cleanings, x-rays and fluoride treatments in addition to fillings, stainless steel crowns and extractions. Emergencies or outpatient treatment is provided at Kosair Children's Hospital for very young children with excessive decay or special needs of any age.

Several faith based organizations have provided the financial support needed to start these services and to keep them operating. In addition, some Christian groups have opened free clinics in church buildings, which are staffed by volunteer dentists who come to the region from all over the state for weeklong mission trips. And yet others hold dental events in Walmart parking lots, handing out free samples of toothpaste, dental floss and toothbrushes to anyone who wants them. Still, case managers and clinicians that have knowledge of local resources and well-developed relationships with local providers tend to lead to better access to dental services. There are, in many communities, those dentists who will serve children in

need who have no ability to pay for dental care. However, overall access is generally considered poor.

In 2008 the General Assembly passed HB 186 which requires a dental screening the first year that a 3, 4, 5 or 6 year-old child is enrolled in a public school, public preschool or Head Start program. The law took effect for the 2010-2011 school year. Supporters hope this law will decrease the number of school days that Kentucky's students miss due to pain associated with dental problems and will establish a dental home for children from early in life, so that more children receive routine dental care and become less reliant on costly and sometimes invasive emergency care in childhood and later in life.

### Vision Care

Kentucky Medicaid provides coverage for members of all ages for most examinations and certain diagnostic procedures performed by ophthalmologists and optometrists. Professional dispensing services, lenses, frames and repairs are covered for persons under age 21.

All Kentucky children are required to have an eye exam by a board certified Optometrist or Ophthalmologist before they enter school. This is in addition to the requirement for immunizations and dental and hearing screenings. For children with vision problems, the Kentucky Lions Eye Foundation (KLEF) is a great resource for assistance with screenings, exams, and eye glasses. Though located in Louisville, KLEF serves citizens across the state by operating the Vision Van, Eye Clinics around the state and providing thousands of photo screenings at the Kentucky State Fair. KLEF includes specialty services for children at their Pediatric Clinic.

Visually Impaired Preschool Services (VIPS) is a Kentucky non-profit agency that provides assessments, early intervention services, child care consultation and play groups/classes for infants, toddlers, and preschoolers who are blind or visually impaired. For parents and caregivers, VIPS provides various opportunities for education and support. While their main offices are located in Lexington and Louisville (metropolitan areas of the state), there is also an Outreach Program that serves rural areas of the state.

### **SUPPORT SERVICES**

All fourteen Regional Boards offer to their communities, consultation and education services regarding behavioral health care and services. There are a number of ancillary support services that are offered in the children's array of services including, but not limited to:

- Respite Services;
- Intensive In-home Services;
- After School Programs;
- Family Peer Support;
- Specialized Summer Programs;
- Therapeutic Child Support Services; and
- Transition Planning for Transition Age Youth.

### Youth and Family Involvement and Support

Across all regions of Kentucky, parents' voices are most consistently heard through their membership on Local and Regional Interagency Councils (LIACs and RIACs). These Councils are responsible for the identification of children with SED and for coordination of the services that they receive. These representatives also make up the State Family Advisory Council (SFAC), which serves in an advisory capacity to the State Interagency Council to Children with an Emotional Disability (SIAC).

The majority of regional Kentucky IMPACT programs, which serve children with SED and their families, also have "Family Liaison" staff positions. These individuals provide peer-to-peer mentoring, facilitate the creation and maintenance of local parent support groups/family network activities, provide education and offer technical assistance on a variety of topics to families and service providers.

A review of the information from the SFY 2014 Annual Plan and Budget applications submitted by Regional Boards reveals that there are ongoing efforts to maintain and increase youth and family involvement at all levels of the service system (The number in parentheses indicates the change from the SFY 2013 Annual Plan and Budget applications. If there is no number, then there is no change.), including:

- Parents participating on Regional Interagency Council (RIAC) in thirteen regions;
- Youth participating on RIACs in three regions (+ 1);
- A parent of a very young child participating on RIAC in nine regions (-1);
- Paid Family Liaisons in eleven regions;
- Kentucky Family Peer Support Specialists in five regions (-1);
- The RIAC Parent Representative participates on the CMHC Board of Directors in seven regions (+3);
- A Dad-specific support group/activity is held in one region (first year collecting this data);
- Outreach to Parents by the Family Liaison and/or Kentucky Family Peer Support Specialist takes place in eleven regions (+1);
- No transition age youth participates on the CMHCs' Board of Directors at this time (-2);
- Parents/caregivers participate in the development of training and professional development materials in six regions and as presenters (or co-presenters) of trainings in eight (+3) regions;
- Youth participate in the development of training and professional development materials in seven regions (+4) and as presenters (or co-presenters) of trainings in six (+4) regions;
- Parents contribute to the development of newsletters and other written materials in 10 regions (+2);
- Youth contribute to the development of newsletters and other written materials in six regions (+6);
- Youth Councils are active in eleven regions (+3);
- Parents receive advocacy and leadership training in nine regions (+1);
- Youth receive advocacy and leadership training in seven regions (+1);
- Parents and youth attend an annual mental health conference at no charge in one region;
- Parents receive a Kentucky IMPACT or Impact Plus orientation in eleven regions;
- Family Fun Events are held in thirteen regions (+3);
- Parenting skills trainings are held in twelve regions (+1);
- A resource library either dedicated for use by parents/youth or available to parents and staff is available to youth and parents/caregivers in thirteen regions (-1);
- Parent/family support groups are held in twelve regions;
- Youth support groups are held in eight regions (+2);
- Educational/training events for families/caregivers are held in all fourteen regions (+1); and
- A parent newsletter is regularly published in ten regions (+2).

KDHBDID tries to lead by example that the voices of youth, parents and caregivers should help shape not only individual treatment decisions, but also program development and policy determinations at the local, regional, and state levels. This principle is strengthened by the advocacy efforts of parents and youth at various points in the system of care. In support of this vision, significant portions of state general funds and approximately 4 percent of Block Grant funds are allocated to family and youth support initiatives.

### Opportunities for Family Leadership

Opportunities for Family Leadership (OFL) is a unit within DHBDID which offers a resource line for parents and caregivers to access education, resources and support. The toll free number for the resource line is (800)374-9146. OFL provides numerous services for families and youth and the systems that serve them, including:

- Training in advocacy, communication, cultural competency, collaboration and legal rights in schools;
- Awarding mini-grants for parent and youth support groups to develop local training events and provide community resource libraries. Over 250 training events are held each year by parent and youth groups.
- Providing technical assistance to ensure Standards of Practice for Family Liaisons and Kentucky Family Peer Support Specialists across the state are met and approving required trainings per the Standards of Practice;
- Awarding mini-grants for parent and youth support groups to develop local training and awareness events;
- Distributing reader friendly versions of Client Rights and Grievance Procedures, and supporting documents to parents, youth and others to ensure that these policies and procedures are understood by everyone; and
- Providing technical assistance to organizations and individuals with regard to children's behavioral health, developmental and intellectual disabilities and substance abuse services and supports. Resource information and training opportunities are among the many items provided on OFL's web site at <http://dbhdid.ky.gov/dbh/OFL.asp>.

### Kentucky Partnership for Families and Children

The Kentucky Partnership for Families and Children (KPFC) is a statewide, family organization working to ensure "that all families raising youth and children affected by behavioral health challenges will achieve their fullest potential." KPFC's mission is to empower families affected by behavioral health challenges to initiate personal and systems change. The board of directors consists of twenty-one to thirty-one members: twelve parent representatives from various community mental health center regions, two transitional-age youth representatives, seven child-family serving agency representatives, and ten flexible positions to assist with identified needs. As a family organization, over 51% of KPFC's board of directors must be parents/primary caregivers raising children with behavioral health disabilities and more than 50% of staff are also parents/primary caregivers that have raised, or are raising, children with behavioral health disabilities.

KPFC's programs and/or activities include:

- Dissemination of a quarterly newsletter via hard-copy or e-newsletter to over 3,000 members;
- Participation on numerous committees with various child-family serving agencies to represent parent and youth voices and perspectives;
- Operation of a web site ([www.kypartnership.org](http://www.kypartnership.org)) and a toll-free phone number (800-369-0533) for parents to access information about KPFC and resource information statewide;
- Provision of an infrastructure for Kentucky Youth MOVE which is comprised of 14-26 year olds who have a behavioral health challenge;
- Coordination and facilitation of the Kentucky Family Leadership Academy and the Kentucky Family Peer Support Specialist Core Competency Training;
- Partnerships with regional community mental health boards to establish Regional Youth Councils and to assist in the identification of youth leaders that will help facilitate the meeting;



- Distribution of resource information and learning opportunities for families raising young children from birth to five that have an emotional-social delay;
- Opportunities for teens (13 – 26 years old) with behavioral health challenges and their parents to learn, connect and network as part of the youth and parent movement; and
- Strengthening of Kentucky's family-driven and youth-guided system of care.

### Early Childhood Mental Health

KDHBDID and the Department for Public Health (DPH) co-administer Kentucky's Early Childhood Mental Health (ECMH) Program, with DPH staff having lead responsibility for program oversight and financing, and KDBHDID staff serving as clinical liaison to the program. Funds are contracted to the fourteen CMHCs for regional program administration.

The ECMH Program was created in state fiscal year 2003 as a component of the early childhood development initiative supported by state tobacco settlement funds, KIDS Now. The primary goals of ECMH are:

- To provide program and child level consultation to early care and education (child care) programs regarding social, emotional, and behavioral issues;
- To provide training for child-serving agencies and individuals on working with young children with social, emotional, and behavioral needs and their families; and
- To provide evaluation, assessment, and therapeutic services for children from birth through the age of five and their families.

ECMH funds the equivalent of fourteen ECMH Specialists, resulting in one or two Specialists per Community Mental Health Center region. The Specialists' time is devoted solely to their regional ECMH programs, and to building the capacity of regional providers to better meet the social, emotional and behavioral needs of children 0-5 and their families.

The ECMH Specialists provide approximately the below listed numbers of services annually:

- 500 children receive clinical (outpatient) services;
- 100 training opportunities to approximately 1,300 child care providers;
- 70 training opportunities to approximately 700 mental health professionals; and
- 3,000 consultations to child care centers.

In 2008, Kentucky was awarded its third SAMHSA CMHS system of care cooperative agreement named Kentucky's System to Enhance Early Development (KY SEED). KY SEED supports an integrated system of care designed to improve the lives of children age birth to five who have social, emotional, and/ or behavioral challenges and their families, by providing coordination of and access to effective services and supports. This has been done through merging the existing infrastructure and service delivery systems of the Kentucky IMPACT and ECMH Programs.

The goals of the KY SEED grant have been the following:

Goal 1: To promote community environments that support child and family well-being.

Goal 2: To create sustainable family and youth guided networks.

Goal 3: To expand access to high quality, developmentally appropriate services and supports.

Goal 4: To support local communities to implement and sustain an effective service delivery system.

Goal 5: To enhance state and regional infrastructure that encourages sound policy and decision making.

In its sixth and final year, KY SEED funds continue to develop an integrated system of care designed to significantly improve coordination of, access to, and effectiveness of services for

young children (birth to 5) who have social, emotional, and/or behavioral challenges and their families. The services and supports being implemented are evidence based, promising and practice-based strategies and developing needed services and building capacity for our young children. KY SEED ensures the family and youth voice is incorporated across the system of care as they are involved at the state, regional, and local level. Improving linkages among entities serving families of young children is being established by the development of KY SEED State Implementation Team (SIT) that serves as an advisory council to the State Interagency Council (SIAC) that is the governing body for KY SEED.

KY SEED has reached out to the funded communities to determine special populations to ensure cultural competency has been addressed. KY SEED has rolled out statewide in four cohorts of Regional Interagency Councils (RIACs). Currently, children and their families are receiving services in eleven of the 17 eligible RIACs.

### **CASE MANAGEMENT SERVICES (SERVICE COORDINATION)**

In Kentucky, targeted case management services for children through the Kentucky IMPACT program are referred to as “Service Coordination” provided by “Service Coordinators.” Kentucky IMPACT is a strengths-based, highly individualized, and collaborative model of case management utilizing Wraparound to address needs across life domains. These life domains include family, financial, living situations, educational/vocational, behavioral/emotional, psychological, social/recreational, health, legal, cultural and safety.

Legislation enacted in 1990 created eighteen Regional Interagency Councils (RIACs) that govern the regional Kentucky IMPACT programs. Each RIAC is comprised of local representatives from the primary child serving agencies and a parent of a child with SED. A Local Resource Coordinator (LRC) serves as staff to the RIAC, and generally manages the regional IMPACT program. While Regional Boards employ the LRC, and IMPACT staff, each RIAC creates and monitors program policy and procedures and provides on-going consultation to the staff of their IMPACT program.

Each RIAC serves as the gatekeeper for children entering and exiting Kentucky IMPACT services. Each RIAC receives an annual per capita allocation from KDHBDID for Service Coordination, RIAC staff support, and resource development. In consultation with its corresponding Regional Board, each RIAC determines how the funds will be obligated for the support of service delivery. Eligibility criteria for acceptance of a child into Kentucky IMPACT are not determined by insurance coverage or a family’s ability to pay.

Flexible funds, set aside by RIACs, may be used to purchase needed goods and services when there is no other available resource. Common expenditures may include tutoring services, summer camp fees, or therapeutic interventions provided to children by trained professional or paraprofessional mentoring staff. Regional Boards act as the fiscal agents for the funds but, again, decision-making authority regarding the use of these funds rests with each RIAC.

#### **Service Coordination 101**

Service Coordination 101 Certification Training is required in order to bill the Kentucky Medicaid Program or KDBHDID for Targeted Case Management Services. Service Coordinators/Case Managers and their supervisors must complete this training within six months of employment. This three day training is offered four times during the calendar year and provides certification for the following Service Coordinators/Case Managers and their supervisors:

- IMPACT Service Coordinators
- IMPACT Local Resource Coordinators

- Supervisors of Service Coordinators
- Department for Community Based Service (DCBS) staff providing Medicaid-funded Targeted Case Management, and their supervisors
- IMPACT Plus Case Managers (i.e., any IMPACT Plus sub provider who will be providing Targeted Case Management services)
- IMPACT Plus supervisors of Case Managers, Behavioral Health Professionals/Behavioral Health Professionals under clinical supervision

The training includes information about Medicaid regulations, the IMPACT and IMPACT Plus programs' history and philosophy, as well as the Wraparound philosophy which includes working with families in collaborative partnerships, and building teams to support children and families. Participants practice leading a child's service team and brainstorming ways to address potential challenges. Small and large group activities are incorporated into the training. Participants must complete all required sessions to receive certification. Certification is required to bill Medicaid and KDBHDID for services.

#### Wraparound Refresher Trainer

KDBHDID staff developed a Wraparound Refresher Training because experienced Service Coordinators expressed a need for the training. In fiscal years 2012-2013, seven trainings were held around the state with staff attending from eleven regions. In total, 219 Service Coordinators received the one-day training. More trainings will be scheduled as requested.

#### Team Observation Measure

In SFY 2013, KDBHDID included the Team Observation Measure (TOM) as a new requirement in the CMHC contract. The TOM assesses adherence to standards of high-quality wraparound during team meetings. It consists of 20 items, with two items dedicated to each of the 10 principles of wraparound. Each item consists of 3-5 indicators of high-quality wraparound practice as expressed during a child and family team meeting. Working alone or in pairs, trained raters indicate the whether or not each indicator was in evidence during the wraparound team meeting session. These ratings are translated into a score for each item as well as a total fidelity score for the session overall. Trained Observers complete a TOM with 10% of each Wraparound Facilitator's active child and family teams within a 6 - month timeframe. Teams are selected for observation using a systematic random sampling method. Fidelity data is submitted via an online data entry system within two weeks of completion of the team observation. Regional reports are provided on a frequent basis.

KDBHDID provides TOM trainings to regional staff. The TOM Observer Trainings are scheduled on an "as needed" basis. Two trainings are scheduled for September 2013 and another in January 2014. In SFY 2012, 53 regional staff received the training and in SFY 2013, 79 staff received it.

### **SERVICES FOR YOUTH WITH CO-OCCURRING MENTAL HEALTH AND SUBSTANCE USE DISORDERS**

Services for youth with co-occurring mental health and substance use disorders are coordinated by the Adolescent Treatment Coordinator. This position began in the Department in 2009 as a result of work that stemmed from our Kentucky Youth First Adolescent Treatment Grant. The Adolescent Treatment Coordinator works with each of the CMHCs to implement and sustain evidence-based practices, applies for and implements federal grants for adolescent services, and is now active in increasing adolescent treatment providers. Kentucky Medicaid notified providers on July 3, 2013 that substance abuse services for children under the age of 21 are covered under the EPSDT program and that providers may bill for substance abuse services as a primary diagnosis for children under the age of 21 who

are enrolled in the Medicaid program or the Kentucky Children's Health Insurance Medicaid Expansion Program (KCHIP).

The Department works closely with the Kentucky Adolescent Substance Abuse Consortium (KASAC). KASAC is a coalition of public and private providers of residential and community-based substance abuse services who are committed to enhancing the quality and types of treatment services available to adolescents through collaboration, support, education, and advocacy. For additional information please visit [www.kasac.org](http://www.kasac.org).

The State Interagency Council (SIAC) has in their strategic plan to address the needs of youth with co-occurring mental health and substance abuse disorders. Recommendations have been established with regard to the role of SIAC and RIACs in serving youth with co-occurring disorders.

Operated within the Regional Boards' Prevention programs is the Early Intervention Program (EIP). EIP is a collaborative between KDHBID and the Office of the Governor (Governor's Title IV Drug Free Communities and Schools funds) and provides multifaceted prevention and intervention services targeting specific needs related to alcohol, tobacco and other drug behavior and choices for youth and their parents. It was established in 2001 and operates under the authority of Kentucky Revised Statute (KRS) 189A in accordance with Kentucky Administrative Regulation 908 KAR 1:315. Target populations include:

- Youth convicted of "Under 21/Zero Tolerance", driving with a blood-alcohol content of .02-.08. These youth are required to go through an Early Intervention Program to satisfy the requirements of their offense. There are seventeen certified Early Intervention Specialists across the Commonwealth to provide these services.
- The second target population is juveniles who are at risk of becoming involved or who already are involved with the Juvenile Justice System and youth who are identified as using or at risk for using substances.

For additional information about this program, please visit their website at: <http://dbhdid.ky.gov/dbh/sa-rpc.aspx>.

#### **OTHER ACTIVITIES LEADING TO REDUCTION OF HOSPITALIZATION**

Children in Kentucky experience high rates of out-of-home care, including psychiatric hospitalization. A Kentucky IMPACT Outcomes report of 2011 data created by the University of Kentucky Center on Drug and Alcohol Research (CDAR) reveals that "the majority of caregivers (79.7%) reported that their children lived with their parents (see table below). The next most frequently reported living arrangement was home with other family members either in kinship care (not considered foster care in Kentucky's child protective service system) or not in kinship care. A smaller percent of caregivers (11.9%) reported other living arrangements for their children in the past 6 months, including foster care, inpatient psychiatric hospitals, emergency shelters, crisis stabilization, residential treatment program, and medical hospital. The table below does not show this detail, but the out-of-home placement that the highest percentage of caregivers reported their children living in was inpatient psychiatric hospital (3.1%, n = 25) but this represented a very small percent of the children. Only 4.3% (n = 34) caregivers reported that their children had lived exclusively in one of the out-of-home placements."

PERCENT OF CAREGIVERS REPORTING SPECIFIC LIVING ARRANGEMENTS THROUGHOUT THE 6 MONTHS BEFORE BASELINE FOR CHILDREN (N=795)

With parents (biological or adoptive)	79.7%
With other relatives	19.7%
Other Out-Of-Home living situations (e.g., foster care, inpatient psychiatric hospital, residential treatment, crisis stabilization, with friends)	11.9%

Children’s Crisis Services

Crisis stabilization programs have become a formal part of Kentucky’s array of services provided by the Regional Boards. These programs use state general revenue funds administered by the Division of Behavioral Health as well as Medicaid funds and others, when appropriate.

There are several models of community-based crisis stabilization in place across the state. Services in these models include the following:

- Mobile Crisis Services
- Crisis Stabilization Unit
- Intensive In-home Services
- Walk-in Crisis Services
- Intensive Outpatient Services
- Crisis Case Management
- Crisis Therapeutic Foster Care and Other Residential Overnight Services
- Crisis Respite
- Crisis Transportation Services

Crisis stabilization units provide short-term stabilization services (typically three to ten days). Most units are comprised of six to twelve beds and offer an array of assessment, treatment and referral services. Of the Regional Boards, nine have residential units and the remaining ones have mobile crisis stabilization programs that utilize beds for overnight residential services from other sources when needed. All of the Regional Boards provide walk-in crisis services during business hours and eight offer walk-in crisis services (at limited locations) during evening and weekend hours after clinics have closed.

Department staff facilitates quarterly Children’s Crisis Stabilization Peer Group meetings for Program Managers. Best practices, data reports, department updates and national trends are discussed and disseminated during these meetings.

**Criterion 2: Mental Health System Data Epidemiology**

**1) Estimates of Prevalence: Adult Mental Health**

*Narrative Question: An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children.*

Kentucky’s earliest estimates of the prevalence of serious mental illness were based on national work. In 1980, the U.S. Department of Health and Human Services (USDHHS) estimated that 3.14 percent of the population had some level of mental disorder, and that 0.75 percent of the population had a mental disorder that causes prolonged disability.

With the passage in 1992 of P.L. 102-321, the Community Mental Health Services Block Grant, Congress required the Center for Mental Health Services (CMHS) to develop a national definition for “adults with serious mental illness.” CMHS was further required to develop an “estimation methodology” based on the definition that state mental health

agencies must use to estimate needs in their state plans. While P.L. 102-321 limits CMHS Block Grant spending to persons who meet the federal definition, it does not require states to serve everyone covered by the definition. The federal definition of “adults with a serious mental illness” was published on May 20, 1993.

Early planning in Kentucky for adults with serious mental illness, using the 0.75 prevalence rate for adults with persistent disability, estimated that approximately 28,000 adults in Kentucky should be the priority population for services. Kentucky's mental health planning has historically focused on this subset of the population in development of its Community Support Program system.

A work group comprised of consumers, family members, and providers reviewed the federal definition and Kentucky's statutory definition of “chronic mental illness”; its recommendations were reflected in Administrative Regulations published in 1994. The regulation provided for operational definitions of the target population of adults with serious mental illness consistent with national policy. Kentucky's definition of “adult with serious mental illness,” as currently operationalized, uses the following criteria for age, diagnosis, disability, and duration: Kentucky's definition is narrower than the definition promulgated in the federal register for “Adult with Serious and Persistent Mental Illness.” Historically, stakeholders have supported the Department's desire to focus limited funding on adults who meet the state's narrower definition.

Variable	Criteria
<b>Age</b>	Age 18 or older
<b>Diagnosis</b>	Major Mental Illness <ul style="list-style-type: none"> <li>• Schizophrenia and Other Psychotic Disorders</li> <li>• Mood Disorders</li> <li>• Personality Disorders (when information and history depict persistent disability and significant impairment in areas of community living)</li> </ul>
<b>Disability</b>	Clear evidence of functional impairment in two or more of the following domains: <ul style="list-style-type: none"> <li>• Societal/Role Functioning: Functioning in the role most relevant to his/her contribution to society and, in making that contribution, how well the person maintains conduct within societal limits prescribed by laws, rules and strong social mores.</li> <li>• Interpersonal Functioning: How well the person establishes and maintains personal relationships. Relationships include those made at work and in the family settings as well as those that exist in other settings.</li> <li>• Daily Living/Personal Care Functioning: How well the person is able to care for him/herself and provide for his/her own needs such as personal hygiene, food, clothing, shelter and transportation. The capabilities covered are mostly those of making reliable arrangements appropriate to the person's age, gender and culture.</li> <li>• Physical Functioning: Person's general physical health, nutrition, strength, abilities/disabilities and illnesses/injuries.</li> <li>• Cognitive/Intellectual Functioning: Person's overall thought processes, capacity, style and memory in relation to what is common for the person's age, gender, and culture. Person's response to emotional and interpersonal pressures on judgments, beliefs and logical thinking should all be considered in making this rating.</li> </ul>

<b>Duration</b>	<p>One or more of these conditions of duration:</p> <ul style="list-style-type: none"> <li>• Clinically significant symptoms of mental illness have persisted in the individual for a continuous period of at least two- (2) years.</li> <li>• The individual has been hospitalized for mental illness more than once in the last two- (2) years.</li> <li>• There is a history of one or more episodes with marked disability and the illness is expected to continue for a two-year period of time</li> </ul>
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The 1999 federal methodology for estimating adults with serious mental illness requires states to use the national estimate of 5.4 percent for the prevalence of adults with serious mental illness, and a rate of 2.6 percent for adults with serious and persistent mental illness (SMI).

The following table uses the federal SPMI prevalence rate of 2.6% and the 2010 census data to estimate the percentage of the targeted population served by the Regional Board during SFY 2012.

<b>Regional Boards</b>	<b>Adult Census 2010</b>	<b>Estimated Prevalence (2.6% of the Adult Census)</b>	<b>Kentucky Adults with SMI Served in SFY 2012</b>	<b>Penetration Rate - SMI Served</b>
Four Rivers	161,545	4,200	2,478	59%
Pennyroyal	158,100	4,111	3,485	85%
RiverValley	161,977	4,211	2,285	54%
LifeSkills	217,231	5,648	2,041	36%
Communicare	200,640	5,217	2,883	55%
Seven Counties	730,843	19,002	8,718	46%
NorthKey	326,235	8,482	3,060	36%
Comprehend	42,757	1,112	726	65%
Pathways	170,601	4,436	2,592	58%
Mountain	119,756	3,114	3,050	98%
Kentucky River	89,550	2,328	2,088	90%
Cumberland River	181,110	4,709	3,226	69%
Adanta	160,202	4,165	2,291	55%
Bluegrass	595,449	15,482	4,513	29%
<b>TOTAL</b>	<b>3,315,996</b>	<b>86,216</b>	<b>43,436</b>	<b>50%</b>

### **Criterion 2.1: Estimate of Prevalence – Children’s Mental Health**

*Narrative Question: An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children.*

Using 2010 census data and the state’s agreed upon prevalence rate estimate of five percent, Regional Boards are aware of the number of children in potential need of services. The Boards also rely heavily on indicators and recommendations from the local communities, parent networks and Regional Planning Councils. Kentucky Kids Count, the annual report distributed by Kentucky Youth Advocates is also helpful for program planning. ([www.kyyouth.org](http://www.kyyouth.org).)

In Kentucky, criteria for determining whether a child has SED were included in the enabling legislation (KRS 200.503) for the Kentucky IMPACT program in 1990. These criteria include the following. A child who:

1. Is under age 18 or under age 21 and was receiving mental health services prior to age 18 and the services must be continued for therapeutic benefit;

AND

2. Has a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is listed in the current addition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders; and presents substantial limitations which have persisted for least one year, or are judged by a mental health professional to be at high risk of continuing for one year without professional intervention in at least two of these five areas:

- Self Care
- Interpersonal Relationships
- Family Life
- Self-Direction
- Education

OR

- Is a Kentucky resident and is receiving residential treatment for an emotional disability through the interstate compact; or
- Has been removed from the home by the Department for Community Based Services (Kentucky's child welfare agency) and has been unable to be maintained in a stable setting due to a behavioral or emotional disability.

The following denotes the child population and the estimated number of children with a severe emotional disability (SED) and thus percentage served.

Estimated 2010 Child Census – 1,023,371

Estimated Number of Children with SED (5% of Kentucky's child population) – 51,169

Kentucky MH Children Served SFY 2011– 55,566 or 5% (of Kentucky's child population)

Kentucky MH Children Served SFY 2012– 59,317 or 6% (of Kentucky's child population)

Kentucky SED Children Served SFY 2011 – 25,978 or 51% (of the 5% SED population)

Kentucky SED Children Served SFY 2012 – 28,578 or 56% (of the 5% SED population)

Regional Boards	Child Census 2010	Estimated Prevalence (5% of the Child Census)	Kentucky Children with SED Served in SFY 2011	Penetration Rate of Children with SED Served in SFY 2011	Kentucky Children with SED Served in SFY 2012	Penetration Rate of Children with SED Served in SFY 2012
Four Rivers	44,367	2,218	1492	67%	1,438	65%
Pennyroyal	51,686	2,584	616	24%	637	25%
RiverValley	51,495	2,575	1042	40%	1,010	39%
LifeSkills	66,964	3,348	1641	49%	1,430	43%
Communicare	68,477	3,424	2660	78%	3,037	87%
Seven Counties	228,248	11,412	6241	55%	6,527	57%
NorthKey	112,412	5,621	1937	34%	2,133	38%
Comprehend	13,721	686	398	58%	537	78%
Pathways	48,935	2,447	1362	56%	1,528	62%



Mountain	34,337	1,717	1076	63%	1,115	104%
Kentucky River	25,212	1,261	588	47%	1,373	109%
Cumberland River	55,508	2,775	2850	103%	3,042	107%
Adanta	47,054	2,353	1748	74%	1,902	81%
Bluegrass	174,955	8,748	2568	29%	3,082	35%
<b>TOTAL</b>	<b>1,023,371</b>	<b>51,169</b>	<b>25,978</b>	<b>51%</b>	<b>28,578</b>	<b>56%</b>

Kentucky's Regional Boards continue to better identify children with SED and to serve more children with SED. The Boards served 2,600 more children statewide in SFY 2012 than in SFY 2011, a 5% increase. Kentucky's estimated prevalence rate falls in the low range of estimates derived from local studies and cited in "Prevalence of Severe Emotional Disturbance in Children and Adolescence" (Friedman et al, 1996). This study acknowledges the lack of epidemiological data and concludes that regardless of the estimated prevalence rate that may be used, children with severe emotional disabilities are greatly under-served, a conclusion Kentucky planners share.

#### Data Sources Used

- Kentucky MIS Client/Event Data Set
- Kentucky State Data Center/US Census Bureau 2010
- Friedman, R. M., Katz-Leavy, J. W., Manderscheid, R., & Sondheimer, D. (1996). Prevalence of Serious Emotional Disturbance in Children and Adolescents. In R. Manderscheid and M. Sonnenschein (Eds.) *Mental Health, United States: 1996* (pp. 71-89). Washington, DC: U.S. Government Printing Office, DHHS Publication Number (SMA) 96-3098.
- U.S. Census Bureau's Decennial Census and National Center for Health Statistics, processed by Kentucky Population Research at the University of Louisville Urban Studies Institute.
- [Kentucky Revised Statute 200.503](#)

### Criterion 3: Integrated Services

#### 1) System of Integrated Services

*Narrative Question: Provides for a system of integrated services appropriate for the multiple needs of children without expending the grant under Section 1911 for the fiscal year involved for any services under such system other than comprehensive community mental health services. Examples of integrated services include:*

- *Social services;*
- *Educational services, including services provided under the Individuals with Disabilities Education Act;*
- *Juvenile justice services;*
- *Substance abuse services; and*
- *Health and mental health services.*

KDBHDID has established collaboration with many child- and youth- serving state agencies, community partners, families, and youth to address the behavioral health needs of children and adolescents. Many of those partners are represented on the State Interagency Council for Services to Children with an Emotional Disability (SIAC), a body composed of Commissioner-level members of child- and youth-serving state agencies, a parent and a youth member.

State Interagency Council

KDBHDID continues to promote activities that build the infrastructure for coordinated and integrated services for children with SED, and their families. Model examples of collaborative efforts found in the regions are often shared with others through technical assistance by the department. As discussed in Criterion 1, the State Interagency Council for Services to Children with an Emotional Disability (SIAC) is a group of representatives, from the primary child-serving agencies, and a parent of a child with an emotional disability, who maintain and oversee a framework of collaborative services for children with emotional disabilities. The hallmark program of this framework is Kentucky IMPACT, but other programs and initiatives may also fall under their auspices. There are eighteen Regional Interagency Councils among the fourteen Regional Board service areas and these Councils work under the umbrella of the SIAC. The table below illustrates the composition of the SIAC and RIACs. Some RIACs also have developed Local Interagency Councils (LIACs) at the county level to mirror the composition of the SIAC and RIACs, but to enhance the ability to develop resources at the local level and to problem solve when systemic issues may arise. The Chair of SIAC rotates each year but the Chair for RIACs is legislatively mandated as the DCBS (child welfare) representative.

**Composition of IMPACT Interagency Councils**

<b>SIAC Representative</b>	<b>Domain</b>	<b>RIAC Representative</b>
Parent of a child with a severe emotional disability	Family Members	Parent of a child with a severe emotional disability
Commissioner, KDBHDID	Behavioral Health	Director of Children’s Services, Regional MHMR Board
Commissioner, Department for Community-Based Services (DCBS)	Child Welfare	Service Region Administrator, Department for Community-Based Services
Commissioner, Department of Public Health (DPH)	Public Health	Representative, County Health Department
Commissioner, Department for Medicaid Services	Medicaid	Not mandated as there is no regional/local counterpart.
Commissioner, Department for Juvenile Justice	Juvenile Justice	Regional Program Manager Department for Juvenile Justice
Executive Director, Dependent Children’s Services within Administrative Office of the Courts	Courts/Diversion	Court Designated Worker selected by local district judges
Executive Director, Family Resource and Youth Services Centers (FRYSCs)	Prevention and Early Intervention	FRYSC Directors who are located in Elementary, Middle and High Schools across the state
Commissioner’s Designee, Department of Education	Education	Special Education, Local Education Authority

Youth Representative	Youth	Youth/young adult who has received mental health services for an emotional disability
Executive Director, Commission for Children with Special Health Care Needs	Health	Not mandated as there is no regional/local counterpart.

An integrated service system for the children and families served by Regional Boards is stronger in some areas of the state than in others. Examples of truly integrated services are sometimes found in communities where professionals and community members are well acquainted and have a long history of working together to achieve commonly held goals for their service recipients. Often where resources are the scarcest, creativity is strongest. Larger communities, while generally having the advantage of more resources, may face greater challenges in coordinating their efforts. Human Services Council meetings in many urban and rural counties serve as an opportunity to share agency information and exchange referrals regularly. In addition, there are numerous other networking and case conferencing mechanisms in place at the local level to encourage and support general agency and client specific information exchange and collaborative planning.

Partners learning the details of each others' specific job roles and their designated service areas is generally a beneficial starting place for assuring that children and families are served in the most effective and least restrictive manner. Most agencies do have specified service areas but adjustments are sometimes made to accommodate special circumstances. The fourteen Regional Board service areas do not completely align with any of the partner agency service areas; however all try to learn each others' county configurations so that they may best serve shared clients.

The interagency structure of Kentucky IMPACT drills down to the level of the child's service team. When a child is admitted to Kentucky IMPACT, a Service Coordinator is assigned to convene an interagency service team. The team consists of the child (when appropriate), his parent(s), his teacher(s), and other involved parties who work with or may otherwise be involved with the child and his family. A Regional Board is also the substance abuse and mental retardation planning authority for its region and most often provides these services as well, Services may be accessed by the Regional Interagency Councils (RIAC) through the Board's representation on the RIAC. This is generally the Children's Services Coordinator who has knowledge of all programs in the service area.

The RIACs are also staffed by a Regional Board employee, the IMPACT Local Resource Coordinator (LRC). The LRC is generally the IMPACT program manager but in some regions, these are separate staff positions.

Staff within the Department continually strive to develop relationships with staff of partner agencies that serve children with SED and their families. The following provides a bit of detail about some of the current focused partnerships.

## **SOCIAL SERVICES**

### Psychotropic Medications Workgroup

The recent national attention to the needs of children and youth in foster care, particularly pertaining to the oversight and management of the use of psychotropic medications with this vulnerable population, as well as an examination of our own state data has prompted a sense of

urgency to comprehensively address this issue in a cross-agency manner in order to ensure that youth receive valid assessments and effective care.

Comprised of Commissioners of the state's primary child-serving agencies, family members, and young adults, the SIAC serves as the governing body for Kentucky's system of care development and oversight. As part of its annual strategic planning, the SIAC identified the need for improved management of psychotropic medication use among all children in Kentucky and identified this as a priority issue.

Creating and implementing integrated oversight and monitoring protocols that ensure the appropriate use of psychotropic medications for children in foster care requires thoughtful collaboration across complex systems. In February, 2012, the SIAC wrote a letter in support of the state's application for technical assistance in response to CHCS' RFA titled, "Improving the Use of Psychotropic Medication among Children and Youth in Foster Care: A Quality Improvement Collaborative".

Although Kentucky did not receive the award, SIAC partner agencies commit to:

- Serve as the multi-stakeholder governing body to oversee the design, implementation, and evaluation of quality improvement efforts;
- Designate a Standing Committee of the SIAC to promote best practices for psychotropic medication use; and
- Support the efforts of a core team of the Standing Committee that will partner with Continuous Quality Improvement committee of the SIAC.

The SIAC partner agencies made the following recommendations:

There is clear and convincing evidence that collaborative planning and service implementation among all child serving entities is the most effective way to ensure a future adult population of productive citizens. Therefore, SIAC recommends:

- Increasing access to Evidence Based Practices across child serving systems
- Increasing use of mental health expertise and consultation to inform medication practices at the client and system level
- Implementation of system-wide screening and assessment to identify mental health needs; using standardized, evidence-based assessments
- Enhancing systems for informed and shared decision-making (consent and assent)
- Enhancing medication monitoring through improved Quality Assurance and Clinical Review Process (Medical) to include accurate health records
- Developing integrated data sharing systems to ensure care coordination and effective monitoring and oversight
- Ensuring all stakeholders (children/youth/family/practitioners/child welfare workers, etc.) have access to complete and accurate information
- Youth engagement and empowerment

#### Foster Care and Independent Living Council

Hosted by the Children's Alliance, the Foster Care and Independent Living Council is a membership council composed of member agencies of Children's Alliance that provide foster care and independent living services. Department staff participate in these meetings as do other partner agencies.

Most recently, there has been interest in collaboratively planning some training opportunities as well as some discussion about using like assessment and outcomes measurement tools. The Department recently collaborated on a grant application submitted by DCBS regarding the use of EBPs and other clinical services for youth in their care.

### Kentucky Partners for Youth Transition

The population estimates from the Kentucky State Data Center indicate that there are approximately 686,853 transition aged youth (14-25 year olds) living in Kentucky. National data suggests that 5% or 34,343 of these youth will have a severe emotional disturbance (SED) or serious mental illness (SMI). Collectively, the Regional Boards serve approximately 6% of the state's youth aged 14 – 25 years old. Youth with severe emotional disturbances (SED) or serious mental illnesses (SMI) face extreme challenges as they transition to adulthood:

- Over 60% of youth with SED/SMI will not complete high school. Employment, continuing education, and independent living skills are often serious limitations.
- These youth have higher rates of substance abuse
- Youth with SED/SMI are 3 times more likely to be involved in criminal activity
- SED/SMI conditions generally continue into adulthood.
- Young adulthood is also a high-risk period for developing new disorders

Research has shown that youth with SED/SMI who have support in coordinating their transition age years (such as vocational and educational support, life skills training, and case management services) have much greater positive outcomes in employment and high school and college achievement; as well as being less likely have mental health or substance abuse issues that interfere with their lives.

Department staff created and continues to facilitate a statewide initiative to address the needs of the specialized population of youth transitioning to adulthood who have behavioral health concerns, including those with SMI or SED and those with co-occurring substance use disorders. Named the *Kentucky Partners for Youth Transition* and adopted as a workgroup of the SIAC, the group has grown to include over 12 state agencies, parents and youth, and other stakeholders and has several committees. In November 2012, the Partners chose the following as the top three priorities to guide their work in the upcoming years:

1. Transition Resources (for youth and professionals)

- Resources for youth that are tech savvy
- User friendly resources
- Coordinated Website with all youth resources

Subgroup Members: Christie Penn, Nina Begley, Helen Willis, Kathy Eversole, Angela Winkfield, Leslie Jones, Janice Johnston

2. Specialized Training for Staff on Transition Issues

- Training staff on transition issues
- Intentional coordination of individual treatment/care/transition plans
- Educating professionals on available resources
- Expand the TAYLRD training to additional agencies

Subgroup Members: Karen King-Jones, Vickey Reilly, Marilyn Rodgers, Cheryl , Janine Dewey, Janice Johnston

3. Youth Empowerment

- Involvement in Youth Empowerment Summit
- Helping identify permanent connections
- Educating young adults on available resources
- Peer to peer support

Subgroup Members: Paula Saenz, Kate Tilton, Janice Johnston

Other areas of interest that may work into the subgroups listed above:

- College and career advising
- Positive media attention related to issues around youth transition

- Updating legislators and staying informed of legislative actions related to
- Standardized expectation for comprehensive

### Regional and Local Voices

At the regional and local levels, CMHC Children's Services Directors report the following specialized arrangements with Department for Community Based Services (social services) (DCBS) for providing priority behavioral health services for their clients:

- Designated clinical staff whose primary function is to provide mental health and substance abuse services to DCBS referrals at the DCBS offices.
- Providing therapy services in the local DCBS offices in counties that do not have a CMHC clinic.
- Providing therapeutic foster care services.
- Providing Emotional Injury Assessments and Emotional Injury Treatment.
- DCBS referrals receive priority scheduling and we reserve top priority funds to provide services to DCBS involved families at their request.
- Ongoing collaboration with DCBS staff, to include DCBS referral of all children 0 to 6-years-old with open abuse cases for triage and assessment;
- Agency staff on-site at DCBS weekly to provide consumer assessments, staff consultations, and to involve consumers and their families in the process of treatment.
- Team meetings to review high priority/intensive cases and discuss treatment goals and coordinate joint outcomes.
- Priority scheduling for DCBS clients.
- Arranged for a referral form to be used to guide DCBS referrals into their intake system and allowing the Center to contact those families directly upon receiving the DCBS referral.
- Timeframes for exchange of information. Associates (SRAA) on a quarterly basis to discuss new services, any change in service array, any possible grant collaborations, and any other issues that may arise.
- Arranged partnership referrals with DCBS for crisis stabilization units, parenting and crisis response.

### **EDUCATIONAL SERVICES, INCLUDING SERVICES PROVIDED UNDER THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT**

KDBHDID staff collaborates extensively with state and local educational agencies in support of IDEA and other initiatives focused on simplifying access to and coordinating services for children and youth with emotional and behavioral needs.

#### Kentucky Educational Collaborative for State Agency Children

The Kentucky Educational Collaborative for State Agency Children (KECSAC) was established through legislation in 1992. KECSAC is a statewide collaborative that works with state agencies, school districts and local programs to ensure that state agency children receive a quality education comparable to all Kentucky students. "State Agency Children" (SAC), are those children in the custody or supervision of the Commonwealth and who are being served in programs funded and/or operated by DJJ, DCBS, or DBHDID in the state of Kentucky. KECSAC Advisory Group members include representatives from the following six agencies:

- Kentucky Department of Education
- Department of Juvenile Justice
- Department for Community Based Services
- Department for Behavioral Health, Developmental & Intellectual Disabilities
- Eastern Kentucky University and the College of Education
- Local Education Agencies

KECSAC is the responsible entity for assuring that the benefits of the Kentucky Education Reform Act (KERA) are extended to children in the custody of state agencies, in day treatment programs, and schools on the campuses of residential programs. KECSAC is a true partnership that links the schools, family and children's services, community mental health, juvenile justice, private providers, and institutions of higher learning.

#### Kentucky Post School Outcomes Advisory Group

KDBHDID is a partner on the **Kentucky Post School Outcomes Center (KyPSO) Advisory Group** ([www.kypso.org](http://www.kypso.org)). This group came together to fulfill the Federal Department of Education, Office of Special Education Programs requirement that all States follow up with former students who had Individual Education Programs (IEPS) to determine the percent of youth who are no longer in secondary school, had IEPs in effect at the time they left school, and were:

1. Enrolled in higher education within one year of leaving high school.
2. Enrolled in higher education or competitively employed within one year of leaving high school.
3. Enrolled in higher education or in some other postsecondary education or training program; or competitively employed or in some other employment within one year of leaving high school”.

Kentucky's survey goes above the federal requirement and asks about other post school outcomes, such as:

- Satisfaction with work and school;
- Goals;
- Barriers;
- What Helped;
- Interaction with community agencies;
- Community involvement; and
- Free time.

This Advisory Group consists of various community partners such as Education, the Department for Community Based Services and the Office of Vocational Rehabilitation. They have partnered with the Human Development Institute and the University of Kentucky in the system development of this initiative.

In 2012, KyPSO published their first Youth One Year Out (YOYO) data (2011). The survey included 157 youth who had an IEP for an Emotional Behavioral Disability. Of those, 18% had been in higher education post school, 41% competitively employed, 13% enrolled in other higher education, 22% were employed with supports, and 28% had not been enrolled in higher education or working competitively post school.

#### Kentucky Interagency Transition Council for Persons with Disabilities

Chaired by the Division of Exceptional Children within the Kentucky Department of Education, the Kentucky Interagency Transition Council for Persons with Disabilities is comprised of representatives from 22 state agencies, including KDBHDID. The Council meets for the purpose of collaborating in the design, delivery, and improvement of statewide transition services for young adults (ages 14 - 21) with disabilities (of all kinds) from school to college and employment.

#### Regional and Local Voices

Ten of fourteen CMHC Children's Services Directors report offering educational and/or vocational services and supports to children or youth transitioning to adulthood. Examples of the services and supports include the following:

- Supported employment services

- Active coordination between Child and Adult Targeted Case Management 24 months prior to transition.
- Ongoing interface with supported employment and Vocational Rehabilitation services 12 months prior to transition.
- Share information about transitioning, training opportunities, Job Corps, community supports, and higher education.
- Transition to adulthood skills, services and supports incorporated into Service Coordination.

## **JUVENILE JUSTICE SERVICES**

### Kentucky Adolescent Treatment Dissemination & Enhancement Grant

Kentucky was fortunate to be awarded a SAT-ED grant in 2012, which is called the Kentucky Adolescent Treatment Dissemination/Enhancement Grant (KAT-ED), KAT-ED builds upon the work of a 2005 – 2009 CSAT Adolescent Treatment Infrastructure grant – *Kentucky Youth First*; over a decade of work with Robert Wood Johnson’s *Reclaiming Futures*; and Kentucky’s 2012 Policy Academy. Funds from this cooperative agreement will be used to implement evidence-based screening, assessment, treatment, and continuing care recovery services for youth with substance use disorders and youth with co-occurring substance use and mental health disorders and their families. Funds will be used for both infrastructure development and treatment enhancement in two high-need geographic regions of the State: Northern Kentucky (Campbell County) and Southeastern Kentucky (Whitley County). Efforts will build upon existing Reclaiming Futures Change Teams to enhance a coordinated network that will develop policies, expand workforce capacity, and disseminate evidence-based practices to improve integration and efficiency of the adolescent behavioral health service delivery system and to improve outcomes for youth and families. These local communities will serve as demonstration sites to support wide-scale replication across the state. The project period begins September 30, 2012 and will run through September 29, 2015. The award is for \$961,386 per year for 3 years to cover costs of treatment for youth, training, infrastructure development, administration and evaluation.

The Grants Management Team will be comprised of state members that will include representatives from the Administrative Office of the Courts, KY Partnership for Families and Children, the Division of Behavioral Health and the State Interagency Council (SIAC) administrator. SIAC will provide oversight for the grant. SIAC members will receive information from an appointed interagency workgroup that will review and analyze required information from the sites. The SIAC will use this data to make recommendations regarding state level policy development; removal of barriers to implementation and dissemination; and assist with replication of best practices.

This grant selected local community-based treatment providers to work collaboratively with the community to improve access and delivery of treatment and supports. For the purposes of this project, the counties of Whitley and Campbell will serve as the implementation sites. These counties were selected based on high need as well as demonstrated readiness for system change. Whitley and Campbell Counties both detain youth for status offenses at rates surpassing the state average, and Campbell County is the among the highest counties in Kentucky with a disproportionate rate of complaints against Black youth filed at about 2 to 3 times greater than their representation in the general population. Both counties have operationalized the Reclaiming Futures Framework for youth with juvenile justice involvement and have participated in SAMHSA – funded system of care initiatives and both counties are participating in the Juvenile Detention Alternatives Initiative (JDAI). Finally, the counties represent geographic diversity that will allow for evaluative comparisons important to future replication.



The participants of focus are youth ages 12 - 18 who are at risk for having a complaint filed and those who have a complaint filed against them but are eligible for diversion and their families. These youth will receive an evidence-based screening at the pre-diversion or diversion level of the justice system. Overall goals of the grant include:

1. Divert youth with substance use and co-occurring mental health and substance abuse issues from juvenile justice to appropriate services and supports within their community using a KY adapted version of the Reclaiming Futures framework.
2. The two implementation providers (identified through an RFA process) will receive training and coaching in the use of the evidence based Global Assessment of Individual Needs (GAIN) screening and assessment instruments and in the use of the evidence based treatment approach, Adolescent Community Reinforcement Approach (A-CRA) while acting as a learning laboratory to provide feedback in order to assist the State with broader implementation efforts and replication;
3. The State will work to discover and remove barriers to successful access and utilization of quality treatment interventions for the population of focus and their families and expand workforce capacity and dissemination for both A-CRA and GAIN
4. Complete a Financial Map and develop a process to use this information for planning services and supports within the system of care for the population of focus and their families.

Currently, youth are being assessed for mental health and substance abuse issues by the Administrative Office of the Courts (AOC) as well as the Department for Juvenile Justice (DJJ). There have been clinical staff trained in assessment methods/tools in most every CMHC and there are state and national trainers within Kentucky to continue to provide training and coaching on the use of the Global Assessment of Individual Needs (GAIN) family of screening and assessment tools. Due to turnover and difficulty with adoption of the GAIN within some treatment provider agencies, the momentum of the assessment has waned. There is a need to encourage the use of the assessment tool as it is not being utilized by the CMHCs consistently.

The need to enhance treatment options for adolescents with juvenile justice involvement is especially pronounced. While some adolescents will engage in troubling behavior, appropriate and consistently-applied discipline can ensure youth have opportunities to learn from mistakes and become successful contributing adults. Unfortunately, Kentucky, like many states has responded to such troubling behavior by detaining youth, including those who commit status offenses, an approach shown to be ineffective and highly expensive (Nelson, 2008). In fact, Kentucky detains youth charged with status offenses at the second highest rate in the nation, even though the most populous county in the state does not use this practice (KYA, 2011). With national estimates of approximately 70% of youth with juvenile justice involvement meet criteria for a diagnosable mental health disorder and about 61% have a co-occurring substance use disorder (National Center for Mental Health and Juvenile Justice, 2006), adolescents with juvenile justice involvement present a unique challenge to the system of care. Not only is the intensity of their needs likely to be greater, but proper response to their multiple needs requires increased collaboration, continuity of care, and the ability to recruit and retain providers who are equipped to treat multiple needs. Unfortunately, many of the youth do not receive much needed behavioral health treatment that could prevent initial involvement with the juvenile justice system or reduce the likelihood of recidivism. The Kentucky Department of Juvenile Justice (DJJ), one of five departments under the Kentucky Justice and Public Safety Cabinet within the Executive Branch, is responsible for statewide detention services, residential placement/treatment services, probation, community aftercare/reintegration programs and youth awaiting adult placement or court. Of Kentucky youth coming into contact with the juvenile justice system, 32% are committed

to the DJJ, 28% are informally adjusted (diverted), and 40% of cases are probated (Kentucky Department for Juvenile Justice, 2006). Thus, the need for accessible and effective treatment is paramount throughout the system.

### Regional and Local Voices

All fourteen CMHC Children's Services Directors report that their Center gives priority to serving children and youth referred by the court system.

## **SUBSTANCE ABUSE SERVICES**

### State Interagency Council

A fairly comprehensive array of services for youth with emotional disorders is available to varying degrees across Kentucky. This is less the case for youth identified with substance abuse treatment needs. While Kentucky has over 20 years of experience in providing behavioral health services to children, youth and their families through a system of care interagency infrastructure called Kentucky IMPACT and utilization of the State Interagency Council (SIAC). SIAC meets monthly to oversee coordinated policy development, comprehensive planning and collaborative budgeting for Kentucky's system of care for children. In addition to representatives from sister agencies from within the Cabinet, there are representatives from AOC, DJJ, Department of Education and parents and youth. SIAC has developed formal recommendations for state and local community changes to support youth with substance use and co-occurring disorders and within the realm of case management services. The SIAC has established a workgroup to focus on adolescent substance abuse and juvenile justice. The purpose of this workgroup is to promote comprehensive, integrated services for youth with substance use or co-occurring substance use and mental disorders.

### Reclaiming Futures

There are two nationally recognized Reclaiming Futures sites and two sites that are working as state Reclaiming future sites. Reclaiming Futures is a proven national model working toward systems change to address youth with substance abuse and juvenile justice issues. Working with the National Reclaiming Futures Office and Kentucky Youth Advocates a "Kentuckyized" version of the model and implementation guide has been completed to address youth with complex issues, who may be status offenders that are being detained and the disproportionate minority contact of youth within our juvenile justice system. A third Reclaiming Futures site established through a SAMHSA/MacArthur Policy Academy/Action Network grant has been established using the Kentucky version of the Reclaiming Futures implementation guide. This third site has focused on working with youth in a pre-diversion status that has focused efforts on screening, assessing, and treating youth on "the front end" of the juvenile justice system as a means of avoiding net widening into the juvenile justice system.

### Kentucky Adolescent Substance Abuse Consortium

The Kentucky Adolescent Substance Abuse Consortium (KASAC) is a group of concerned individuals who come together to advocate for the quality of and access to adolescent substance abuse and co-occurring disorders treatment through collaboration and education. KASAC is committed to providing training opportunities that target the needs of professionals who work with adolescents and focus on state-of-the-art and evidence based practices. KASAC is a partnership of many treatment providing agencies and other stakeholders, including KDBHDID.

## **HEALTH AND MENTAL HEALTH SERVICES**

### Physical Activity, Nutrition, Tobacco, Asthma Plus: A School Resource Guide

Staff from the Public Health, Behavioral Health and Education collaborated have collaborated to create two editions of the Physical Activity, Nutrition, Tobacco, Asthma Plus ([PANTA Plus](#)) School

Resource Guide (2006 and 2011). The Guide assists schools as they work towards a coordinated approach to school health. It provides the framework, structure, tools and resources to strengthen and expand school health programs and policies. The Guide includes information about the connection between health and academics; emerging, promising and best practices; designing and planning policies and programs; assessing the school health environment and use of data; encouraging environmental change; and promoting overall health of students, staff and the school community.

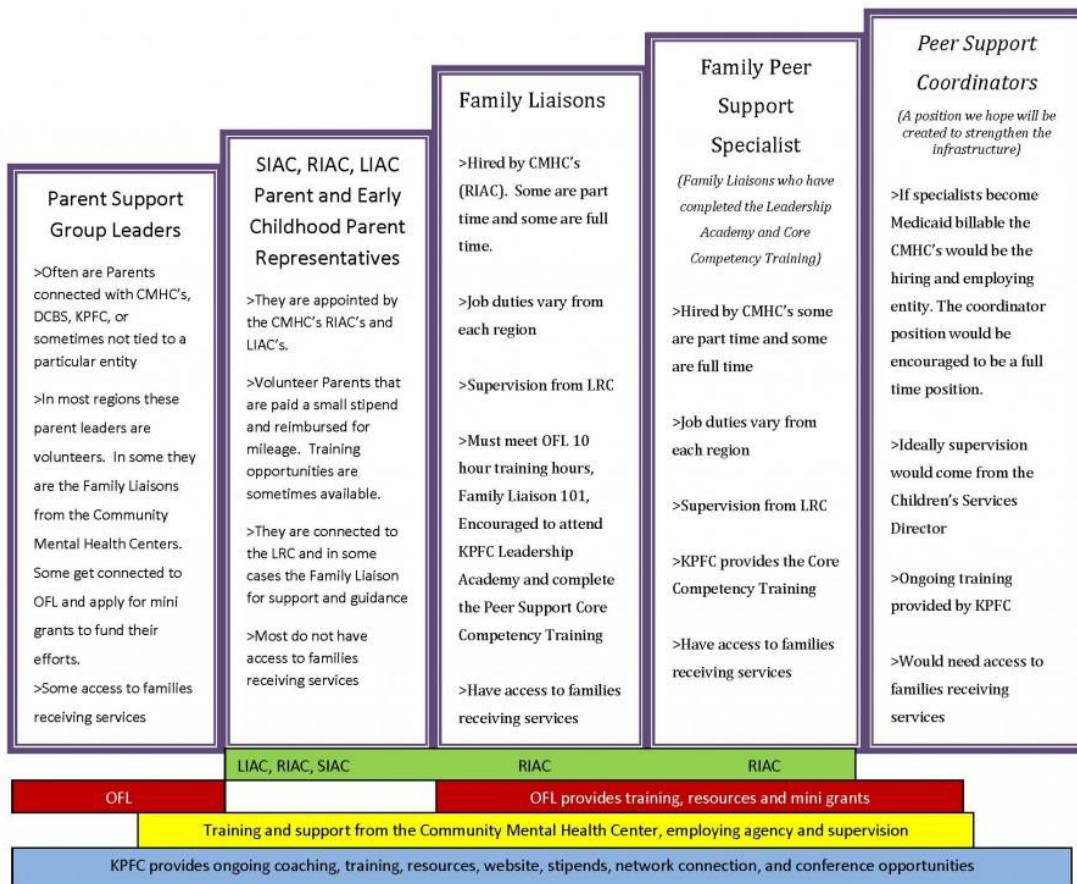
#### Early Childhood Mental Health

Staff from the Department for Public Health and KDBHDID meets regularly as they share oversight of the Early Childhood Mental Health Initiative and the designated Specialists. There is also shared oversight of the Bioterrorism Preparedness program.

### **FAMILY AND YOUTH INVOLVEMENT**

#### Kentucky Partnership for Families and Children

In creating a “family-driven and youth-guided” system of care, the Kentucky Partnership for Families and Children (KPFC) along with many partners are working to create an infrastructure that invites youth and parents across the state to “Join the Movement.” The Kentucky Family and Youth Movement Steering Committee is working to increasingly empower youth with behavioral health challenges and their families through leadership development and advocacy skills. Furthermore, the principle of this movement focuses on the benefits of family peer-to-peer and youth peer-to-peer involvement. Peer-to-peer involvement gives hope, fosters support and allows for increased opportunities for our youth and families. As the movement grows and strengthens, Kentucky’s youth and parent voice will be a tipping point for positive, long-term change. ([www.kypartnership.org](http://www.kypartnership.org)).



### Youth M.O.V.E. Kentucky

The Kentucky Partnership for Families and Children (KPFC) coordinates a statewide youth council for transition aged youth (14 – 26 years old) called Youth M.O.V.E. Kentucky. The Council consists of eighteen youth members who have an emotional or behavioral health diagnosis. The Council is required to meet at least four times per year. The council's goals are:

- Reduce the stigma related to children's mental health challenges;
- Improve members' leadership skills;
- Provide a united voice to advocate on behalf of ourselves and other youth with behavioral health disabilities; and
- Access to a peer group that can provide support.

Youth M.O.V.E. Kentucky provides a Youth Representative on the State Interagency Council (SIAC).

Activities of Youth M.O.V.E. Kentucky include:

- Provide a Youth Representative on the State Interagency Council (SIAC).
- Advocate for the development of Regional Youth Councils across the state.
- Assist with KPFC's annual Youth/Parent Conference.
- Provide training to professionals and parents on issues related to youth.
- Sit on various local and state committees.
- Serve as board members on the KPFC Board of Directors.
- Develop awareness materials for youth, parents, and professionals.
- Serve as Youth Trainers for various trainings such as the KY Family Leadership Academy, Service Coordination 101, Trauma Informed Care, Wraparound Fidelity.

- Speak at events such as Children’s Mental Health Awareness Day to share experiences and concerns.
- Bring a focus on issues we are concerned about such as:
  - Reducing seclusions & restraints;
  - Successful transition to adulthood;
  - Youth rights and voice in treatment;
  - The need for peer to peer support; and
  - Adequate insurance coverage for youth and young adults.

### Regional Youth Councils

Regional Youth Councils are active in eleven of the fourteen CMHC regions. The councils are usually (but not always) started and supported by the Kentucky IMPACT program within each region of the state. The Kentucky IMPACT program and the Community Mental Health Center decide how the council in their region is organized – when and how often they meet, where, ages of youth, and who is eligible (i.e. IMPACT only, any youth with an open chart, etc.). Generally, the youth council meets once a month for an hour and a half.

Regional Youth Councils support positive youth development by:

- Building assets that are supported by nurturing adults and communities.
- Ensuring that youth have the opportunity to explore talents and interests and to develop a sense of competence and personal identity.
- Encouraging youth to engage in leadership and develop a sense of control over their future.

The areas that the youth councils focus on are:

- Independent living skills – employment, education, medical, self-care, healthy relationships, housing, transportation;
- Peer to peer support – having access to a peer group that has issues similar to their own, peer mentoring;
- Community service – giving back, connecting with their community in a positive way, seeing that they have the ability to help others;
- Leadership development – developing appropriate and effective skills to have a voice in their own treatment, on their own team, and possibly within their community or state; and
- Youth engagement and empowerment – strong partnerships with adults, understanding their diagnosis and symptoms as well as the services they are receiving/could receive

## **Criterion 4: Targeted Services to Homeless, Rural, and Older Adult Populations**

### **1) Outreach to Homeless: Adult Mental Health**

*Narrative Question: Describe State's outreach to and services for individuals who are homeless*

KDBHDID recognizes the importance of system coordination among the numerous agencies and programs involved with services to this population. At the state level, KDBHDID participates in the Kentucky Interagency Council on Homelessness (KICH), a group of state and local providers, consumers and government officials, established as a result of Kentucky’s participation in a Homeless Policy Academy funded by the Departments of Housing and Urban Development (HUD) and Health and Human Services (HHS). The goal of

this group is to develop statewide systems and policies, and forge partnerships among state agencies and private social service organizations to achieve local solutions to homelessness. The Council drafted a Homelessness Prevention Plan and Kentucky's Ten-Year Plan to End Homelessness.

KDBHDID, KICH and Kentucky Housing Corporation (KHC) are currently collaborating on two (2) initiatives: the SSI/SSDI Outreach, Access, and Recovery (SOAR) Technical Assistance Initiative - which provide training for case managers and homeless service workers in assisting eligible persons in applying for disability benefits; and the development of case management training for homeless service providers. The manual for this training will soon be posted on the KICH website. Efforts are also underway to increase access and availability of housing options for homeless individuals through the promotion of the "Housing First" model.

Most Regional Boards offer individualized services designed to alleviate homelessness as well as to provide "mainstream" mental health treatment to persons who are homeless and mentally ill. Regional Boards report in their system of care plans for adults with severe mental illnesses the following level of participation:

- All Regions give a service priority to homeless individuals;
- Twelve (12) Regions participate in routine regional Continuum of Care meetings;
- Seven (7) have received Continuum of Care funding;
- Ten (10) Regions do consultation with local shelters;
- Nine (9) Regions regularly visit local homeless shelters;
- Nine (9) Regions provide a walk-in psychiatric clinic;
- Eight (8) Regions have staff dedicated to homeless individuals; and
- Four (4) Regions do street outreach.

KDBHDID received \$473,000 from SAMHSA/CMHS for SFY 2013 for homeless services through the Projects for Assistance in Transitioning from Homelessness (PATH) Grant. The Department continued to contract with the seven (7) Regional Boards awarded funding in SFY 2012; three (3) urban, two (2) rural and two (2) that are a combination of urban and rural, to provide homeless services within their area.

The seven (7) PATH regions are:

Bluegrass Regional MHMR Board, Inc., which subcontracts and works with the HOPE Center, a private non-profit shelter and homeless service provider, to provide outreach, screening and diagnostic services, case management, mental health treatment, rehabilitation and staff training in the Lexington / Fayette County area.

LifeSkills, Inc., which provides outreach, case management and training in the Bowling Green / Warren County area.

NorthKey Community Care, which utilizes a multidisciplinary outreach team employed by the CMHC to provide screening, treatment, and case management, and subcontracts with Welcome House of Northern Kentucky, a private non-profit shelter and homeless service provider, for case management and payee services. The program serves the northern region of Kentucky, just south of Cincinnati, Ohio. The majority of clients served in the PATH program come from Boone, Campbell, and Kenton counties which are the most urban areas.

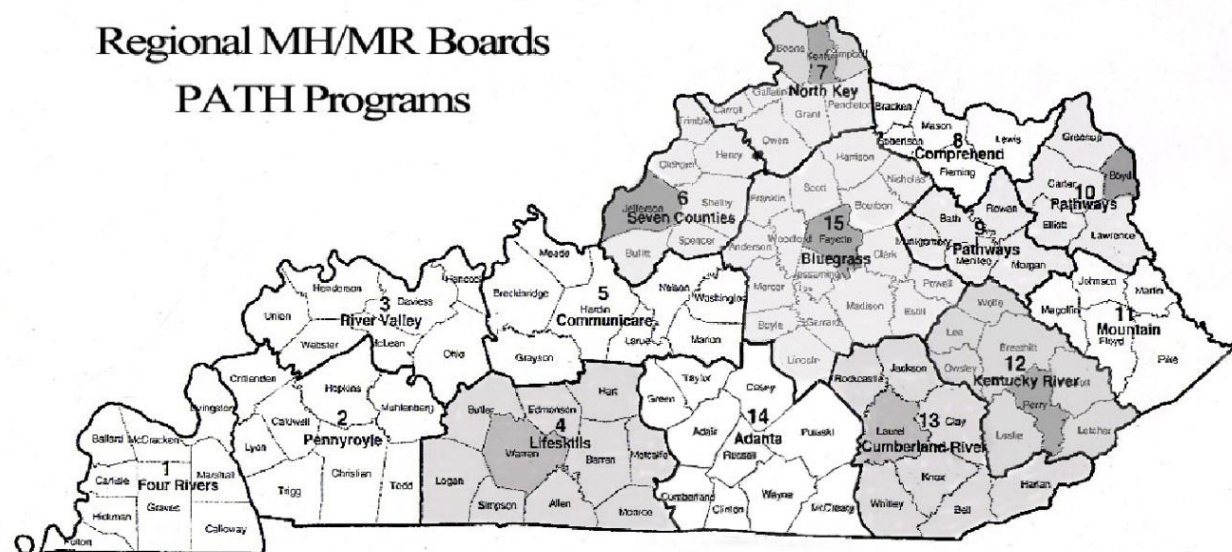
Seven Counties Services, Inc., which provides outreach, assessment, 24 hour crisis intervention, case management, referral and linkage to community resources and supportive

services through their Homeless Outreach Team. The program is located in Jefferson County, Kentucky.

Pathways, Inc., which provides outreach and case management in the Ashland / Boyd County area.

Kentucky River Community Care, which provides outreach, case management, housing support services, and support for six (6) emergency apartments for homeless persons with a mental illness located in Hazard / Perry County, but which also draws from Breathitt, Knott, Lee, Leslie, Letcher, Owsley, and Wolfe Counties in southeast Kentucky.

Cumberland River Regional MHR Board, which provides outreach, case management and housing support services in Laurel County.



Regions with PATH Programs are shaded in grey. Dark grey indicates a county specific program; medium grey indicates a region-wide or extended service area.

By combining PATH and other McKinney funds (that support specialized services) with state and federal funds (that support Community Support Services), KDBHDID and the Regional MH/MR Boards attempt to provide a statewide system of outreach, community support, and mental health services for persons with severe mental illness who are homeless. The role of the State PATH Coordinator is central to supporting local PATH providers throughout Kentucky. The Coordinator prepares the annual PATH application in collaboration with local providers, insures that annual data collection requirements are met, and insures that fund allocation and contracts are in place. Support is also provided through notification of relevant training, updates on homeless issues, and on-site technical assistance as needed.

The Department is also involved with other homeless initiatives including:

- KDBHDID, in collaboration with Lake Cumberland MHR Board, Inc., the Department of Corrections, the Department for Community Based Services, the Louisville Coalition for the Homeless, and Families and Children Place, administers a Homeless Prevention Project. This assists persons being discharged from state facilities in accessing housing and mainstream services, in an effort to limit discharges to homeless shelters. This project assists persons serving out of the prison system, persons being discharged from psychiatric institutions, and persons aging out of foster care.

- KDBHDID collaborates with the Specialized Housing Resources Department within KHC in the operation of local homeless planning boards (“Continuum of Care Committees”) in Kentucky’s area development districts (which correspond to the fourteen mental health regions). Regional Boards are encouraged to participate in this process for the benefit of individuals with severe mental illness who are homeless or may become homeless in their regions.
- KDBHDID provides state funds to the St. Johns’ Day Center in Louisville to hire an outreach worker. This staff person provides on-site assessment and links individuals with services at Seven Counties Services, the Regional Board for Louisville.
- CMHS Block Grant funds will continue to support a Rural Homeless Outreach program in the Mountain Regional Board area. The goal of this program is the identification of individuals with serious mental illness who are homeless and linkage with mainstream mental health services. Consultation and training to homeless service providers is also provided under this initiative.

#### **Criterion 4: Targeted Services to Rural and Homeless Populations**

##### **1) Outreach to Homeless: Children’s Mental Health**

*Narrative Question: Describe State’s outreach to and services for individuals who are Homeless*

The Kentucky Housing Corporation conducts a Point-In-Time Count of the Homeless every year to best monitor the homeless situation in Kentucky. The U.S. Department of Housing and Urban Development (HUD) requires such a count every other year, but KHC believes it best serves the people of Kentucky to conduct this count yearly. A summary of the results of the 2013 Count are reported in Table 1. The results of the Point-In-Time Count demonstrate the need for resources for housing and services for homeless persons in each community. The Count also helps determine how much federal funding will be awarded from HUD for homeless programs. In addition, the Count helps assess progress under Kentucky’s Ten-Year Plan to End Homelessness and provide important information for updating the plan. Beginning in 2014, the Point-In-Time Count will be called the K-Count. The 2014 K-Count will be held Wednesday, January 29, 2014.

The 2013 Point-In-Time Count located 5,245 homeless individuals. Of concern is the fact that 23% of the homeless were children under the age of 18 and 10% were young adults age 18-24. Families comprised only 3% of the homeless population, but they were 28% of the chronically homeless. This 2013 Count indicates a 21% decrease in individuals who are homeless compared to the last statewide Point-In-Time Count in 2010.

According to the Kentucky Department of Education (KDE), which provides the most accurate number of homeless children, there were 33,198 homeless children statewide in all grades during the 2010-2011 school year and 35,891 for the 2011-2012 school year (an 8% increase).

To determine if a child is homeless, Kentucky Department of Education uses the Department of Education/McKinney-Vento Education for Homeless Children and Youth definition of homelessness which is broader than the HUD definition. The HUD definition of homelessness excludes those living in substandard housing conditions, doubled-up with family or friends, or expecting eviction within seven days who have a community support



network to assist them. According to HUD, these individuals are precariously housed, not homeless. The Department of Education/McKinney-Vento Education for Homeless Children and Youth definition states that homeless students/people are those who lack a fixed, regular and adequate nighttime residence. This includes children and youth, ages three through 21 who are:

- Sharing housing due to loss of housing or economic hardship;
- Living in motels, hotels, dilapidated trailers or camping ground due to lack of alternative adequate housing;
- Living in emergency or transitional housing;
- Abandoned in hospitals;
- Awaiting foster care;
- Having a primary nighttime residence that is a public or private place not designed for, or ordinarily used as regular sleeping accommodations;
- Living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations; or
- Migratory students who live in housing described above.

According to the National Center on Family Homelessness report, America's Youngest Outcasts, children experiencing homelessness are compared to non-homeless children: 4x more often sick than other children; 4x as likely to have respiratory infections; 2x as likely to have ear infections; 5x more likely to have gastrointestinal problems; 4x more likely to have asthma; 2x more likely than other children to go hungry, yet they have high obesity rates due to nutritional deficiencies; and **3x more likely to have emotional and behavioral problems compared to non-homeless children.**

According to the National Center on Family Homelessness report, America's Youngest Outcasts, one in every 50 American children is homeless each year and do not have a safe place to sleep. The National Center on Family Homelessness 2009 report, America's Youngest Outcasts: State Report Card on Child Homelessness, ranked Kentucky 42nd. This ranking was based on the state's overall performance across four domains:

- 1) Extent of Child Homelessness (adjusted for population size)
- 2) Child Well-Being
- 3) Risk for Child Homelessness
- 4) State Policy and Planning Efforts

Almost 20 percent of homeless households interviewed in the 2010 Point-In-Time Count reported having children with them; national statistics put this number at closer to 50 percent.

### Special Populations

The 2013 Point-In-Time Count also reports on "special populations" such as veterans, individuals who are severely mentally ill, individuals experiencing chronic substance abuse, veterans, and victims of domestic violence (see table 2). Veterans comprise 11% of the homeless in Kentucky (male veterans 94%, female veterans 6%), individuals who are severely mentally ill are 17% of the homeless whereas domestic violence victims make up 15%. Individuals who experience chronic substance abuse are most likely to experience homelessness (27% of the homeless total).

**Table 1**

**2013 Commonwealth of Kentucky Point In Time Count**

	Total Homeless	Emergency Shelter			Unsheltered			Chronically Homeless			Transitional Housing					
		Total # of persons in Emerg. Shelter	Under age 18	18-24	Over age 24	Total # of persons Unsheltered	Under age 18	18-24	Over age 24	Total # of Persons Chronically Homeless	Persons in Families	# of Individuals (18 and over, alone)	Total # of Persons	Under age 18	18-24	Over age 24
KY	5,245	2,433	513	222	1,704	754	90	97	567	520	143	377	2,042	599	204	1,239
% of Total Homeless		46%	10%	4%	32%	14%	2%	2%	11%	1%	3%	7%	39%	11%	4%	24%
% of Category			21%	9%	70%		12%	13%	75%		28%	72%		29%	10%	61%

**Table 2**

<b>Special Populations</b>						
	<b>Total Veterans</b>	<b>Male Veterans</b>	<b>Females Veterans</b>	<b>Individuals Who Are Severely Mentally Ill</b>	<b>Victims of Domestic Violence</b>	<b>Individuals Experiencing Chronic Substance Abuse</b>
	595	562	33	880	773	1,398
% of Total Homeless	11%	11%	<1%	17%	15%	27%
% of Total Veterans		94%	6%			

## 2) Rural Area Services: Adult Mental Health

*Narrative Question: Describe how community-based services will be provided to individuals in rural areas.*

Using the definition of Standard Metropolitan Statistical Area, and information from the 2010 Census, Kentucky has 32 counties considered urban and 88 considered rural. Population distribution is shown in the chart below.

Regional MH/MR Boards	Adult Census 2010	Urban Adult Population	Rural Adult Population
1. Four Rivers	161,545	81,338	80,207
2. Pennyroyal	158,100	88,909	69,191
3. River Valley	161,977	108,431	53,546
4. LifeSkills	217,231	100,939	116,292
5. Communicare	200,640	78,127	122,513
6. Seven Counties	730,843	699,976	30,867
7. NorthKey	326,235	282,835	43,400
8. Comprehend	42,757	13,225	29,532
9/10. Pathways	170,601	87,533	83,068
11. Mountain	119,756	0	119,756
12. Kentucky River	89,550	0	89,550
13. Cumberland River	181,110	0	181,110
14. Adanta	160,202	19,047	141,155
15. Bluegrass	595,449	506,999	88,450
<b>Total</b>	<b>3,315,996</b>	<b>2,067,359</b>	<b>1,248,637</b>

Transportation barriers remain one of the greatest concerns among providers, consumers and family members. The Human Service Transportation Delivery Program pools existing public transportation funds including Medicaid non-emergency transportation. A total of 16 transportation regions statewide operate 24 hours a day/seven days a week with a single broker or broker/provider established in each region. Consumers access transportation services through a toll-free phone number. Ten of fourteen Regional Boards report engaging in initiatives to better coordinate transportation services in their regions. Region 10 (Pathways) has the most developed transportation initiative as they pay staff to transport individuals from almost any location in the Region to outpatient sites or to the crisis stabilization programs in Morehead and Ashland. Transportation remains, however, the number one barrier to accessing services in rural parts of the Commonwealth as reported by the Boards and their Regional Planning Commissions.

Rural communities often have fewer staff and resources to provide mental health services. It is important for rural mental health agencies to develop collaborative agreements with primary care physicians, senior citizens centers, church groups, and government agencies. Rural case managers have been resourceful in assisting persons with a severe mental illness in meeting their needs through the identification and development of local resources, and are critical linkages to formal and informal services and supports in rural Kentucky. Some changes in Kentucky law over the years have increased the types and numbers of mental health professionals who can be Qualified Mental Health Professionals and created licensure for professional counselors to provide mental health services. The KDBHDID will continue to work

with rural communities and other entities in addressing funding, training, and in bringing all stakeholders together at the state and local level to strategize best practices.

Several Regional MH/MR Boards now report delivering or accessing services from the telehealth network. Nine out of fourteen regions have telehealth equipment and utilize it for coordinating some services (i.e. case management assessments regarding state hospital discharge). Some of these uses include:

- Comprehend, Inc. uses the telehealth network for quarterly meetings with Eastern State Hospital and for trainings and other educational activities.
- Pathways, Inc. is developing telemedicine services and has sites in three counties.
- Kentucky River Community Care, Inc., has several sites equipped for video conferencing. Two sites are a part of the Appalachian Regional Healthcare network and one site is a part of the Centernet network. They convene business meetings, Olmstead meetings, case conferences, trainings and other events over these networks.
- Bluegrass Regional MH/MR Board uses Telehealth for discharge planning meetings between ESH and outpatient offices. Bluegrass also utilizes trainings from the University of Kentucky's TeleHealth network for continuing education of staff and general grand rounds.
- Lifeskills currently utilizes the telehealth network for discharge planning between WSH and outpatient offices. Specifically they use this technology to introduce hospital clients to their prospective case managers and outpatient therapists prior to discharge.
- Four Rivers currently utilizes the telehealth network for psychiatric screening and services as well as mental status assessments, case conferences, staff trainings and meetings.
- River Valley has a contract with the University of Louisville to provide psychiatric services via telehealth in a percentage of their outpatient clinics.

In May of 2009, the regulation regarding telehealth services was rewritten by Medicaid and submitted to CMS for approval. The original telehealth regulation approved only psychiatrists or advanced registered nurse practitioners as providers. In March of 2011, the telehealth amendment was approved by CMS. Medicaid now approves reimbursement for several other professionals (physicians, licensed psychologists, marriage and family therapists, professional counselors, licensed clinical social workers, psychiatric registered nurses, psychiatric medical residents) to provide the following services under telehealth:

- Consultations;
- Mental health evaluations and management;
- Individual and Group therapy;
- Pharmacological management; and
- Psychiatric/Psychological/Mental Health diagnostic interview examination.;

Regional Boards have begun to expand these reimbursable services into their array and it is hoped that more rural consumers will have better access to services and better continuity of care between providers. Prohibitive factors remain the extensive expense of the necessary equipment and the fact that not every Regional Board has this equipment at this time.

The DIVERTS (Direct Intervention: Vital Early Responsive Treatment System) project in the Western State Hospital catchment area, as well as the onset of reimbursement for telehealth services has spurred the increased utilization of this technology in that region of the state, in particular. The four Regional Boards that use Western State for inpatient care, have all

purchased telehealth equipment with the primary purpose of diverting as many individuals as possible from inpatient care, as well as insuring continuity of care upon discharge from the hospital. Staff from both the hospitals and the CMHCs involved in discharge planning use the technology to provide services as well as to discuss scheduling, clinic referrals, follow-up, and to allow inpatient psychiatrists to consult with local clinical practitioners in pre-screening admission.

## 2) Rural Area Services: Children’s Mental Health

*Narrative Question: Describes how community-based services will be provided to individuals in rural areas.*

Using the Rural-Urban Continuum Codes and the 2010 Census information, Kentucky has 35 (29%) counties considered metropolitan, 49 nonmetropolitan urban (41%), and 36 nonmetropolitan completely rural (30%). See table below. The three most common barriers to mental health services in rural areas are the isolation of families who have a child with an emotional disability, limited workforce and limited public transportation. Isolation can be partially attributed to the geographic distance between neighbors, but may be more closely associated with the heightened stigma associated with mental health services in rural areas and the difficulty of ensuring confidentiality and anonymity in a small community.

Rural-Urban Continuum Codes	Description of Rural-Urban Continuum Codes	# of KY Counties
1	Metro - Counties in metro areas of 1 million population or more	14
2	Metro - Counties in metro areas of 250,000 to 1 million population	11
3	Metro - Counties in metro areas of fewer than 250,000 population	10
4	Nonmetro - Urban population of 20,000 or more, adjacent to a metro area	2
5	Nonmetro - Urban population of 20,000 or more, not adjacent to a metro area	4
6	Nonmetro - Urban population of 2,500 to 19,999, adjacent to a metro area	19
7	Nonmetro - Urban population of 2,500 to 19,999, not adjacent to a metro area	24
8	Nonmetro - Completely rural or less than 2,500 urban population, adjacent to a metro area	11
9	Nonmetro - Completely rural or less than 2,500 urban population, not adjacent to a metro area	25

Data Source: USDA, Economic Research Service, May 2013

Limited public transportation contributes to problems with accessing services and also increases the cost of services. The Human Service Transportation Delivery (**HSTD**) Program provides non-emergency, non-ambulance medical transportation services to eligible Medicaid, Vocational Rehabilitation, and Department of the Blind recipients. HSTD services are coordinated by the Kentucky Transportation Cabinet, Office of Transportation Delivery. The state is divided into twelve transportation regions with a single delivery broker established in each region. Consumers access transportation services through a toll-free phone number. When no other source of funding is available to Kentucky IMPACT clients, wraparound funds may be used to pay transportation costs, or if appropriate, costs to repair or secure an automobile.

### Telehealth

The advantages of establishing a telehealth capability across rural areas are well known. Due to difficulties in recruiting qualified medical and clinical staff to work in more rural areas, telehealth can be used to extend staff coverage from a central site to outlying rural clinics and other service sites. Specialized services (e.g., therapists who are fluent in sign language, psychiatry, crisis services) can be effectively extended through the use of technology. The Kentucky Department for Medicaid Services reimburses providers for tele-psychiatry, psychotherapy, family therapy and group psycho-therapy when services are provided to DMS eligible members through real-time telecommunications and conducted by a legally authorized representative for a medically necessary service.

Another strategy to address rural access problems is the recruitment and development of family support staff, who are parents of children with severe emotional disabilities. These parents are responsible for facilitating a regional network of parent-to-parent support and advocacy, which provide informal connections between parents to supplement kinship networks. An additional problem is the difficulty of recruiting staff to work in the rural areas, which limits the capacity to expand and create alternative, non-traditional services.

### Opportunities for Family Leadership

Opportunities for Family Leadership (OFL) is a unit within DHBDID which offers a resource line for parents and caregivers to access education, resources and support. The toll free number for the resource line is (800)374-9146. OFL provides numerous services for families and youth and the systems that serve them, including:

- Training in advocacy, communication, cultural competency, collaboration and legal rights in schools;
- Awarding mini-grants for parent and youth support groups to develop local training events and provide community resource libraries. Over 250 training events are held each year by parent and youth groups.
- Providing technical assistance to ensure Standards of Practice for Family Liaisons and Kentucky Family Peer Support Specialists across the state are met and approving required trainings per the Standards of Practice;
- Awarding mini-grants for parent and youth support groups to develop local training and awareness events;
- Distributing reader friendly versions of Client Rights and Grievance Procedures, and supporting documents to parents, youth and others to ensure that these policies and procedures are understood by everyone; and
- Providing technical assistance to organizations and individuals with regard to children's behavioral health, developmental and intellectual disabilities and substance abuse services and supports. Resource information and training opportunities are among the many items provided on OFL's web site at <http://dbhdid.ky.gov/dbh/OFL.asp>.

While the three problems of isolation, transportation and workforce are common to rural areas, each rural community has its own unique problems because of cultural, geographic and social differences. Thus, the strategies to address them must be collaborative among local, regional and state level stakeholders.

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While the three problems of isolation, transportation and workforce are common to rural areas, each rural community has its own unique problems because of cultural, geographic and social differences. Thus, the strategies to address them must be collaborative among local, regional and state level stakeholders.

### **3) Older Adults**

*Narrative Question: Describes how community-based services are provided to older adults.*

According to the 2010 Census, Kentucky's population of persons 60 and older is approximately 829,193 persons, representing approximately 19.1% of the state's population. It is anticipated that this population will increase by 91.4% by the year 2030, due to the aging of the "baby boom" generation. With regards to persons 60 and older with mental health issues, community mental health centers serve approximately 6% on a National level.

Chronic depression is not a normal part of the aging process, but it does occur frequently among older adults. More than 15 percent experience depression at some point in their later years. Nearly 50 percent of people with Parkinson's Disease and 35 percent of those suffering from Alzheimer's Disease become chronically depressed. Diagnosis of mental health conditions can be more complicated with older adults. Many are not treated for their mental health problems due to lack of recognition of the problem, ageism, stigma, and lack of trained professionals who can identify and treat these mental health disorders.

There is a lack of flexibility in funding to provide the services that older adults need. Medicare is a funding source for most of these persons, but Medicare reimburses at 50 percent of an approved cost for mental health services. Medicare will reimburse for acute care, but not for services that might be defined as rehabilitative.

Kentucky is committed to addressing the need of expanded access to mental health treatment for older adults with serious mental illness. In 1999, Kentucky received a SAMHSA grant that eventually led to the development of a state level Mental Health and Aging Coalition. The state level coalition consists of representatives from KDBHDID, Department for Aging and Independent Living (DAIL), Area Agencies on Aging, Office of Vocational Rehabilitation, University of Kentucky, University of Louisville, CMHCs, consumers, caregivers, and other interested stakeholders. Coalition goals for SFY 2013/2014 are:

- To encourage every local coalition to include at least one adult consumer of behavioral health services or caregiver representative of an older adult consumer of behavioral health services, in their coalition;
- To establish Mental Health and Aging Coalitions in every region across the state through continued outreach and to establish a formalized alliance with DAIL;
- To explore the feasibility of participating in the advocacy planning technical assistance project from the Geriatric Mental Health Alliance of New York;
- To continue to explore ways to maximize relationships in order to develop name recognition and partner with other entities to advance mutual goals and objectives;
- To continue to increase awareness/knowledge of regional initiatives by hosting at least one statewide coalition meeting per year at a regional coalition annual meeting/conference; and

- To provide “Mental Health First Aid” “Train the Trainers” training to two people who agree to provide trainings for the local coalition.

There are currently ten (10) Mental Health and Aging Coalitions in Kentucky. Mental Health Block Grant funds are used to support the following activities through these coalitions:

- Regional training/conferences for professionals, caregivers and consumers;
- Public education and awareness activities;
- Traveling exhibit boards;
- Development and distribution of resource manuals;
- Health fairs and depression screenings;
- Suicide prevention projects;
- Anxiety reduction programs; and
- Mental Health First Aid training.

In Kentucky there are fifteen (15) Area Development Districts (Area Agencies on Aging), which focus on the needs of Older Adults. The Area Agencies on Aging are under the umbrella of the Department of Aging and Independent Living (DAIL). The KDBHDID collaborates with DAIL and the Regional Boards in a variety of ways, including:

- Staffing the statewide Mental Health and Aging Coalition;
- Participating in training events regarding mental health and aging;
- Staffing the Mental Health Planning and Advisory Council;
- Participating in numerous committees such as KinCare Subcommittee, Alzheimer’s Disease and Related Conditions Council, Grandparents Raising Grandchildren-Bluegrass chapter, and the Kentucky Elder Readiness Initiative; and
- Grant applications regarding older adults and mental health.

A staff person from the DBHDID serves as a designee for the Commissioner on the NASMHPD Older Person’s Division. This is a national group comprised of one designee from each state and territory, as well as a liaison from NASMHPD. This group strives to consistently provide resources and consultation to the state mental health authorities regarding the imperatives in the Surgeon General’s Report and the President’s New Freedom Commission Report regarding mental health needs throughout the life span. The Older Person’s Division keeps abreast of the national agenda in this arena and shares information with membership through monthly conference calls.

## **Criterion 5: Management Systems**

### **1) Resources for Providers: Adult and Children’s Mental Health**

*Narrative Question: Describes financial resources, staffing, and training for mental health services.*

This criterion addresses three critical components of the overall management of the systems of care that serves adults with SMI and children with SED. These components include Financial, Workforce and Training. Kentucky struggles to maintain and improve performance with serious financial constraints and workforce shortage issues. Thoughtful and collaborative planning is key to moving the system forward in the face of such challenges. Offered below is discussion about the current status of the three components for this Criterion.

#### **Component 1: Financial**

Regional Boards have been hard hit financially in the past year in several salient ways, including:

- Frozen Medicaid rates for key services, including Case Management;



- Increases in costs to provide health insurance for their employees;
- Increases in the percentage employers must pay towards retirement plans; and
- National economic crisis (increased access; increased transportation issues).

As described in Section I of this grant application, Regional Boards are required by statute and contract to provide a core array of services and are held accountable to selected performance indicators, but are given considerable autonomy in how funds are distributed based on regional priorities. Detailed block allocations for SFY 2014 are provided elsewhere in this document.

### **Component 2: Workforce**

KDBHDID contracts directly with each Regional Board to provide direct services and each Board employs the staff who deliver services. Thus, KDBHDID involvement in human resource development activities for the Regional Boards and their staff have traditionally been indirect, focusing on staff training, technical assistance and the establishment of minimum qualifications and core training requirements for providers.

The system has also been hard hit by an exodus of retirees in both central office and the Regional Boards. This exodus is occurring because enhanced pension benefits that have been available for several years ended on January 1, 2009. The Boards have experienced many recent changes in management. Half of the fourteen Chief Executive Officers for the Regional Boards have retired as well as many in other leadership positions.

### **Component 3: Training**

KDBHDID strives to provide access to on-going training and technical support for all Central Office staff as well as partner agencies and providers statewide. There is a full time Training Coordinator position within the Department to assist with these efforts. The Department seeks to utilize available technology to provide educational/training and consultation opportunities. One example is the TrainingFinder Real-time Affiliate Integrated Network (TRAIN). TRAIN is comprised of the national TrainingFinder.org site and participating TRAIN affiliates. TRAIN is a web-based system allowing anyone with internet capability to access the description and registration process for a number of trainings. KDBHDID is developing on-line modules through a software program called LECTORA. These presentations can provide basic information more efficiently as participants can proceed at their own pace in their own locations.

KDBHDID provides or sponsors and participates in a variety of other training initiatives. This includes many opportunities for central office staff, as well as contracted and private service providers to increase their knowledge and skill level in various best practices. Many offerings provide participants with needed continuing education units (CEUs) for professional board certification or licensure.

The Department provides scholarships (limited) for consumers, parents/family members, and Regional Board staff to attend training events. Funds are also used to provide Certified Psychiatric Rehabilitation Practitioner (CPRP) examinations from the US Psychiatric Rehabilitation Association (USPRA) for Regional Board staff, as well as to support technical assistance for the development and maintenance of adult and children's programming (e.g., Targeted Case Management, Therapeutic Foster Care). The table below details some available training events.

## Division of Behavioral Health Sponsored/Provided Training Events

<i>Trainings Relevant to Adult Services</i>			
Type of Training	Intended Audience	# of Participants Anticipated	Frequency/ Length of conference
Case Management Certification Training—Level I (required for providers)	Mental Health Case Managers who work with Adults with SMI and their supervisors	Approximately 80	Online component available continuously plus a 1 day face-to-face training offered 4 times per year
<b>Adult Case Management Training—Level II</b>	Mental Health Case Managers who work with Adults with SMI and their supervisors	Approximately 80	4 per year 2 days each
Community Support Program (CSP) Directors Technical Assistance Meetings	CSP Directors	Approximately 25	Quarterly 1 Day
<b>Hearing Voices that are Distressing</b>	Behavioral health providers and administrators, consumers and family members	Maximum of 40	As requested 3 hours
Kentucky Peer Specialist Training	Consumers of behavioral health services	Varies depending on location across the state	At least 1 per year 5 days
Leadership Academy	Consumers of behavioral health services	Approximately 25	4 per year 2.5 days
SSI/SSDI Access, Outreach and Recovery (SOAR)	Case Managers, Social Service Workers, Homeless Service Providers	Approximately 30 per session	6-8 per year; 2 days
<b>Working with Adults with SMI who have Hearing Loss: Case Management Level II Training</b>	SMI Case Managers	Approximately 25 per session	1.5- 3 hours. Embedded in Case Management training and available by request

**BOLD** Denotes that Continuing Education Units (CEUs) are offered for these training sessions. The following offers additional detail about some of the major training events listed above.

## ***Description of Trainings Relevant to Adult Services***

### **Adult SMI Targeted Case Management Certification Training**

The adult certification program consists of an online training module and an online certification examination administered through TRAIN, and a one day mandatory face-to-face training. The face-to-face training is held four times per year, two in the fall and two in the spring. The curriculum for these trainings has been developed by a team of professionals, consumers and advocates. The faculty seeks to continually improve upon the content and delivery of the information deemed most relevant. This group is enthusiastic about follow-up training and support for case managers and it is hoped that staff retention will be affected by the work being done.

*There are two distinct Case Management/Service Coordination training programs designed separately for adult case managers and child service coordinators.*

### **Adult SMI Case Management Training—Level II**

This two-day training will be open for adult case managers and case management supervisors. This seminar will be offered during SFY 2011, as a statewide event open to all child and adult case managers.

### **Hearing Voices that are Distressing**

This is based on a training module developed by Patricia E. Deegan, Ph.D. This training consists of activities designed to simulate auditory hallucinations. The goal is to foster understanding and empathy in providers.

### **Kentucky Peer Specialist Training**

This five day, thirty hour training prepares participants to pursue employment as Kentucky Peer Specialists. The training is provided primarily by consumers using a curriculum developed from national peer support experts, Ike Powell and Larry Fricks.

### **Leadership Academy**

Since 2003, the Office of Consumer Services within KDBHDID has sponsored a Leadership Academy for adult consumers of mental health services. This training prepares consumers to assume a position of strong leadership in changing the system of care. The Leadership Academy provides two levels of education:

Level 1: Participants learn to take the initiative, develop projects, collaborate with others, participate in policy decisions, influence the budgets at the state and local levels, improve services, create new services, and educate the community.

Level 2: Prepares participants to present trainings in their communities. Topics include, Advance Directives, Consumer Rights, Leadership Academy, Recovery and Transitioning Skills.

### **SSI/SSDI Access, Outreach and Recovery (SOAR)**

The Department collaborates with Kentucky Interagency Council on Homelessness and the Kentucky Housing Corporation to provide these trainings in communities across the state. These trainings educate providers about the application process for social security benefits and how best to assist consumers.

### **Community Support Program (CSP) Directors TA Meetings**

These meeting are held quarterly and are open to all Regional Board Community Support Directors as well as other staff working in community programs serving adults with SMI.

<b>Trainings Relevant to Children's Services</b>			
<b>Type of Training</b>	<b>Intended Audience</b>	<b># of Participants Anticipated</b>	<b>Frequency/ Length of conference</b>
<b>Ages and Stages Questionnaire – Social Emotional</b>	Mental Health Practitioners and other clinicians who provide services to the birth to five population	60	As needed; 2 days
Behavioral Health Professionals (BHPs) Regional Forums	IMPACT Plus Sub providers, CMHC partners (LRCs) (Offered Regionally)	Varies depending on location	4 Hours As needed
<b>Behavior Institute, co-sponsor</b>	Educators, administrators, agency service providers, and families	Approximately 1200	Annually; 2.5 days
<b>Child Parent Psychotherapy Learning Collaborative</b>	Early Childhood Master's Level Clinicians	30	Learning Collaborative 18 months
<b>Child System of Care Summit</b>	Children's Targeted Case Management Providers and their Supervisors, Parents, Central Office Staff, Representatives from Collaborating Agencies	Approximately 200	Annually 2-3 Days
<b>Child Targeted Case Management/Service Coordination 101 Certification</b> (required for providers of TCM)	Prospective providers of Children's Targeted Case Management services (IMPACT and IMPACT Plus and their Supervisors)	Up to 50 per Session	Quarterly 2.5 Days
<b>DC:0-3R</b>	Mental Health Practitioners and other clinicians who treat disorders of infancy and early childhood	60	As needed; 2 days
Effects of Prenatal Drug Exposure/FASD	Behavioral Health service coordinators, clinicians, prevention specialists	15-20	As needed
Evaluation Webinars	Service Coordinators, LRCs, and LRC Assistants	15	Monthly 2 hours
Family Leadership Academy	Caregivers of children with behavioral health issues, young adults (16-25) with emotional disabilities	Up to 50 per Session	Biannually 3 Days

<b>Trainings Relevant to Children's Services</b>			
<b>Type of Training</b>	<b>Intended Audience</b>	<b># of Participants Anticipated</b>	<b>Frequency/ Length of conference</b>
Family Liaison Orientation	New Family Liaisons	The training is typically one-on-one with new Liaisons.	3-4 Hours As needed.
IMPACT Introduction to Deafness	IMPACT Service Coordinators	Approximately 25 per Session	1.0-1.5 hours embedded in Service Coordination 101 OR available by request 1-3 Hours
<b>IMPACT Plus Behavioral Health Professional (BHPs) Training 101</b>	IMPACT Plus BHPs and BHPs under Clinical Supervision (Offered Regionally)	Varies depending on location	Quarterly 1 Day
Introduction to Child Development of Children who are Deaf or Hard of Hearing	Providers of early intervention and children's services, Kentucky School for the Deaf staff, and others by request	Target 10-20 per Session	As requested and tailored to needs of group
Introduction to Evaluation Family Interviewer Training	Family Interviewers for RIACs receiving KY SEED funds	5	Annually; 1.5 days
Kentucky Family Peer Specialist Support Specialist Core Competency Training	Family Leadership Academy Graduates	Up to 30	5 Days Biannually
KY SEED Monthly Cohort Meeting and Technical Assistance	RIACs that provide ECMH services	Cohort 1 & 2; approximately 25 participants	Monthly; 2 hours
KYSEED New Cohort Orientation	Newly funded RIACs that will provide ECMH services.	4 regions, approximately 45 participants	Annually; 2.5 days
KY SEED Regional Interagency Council Technical Assistance Meetings	RIAC members, regional CMHC staff	Cohort 1 & 2; approximately 25 participants	As needed; 1 day
Lifelines Prevention Curriculum	6 <sup>th</sup> -12 <sup>th</sup> grade students (about 10,000 over the next 2 years)		
<b>Mental Health First Aid USA</b>	Any Family or Community Partner	25	As requested 2 Days

<b>Trainings Relevant to Children's Services</b>			
<b>Type of Training</b>	<b>Intended Audience</b>	<b># of Participants Anticipated</b>	<b>Frequency/ Length of conference</b>
<b>Motivational Interviewing</b>	IMPACT Program Staff from Regional Boards (Offered Regionally)	Up to 25 per Session	Provided for each Region 1 Time
<b>Parent –Infant Dyad Therapy</b>	Regional Perinatal Depression contacts, Early Childhood Mental Health Specialists	Up to 25 per Session	3-4 Times per Year 2 Days
<b>Parent Child Interaction Therapy</b>	Mental Health Practitioners and other clinicians who treat disorders of infancy and early childhood	60	As needed; 3 days
<b>School Law</b>	IMPACT Program Staff from Regional Boards & Family Members, Community Partners (Offered Regionally)	Up to 40 per Session	Annually 3 Hours
<b>Service Coordination 101</b>	IMPACT Service Coordinators, IMPACT Local Resource Coordinators, Supervisors of Service Coordinators, Department for Community Based Service (DCBS) staff providing Medicaid-funded Targeted Case Management, and their supervisors, IMPACT Plus Case Managers, IMPACT Plus supervisors of Case Managers, Behavioral Health Professionals/Behavioral Health Professionals under clinical supervision	60	4 Times per Year 2.5 days
<b>Seven Challenges</b>	Community Mental Health providers that are under the umbrella license Fidelity visit-same as above	15	1 day as needed Fidelity visits from Seven Challenges llc, 1 x per year
School-Based Suicide Prevention	School Administrator, Educators, Staff	40	As requested
Team Observation Measure	CMHC Kentucky IMPACT Staff	20-30	3 hours 2-4 times per year
Transition Aged Youth Launching Realized Dreams (TAYLRD)	Child and Adult Case Managers	60	As requested 1 Day
<b>Trauma-focused Cognitive Behavioral Therapy Learning Collaborative</b>	Master's Level Clinicians	25	1 Year Learning Collaborative

<b>Trainings Relevant to Children's Services</b>			
<b>Type of Training</b>	<b>Intended Audience</b>	<b># of Participants Anticipated</b>	<b>Frequency/ Length of conference</b>
<b>Trauma Informed System of Care Training</b>	Any Community Providers	50	As requested 3 Hours
<b>Trauma Informed System of Care Training for Trainers</b>	Trainers within various child serving agencies	25	1 day, plus follow-up sessions, 2 per year
Wraparound Refresher Training	Mental health staff, educators, child welfare staff, juvenile justice staff, court staff	50	As requested 1 Day
Youth/Parent Conference	Youth between the ages of 13 and 24 with emotional, behavioral, mental health, and substance use disabilities and their parents or caregivers.	100	2 Days Annually

**BOLD** Denotes that Continuing Education Units (CEUs) are offered for these training sessions. The following offers additional detail about some of the major training events listed above.

### **Description of Trainings Relevant to Children's Services**

#### Ages and Stages Questionnaire: Social Emotional

KY SEED hosted the ASQ and ASQ: SE Train the Train sessions for early intervention program staff, child development specialists, public health professionals, social workers, child care providers and early childhood mental health specialists. Participants were given an introduction to developmental screening, legal mandates, and the benefits of developmental screening; the methods of administering the questionnaires, tracking results, scoring the questionnaires, and communicating screening results to families; how to interpret ASQ-3 scores and how to make referral decisions based on those scores; and implementation issues.

#### Behavioral Health Professionals Regional Forums

Regional Forums are held to focus on issues related to training needs (some include trainings), resource development and collaboration within regions as well as information dissemination. This year, 1200 educators, school administrators, pupil service personnel, child-serving agency providers, and youth and families attended.

#### Behavior Institute (sponsor)

The Behavior Institute is a cutting edge two-day behavior conference sponsored by the Kentucky Council for Children with Behavior Disorders, the Kentucky Department of Education, Kentucky's System to Enhance Early Development through Kentucky Division of Behavioral Health, Kentucky Autism Training Center and the Central Kentucky Special Education Cooperative.

#### Child Parent Psychotherapy

Child Parent Psychotherapy is an intervention for children from birth-5 who have experienced at least one traumatic event and, as a result are experiencing behavior, attachment, or mental health issues. The goal of CPP is to support and strengthen the relationship between the child and his or her caregiver to help restore the child's sense of safety, attachment and appropriate affect and improving the child's cognitive, behavioral, and social functioning.

### Child System of Care Summit

This is an event planned to bring all child serving agencies together to discuss System of Care development across the state and across all agencies. Generally a theme around a specific topic (e.g., Co-occurring MH and SA among adolescents) emerges throughout the year and is the focus of the plenary session.

### Child Targeted Case Management/ Service Coordination (SC 101) Certification Training

The Department is responsible for certifying children's case managers and offers quarterly training in different areas of the state. The faculty consists of regional providers, parents and a Medicaid representative. The content of the training is skills-based. Supervisors are provided a manual to use with staff to cover additional areas of interest and on-line modules are being considered for the coming year. The training is continually evaluated and improvements to the content and delivery are made accordingly. Information about co-occurring mental health and substance abuse and information about deafness are currently being added to the curriculum. *There are two distinct Case Management/Service Coordination training programs designed separately for adult case managers and child service coordinators.*

### DC: 0-3R

KY SEED hosted two training sessions about the proper utilization of the DC:0-3R - Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood. This developmentally based system for diagnosing mental health and developmental disorders in infants and toddlers will assist mental health clinicians, counselors, physicians, nurses, early interventionists, early childhood educators, and researchers as they provide ECMH services. The DC:0-3R is an indispensable guide to evaluation and treatment planning with infants, toddlers, and their families. On-going mentoring regarding the utilization of the DC:0-3R is provided to service providers by the KY SEED clinical staff.

### Effects of Prenatal Drug Exposure/FASD

The Department's Substance Exposed Infants Workgroup and FASD Prevention Enhancement Site offer trainings quarterly recognizing children who may need an FASD assessment, providing services and supports for these children, and preparing the family and young adult for transition to adulthood.

### Family Leadership Academy

The Department has partnered with the statewide family advocacy organization, KPFC to create curriculum and offer quarterly week-long sessions for parents/caregivers of youth with SED.

### Family Liaison Orientation

A Kentucky Peer Support Specialist from the Opportunities for Family Leadership (OFL) meets with new Family Liaisons to conduct a 3-4 hour OFL 101 training. She supplies the Liaison's with books on diagnoses, advocacy and other topics they need to carry out their role.

### IMPACT Introduction to Deafness

This training can be adapted from 1-3 hours as an introduction to working with Deaf-member families. Focus is on understanding the cultural and linguistic implications of hearing loss, adapting services, and knowing the appropriate resources.

### IMPACT Plus Behavioral Health Professionals Training 101

Training is provided to BHPs and BHP under clinical supervision to provide information on the wraparound model, developing goals that focus on the strengths of the child and family as a way to address unmet needs. The sessions also include information on boundaries and ethics as well as documentation as outlined in the IMPACT Plus regulations.

### Introduction to Child Development with Children Who Are Deaf or Hard of Hearing



This workshop challenges providers to think about the psychosocial development of children with hearing loss and how best to provide wraparound services that meet the needs of the whole child.

#### Introduction to Evaluation - Family Interviewer Questions

These are trainings given to Family Interviewers as part of the KY SEED project.

#### Kentucky Family Peer Support Specialist Core Competency Training

The Department partnered with the statewide family advocacy organization, KPFC, in 2009 to provide this intensive, skills-based five (5) day training. Parents/caregivers must be a graduate of the Family Leadership Academy and complete an application process and to qualify for this training. The Department continues to work with Medicaid Services to make Specialists' services Medicaid billable.

#### KY SEED Monthly Cohort Meeting and Technical Assistance

RIACs that receive funding from KY SEED participate in monthly conference calls with KY SEED staff to discuss implementation issues including accomplishments, challenges, best practices or possible solutions, staff needs, budget execution and monitoring, and clinical information to enhance ECMH services. KY SEED staff provide technical assistance or identify resources to support the RIACs.

#### KY SEED New Cohort Orientation

KY SEED staff and other organizational partners conduct a 2 ½ day orientation session for newly funded RIACs. This session includes information about the concepts and philosophy of system of care and its history in KY, early childhood development, social marketing, evaluation, and cultural and linguistic competency. Practical information about implementation of this initiative is also provided including reporting requirements, budget administration, technical assistance, and community readiness.

#### KY SEED Regional Interagency Technical Assistance Meetings

Meeting/training held to orient new cohorts to the early childhood system of care grant initiative.

#### Lifeline Prevention Curriculum

The Lifelines Prevention Curriculum educates students on the facts about suicide and students' role in suicide prevention. It provides information on where to find suicide prevention resources in the school and community. Training materials are included for faculty and staff that provide accurate and practical information on identifying and referring students who might be at risk for suicide. *Lifelines: A Suicide Prevention Program* also includes a presentation for parents that answers questions about youth suicide and prevention, and it involves them in the school's suicide prevention activities.

#### Motivational Interviewing

These trainings are designed to help participants gain a greater understanding of adolescent development, Stages of Change Theory, and Motivational Interviewing and how they each relate to effectively working with teens and their families. The course includes experiential "real plays", brief lectures and videos in a six hour time frame.

#### Parent-Infant Dyad Therapy

This two-day training is skills-based and offered to the Regional Board staff who are designated as the Perinatal Depression "point persons" and the Early Childhood Mental Health Specialists.

#### Parent Child Interaction Therapy

KY SEED provides quality training and support to ECMH service providers which can improve the quality of mental health services provided to children and families. Parent-Child Interaction Therapy (PCIT) is a proven parent-child treatment program that assists parents of children with behavioral problems (aggression, non-compliance, defiance, and temper tantrums). This unique treatment program focuses on promoting positive

parent-child relationships and interactions while teaching parents effective child management skills. It is our goal to increase the number of trained and qualified mental health providers in rural and urban areas with the expertise to comprehensively respond to the special needs of children and families through the delivery of PCIT services.

#### School-Based Suicide Prevention

Participants leave this workshop with practical information on how to implement evidence-based universal and targeted suicide prevention programs, the issue of suicide contagion in Kentucky schools, and suicide postvention procedures.

#### School Law

The Department partners with Protection and Advocacy to offer a three-hour overview seminar that provides audience with basic knowledge of IDEA, NCLB, and KDE disciplinary actions protocol. Participants are provided with an array of resources for additional further study and tools for advocating in school meetings for their own or other children.

#### Service Coordination 101

Service Coordination 101 Certification Training is required in order to bill the Kentucky Medicaid Program or the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), Division of Behavioral Health for Targeted Case Management Services. Service Coordinators/Case Managers and their supervisors must complete this training within six months of employment. This three day training is offered four times during the calendar year and provides certification for Service Coordinators/Case Managers and their supervisors.

#### Seven Challenges

The Department carries an umbrella license for the Community Mental Health Agencies to use the Seven Challenges Model. The trainings that occur will be for providers who need to train agency staff as providers but will need to have one person in their agency designated as a “leader” and have attended the “leader training” that is only offered by Seven Challenges LLC. Seven Challenges LLC also requires that there is a once a year fidelity visit that all leaders and providers must attend in which not only is fidelity issues discussed and reviewed but also continued support and education/training is given to those in attendance around the Seven Challenges model and philosophy

#### Technical Assistance Meetings for IMPACT Local Resource Coordinators, Early Childhood Mental Health Specialists, Children’s Crisis Program Directors, Therapeutic Foster Care Providers, Children’s Services Directors, Family Liaisons, Kentucky Family Peer Support Specialists, State Family Advisory Council Members,

These meeting are held quarterly for 1-1½ days and are open to all Regional Board staff belonging to one of these peer groups.

#### Team Observation Measure Training

A training to teach Kentucky IMPACT staff how to implement the Team Observation measure, a wraparound fidelity instrument.

#### Trauma Informed System of Care Training

A cross-agency overview of trauma and trauma and trauma informed care.

#### Trauma Informed System of Care Training for Trainers

A cross-agency training to train child serving agency trainers on a “Trauma Informed System of Care Basics Training” so that they, in turn, can train their agencies on a general overview of trauma and trauma informed care.

#### Wraparound Refresher Training

This 1-day training will provide experienced team facilitators with knowledge about the principles and phases of Wraparound.

Youth/Parent Conference

An annual 2 ½ day conference that offers tracks for youth between the ages of 13-17 years old that have an emotional, behavioral, mental health, and/or substance use disability; young adults (transitional age: 18-25 years old) that have an emotional, behavioral, mental health, and/or substance use disability; and parents of these youth and young adults.

<b>Trainings Relevant for Both Adult and Children’s Services</b>			
<b>Type of Training</b>	<b>Intended Audience</b>	<b>Number of Participants Anticipated</b>	<b>Frequency/ Length of conference</b>
Access Options for Consumers with Hearing Loss	Each CMHC Region and other Providers Upon Request	Ranges from 5-125 per Session	As Requested; In Partnership with Hamilton Relay
Adapting Substance Abuse Treatment for Deaf or Hard of Hearing Consumers	Any provider currently or interested in serving consumers with hearing loss.	Target 8-25 per Session	As requested. Tailored to needs of audience.
<b>American Sign Language Interpreter Peer Supervision Groups on Mental Health Interpreting</b>	Certified, Licensed Interpreters and interns working in mental health settings across the state. Groups exist or are forming in Lexington/Danville, Louisville, Northern KY, and Bowling Green	Target 5-10 per Session	Every 4-6 weeks One Day
Applied Suicide Intervention Skills Training: Training for Trainers	CMHC Crisis Directors and Master’s Level Clinicians	25 across the state	
<b>Assessing and Managing Suicide Risk: Core Competencies for Mental Health</b>	CMHC Behavioral Health Clinicians	Target-30 per Session	As requested One Day
<b>Assessing and Managing Suicide Risk: Training for Trainers</b>	CMHC Behavioral Health Clinicians	20	
Barbara Stanley Suicide Safety Planning Training	CMHC Clinicians, Crisis Staff, Administrators	1,000-1,500 over next 2 years	

**Trainings Relevant for Both Adult and Children's Services**

<b>Type of Training</b>	<b>Intended Audience</b>	<b>Number of Participants Anticipated</b>	<b>Frequency/ Length of conference</b>
Collaborative Assessment and Management of Suicidality (CAMS)	CMHC Master's Level Clinicians and Crisis Staff, Psychiatrists, Crisis Directors, Administrators	250 Statewide	
<b>Cognitive Behavior Therapy for Consumers who are Deaf with Language and Learning Challenges</b>	Therapists, case managers, rehabilitation counselors for the deaf, and others.	40	As needed.
<b>Cognitive Behavior Therapy for Perinatal Depression</b>	Regional Perinatal Depression contacts, Early Childhood Mental Health Specialists	30-50 per Session	3 Times per Year 2 Days
Columbia Suicide Severity Rating Scale Training	Behavioral health care providers	1,000-1,500 statewide over two years	
<b>Crisis Intervention Team Training (CIT)</b>	Law Enforcement Officers	Approximately 180 Total	6 per year 5 Days (40 hours)
<b>Cultural Competency Training of Trainers</b>	Current and prospective providers of Cultural Competency Training at the KDBHDID operated or contracted facilities and Regional Board staff and KDBHDID central office staff	Varies depending on location across the state	As requested 2-3 Days
<b>Deaf and Hard of Hearing Providers' Symposia</b>	DHHS Specialists and other CMHC staff with consumers with hearing loss.	20	Quarterly
<b>Deafness 101</b>	Overview of Cultural and Linguistic Issues in Serving Deaf or Hard of Hearing Consumers for any interested providers of mental health, developmental disability, or addiction services	Varies depending on interest and location – available statewide. Target is 100.	As Requested by Any Provider or Educational Institution across the State. Goal is to have it offered at every CMHC and facility. 1.5 to 3 hours

**Trainings Relevant for Both Adult and Children's Services**

<b>Type of Training</b>	<b>Intended Audience</b>	<b>Number of Participants Anticipated</b>	<b>Frequency/ Length of conference</b>
<b>Deafness 102</b>	1.5 to 3 hour Overview of adapting clinical practices to be culturally and linguistically affirmative for those with hearing loss. Available to current or prospective providers	Varies depending on interest and location. Available statewide. Goal is 100.	As Requested by Any Provider or Educational Institution Across the State. Goal is to have it offered at every CMHC and facility. 1.5 to 3 hours
Department of Psychiatry Grand Rounds	Department staff	5-110	1 ½ - 2 Hours Bimonthly
<b>Emergency Services Training</b>	Behavioral health providers and administrators, community providers and leaders, local interest groups.	Available statewide	As needed
<b>Evidenced Based Care for the Client At-Risk for Suicide</b>	Behavioral health clinicians	Target-80	As requested One Day
<b>Kentucky Registry of Interpreters for the Deaf (RID)</b>	DHHS Interpreters from across the state	17-40	Annually
KDBHDID Orientation	Newly Hired Central Office Staff	Average 4-8	Quarterly and as needed 1 Day
Kentucky Behavioral Health Planning and Advisory Council Member Orientation	New and current members	15	Annually
<b>Kentucky School of Alcohol and Other Drug Studies</b>	Behavioral health providers and administrators, consumers and family members	Approximately 600	Annually 4.5 Days
<b>Law Enforcement Response to Individuals with Special Needs</b>	Police Officers, Deputies, School Resource Officers	25	5 Days 40 Hours

**Trainings Relevant for Both Adult and Children's Services**

<b>Type of Training</b>	<b>Intended Audience</b>	<b>Number of Participants Anticipated</b>	<b>Frequency/ Length of conference</b>
Lethal Means Restriction in Emergency Departments Training	Hospital Emergency Department nurses, doctors, case managers	1,000-1,500 over next 2 years	
Let's Talk Safety for Families: Access to Lethal Means	General Audience	New offering for suicide prevention	As requested 1.5 Hours
<b>Let's Talk Safety: Clinical Issues Associated with Access to Lethal Means</b>	Behavioral Health Clinicians	New offering for suicide prevention	As requested 1.5 Hours
Mental Health Interpreting Peer Supervision Groups	A supervision group for clinicians serving clients who are deaf or hard of hearing.	5-15	Monthly
Motivational Interviewing	Case managers, clinicians and other behavioral health staff	30-40	As needed 1-4 days
Question, Persuade, and Refer Training (QPR)	Behavioral health service providers, state operated or contracted facilities, consumers, local interest groups and central office staff	Varies depending on location across the state	Quarterly and as Requested 1.5 Hours
Therapists' Retreat for those Serving Consumers with Hearing Loss	Behavioral health service providers, state operated or contracted facilities, consumers, local interest groups and KDBHDID central office staff	Ranges from 4-25	4 per year
Transition Age Youth Launching Realized Dreams	Adult Case Managers and Children's Service Coordinators	60	1 Day As requested
Understanding Self-Harming Behavior	General audience as well as educators	New offering	As requested 2 Hours

<b>Trainings Relevant for Both Adult and Children's Services</b>			
<b>Type of Training</b>	<b>Intended Audience</b>	<b>Number of Participants Anticipated</b>	<b>Frequency/ Length of conference</b>
<b>Working with the Suicidal Client</b>	Behavioral health clinicians	Target-200	As requested 2 Hours
Workshops for the Deaf Community	Existing consumers and others who may be in need of mental health services.	10-55	Monthly and as needed

**BOLD** Denotes that Continuing Education Units (CEUs) are offered for these training sessions. The following offers additional detail about some of the major training events listed above.

### ***Trainings Related to Both Adult and Children's Services***

#### Applied Suicide Intervention Skills Training (ASIST) Training for Trainers

Applied Suicide Intervention Skills Training (ASIST) is a two-day intensive, interactive and practice-dominated course designed to help clinical, non-clinical caregivers and parents recognize and review risk, and intervene to prevent the immediate risk of suicide.

#### Assessing and Managing Suicide Risk: Training for Trainers

This one-day training focuses on competencies that are core to assessing and managing suicide risk. The program includes: pre-workshop reading materials; 6.5 hours of training, comprised of an engaging mix of lecture and exercises; a 110-page participant manual, including an extensive bibliography and other valuable resources; journaling throughout the day; and time for discussion.

#### Barbara Stanley Suicide Safety Planning Training

This training will teach behavioral health professional how to do effective safety planning with suicidal individuals.

#### Collaborative Assessment and Management of Suicidality (CAMS) Training

The Collaborative Assessment and Management of Suicidality (CAMS) identifies and targets Suicide as the primary focus of assessment and intervention.

#### Columbia Suicide Severity Rating Scale Training

This is a training is to teach behavioral health care providers how to use the Columbia Suicide Severity Rating Scale.

#### Crisis Intervention Team

In collaboration with National Alliance for the Mentally Ill (NAMI) and Kentucky CIT, KDBHDID provides training for law enforcement officers regarding how to better respond to encounters with individuals who may be experiencing a behavioral health crisis.

#### Cultural Competency

Training regarding cultural competency issues is part of the initial orientation package for each Department employee. The Regional Boards are also required to provide cultural competency training for all staff members. The Cabinet also offers training through the Office of Diversity and Equality. Cabinet trainings are offered once a month.

#### Cultural Competency Training for Trainers

Department trainers provide this 2-3 day training to trainers in state-run or contracted facilities and community mental health centers on an as-needed basis.

#### Deaf and Hard of Hearing Services Providers' Symposia

Offered quarterly, these trainings bring together DHHS specialists as well as other CMHC staff who have consumers with hearing loss. Due to the lack of training in contiguous states, we have had participants from Ohio and Indiana as well.

#### Department of Psychiatry Grand Rounds

The Department accesses via video-conference the Department of Psychiatry Grand Rounds presentations for both the University of Louisville and University of Kentucky Schools of Medicine. The Department facilitates access to these presentations by the state facilities and the Community Mental Health Centers, often offering CEUs to staff who participate.

#### DDCAT/DDMHT Training and Technical Assistance

Our Department continues to develop a treatment delivery system in which all publicly-funded Mental Health and Substance Abuse treatment facilities across the state are co-occurring diagnosis capable, as measured by the Dual Diagnosis Capability in Addiction Treatment (DDCAT) and DDMHT (Mental Health Treatment) Fidelity Instruments. Trainings and technical assistance is being offered to Department and CMHC to learn the following:

- To have an understanding of Addiction/Mental Health Only Services vs Dual Diagnosis Capability vs Dual Diagnosis Enhanced Programs;
- To comprehend the program requirements for achieving DDC and DDE;
- To become competent in conducting DDCAT/DDMHT assessments;
- To be able to utilize DDCAT/DDMHT results in strategic planning; and
- To recognize the potential statewide impact of utilizing the DDCAT/DDMHT.

#### Emergency Services Training

Each Regional Board is encouraged to educate emergency services personnel (the courts, peace officers, inpatient psychiatric facilities, Rape Crisis Centers, etc.) in their area, as to applicable statutes concerning involuntary hospitalization and how to access evaluation services on a 24-hour per day, seven days a week basis. In collaboration with the Kentucky Association of Regional Programs (KARP), suicide risk assessment training (QPR) at each local mental health center is provided.

#### Kentucky Registry of Interpreters for the Deaf Conference

Deaf and Hard of Hearing Services provides a mental health track at the Interpreters' Conference, 3 workshops.

#### Kentucky School of Alcohol and Other Drug Studies

The annual "Kentucky School" is the premier training event for Kentucky's substance abuse prevention specialists, substance abuse treatment providers, and persons in recovery. It has grown to include a wider audience and a broader focus to include mental health and professionals from a variety of disciplines including child welfare, corrections, and juvenile justice. There are intensive sessions on a variety of topics including Adolescent Substance Abuse and Co-Occurring Disorders.



### Law Enforcement Response to Individuals with Special Needs

This 40-hour training is offered biannually to law enforcement officers and school resource officers. The focus of the training is how to provide a sensitive, appropriate response to adults and youths with mental illness, diagnosed with an autism spectrum disorder, deaf, who have a substance-related disorder, or dementia.

### Mental Health Interpreting Peer Supervision Groups

Training provided in Northern Kentucky and Louisville areas (statewide as requested). This peer supervision group is the only ongoing training of its kind in the country.

### Motivational Interviewing

Motivational interviewing is non-judgmental, non-confrontational and non-adversarial way of engaging with clients. The approach attempts to increase the client's awareness of the potential problems caused, consequences experienced, and risks faced as a result of the behavior in question. Alternately, therapists help clients envision a better future, and become increasingly motivated to achieve it.

### Suicide Prevention Training

In keeping with the state suicide prevention plan, the Department offers a series of trainings related to suicide prevention, across the state, to train providers, educators, consumers, family members and the public about suicide prevention, awareness, intervention and evaluation. Specific suicide modules are listed in the training grid above.

### QPR Community Suicide Prevention Presentation.

QPR stands for Question, Persuade and Refer. This is a basic community oriented presentation designed to create greater awareness, recognition of warning signs and knowledge of what to do if someone you know is struggling with a potential suicidal crisis. This program is 90 minutes in length and includes PowerPoint, video, and group interaction. Each participant receives a booklet containing the basic program information.

### Transition Age Youth Launching Realized Dreams

A specialized training for providers who work with transition age youth focusing on best practices and resources for this population.

### Understanding Self-Harming Behavior

This workshop can be designed for either clinical audiences or school staff and family members. The school and family presentation is 2hrs and the clinical version is a 3hr presentation. Both workshop formats explore the issue of prevalence and understanding the phenomenon of self harm itself in the context of developmental issues associated with adolescents and young adulthood. In the school and family format there is a consideration of appropriate school protocol and what family members can do. For the clinical format, focus is directed to evidence-based treatment and working with a client who engages in this behavior. Approved CEU's can be provided for mental health providers.

### Working with the Suicidal Client

This is a clinical training appropriate for mental health providers, case managers or those working in the healthcare field. This workshop is flexible - 2hr, 3hr and full day lengths. The material can be utilized to earn approved CEUs. Specific content can be flexed to meet the needs a given group. Modules include: Prevalence; Risk & protective factors; Issues of provider competence; Understanding the suicidal mind; How to conduct a solid risk assessment; establishing a therapeutic connection; and what we know about effective treatment. The workshop presentation includes PowerPoint, video, group exercises and interactive dialogue; each participant receives a notebook with a generous number of resources.

### Workshops for the Deaf community

Most states focus on existing consumers; we are doing case finding as well as reducing stigma by presenting in diverse environments such as the KY Association for the Deaf, KY School for the Deaf's Family Learning Vacation, and with VR counselors in their regions ("Taking Care of Yourself in Tough Economic Times").

## **Criterion 5: Management Systems**

### **2) Emergency Service Provider Training – Adult Mental Health**

*Narrative Question: Describe training of providers of emergency health services regarding mental health*

Senate Bill 104, which was passed during the 2007 General Assembly, mandated KDBHDID with the development of a 40 hour Crisis Intervention Team (CIT) training curriculum to be utilized to train law enforcement officers to better respond to persons with mental illness. CIT training began in Memphis, Tennessee and is now known as "The Memphis Model." Kentucky's CIT training curriculum includes modules regarding children's mental health, suicide prevention, developmental disabilities, serious mental illness as well as substance use disorders. Included in this 40 hour training is a requirement for law enforcement officers to spend an entire day practicing skills taught during the week, while being critiqued from a panel of experts. The DBHDID currently contracts with a retired police lieutenant to organize and implement training of law enforcement officers across the state in the CIT model. This contract requires collaboration with the Department of Criminal Justice Training, which approves the curriculum and trainers for each course. Training events also require the collaboration of the local Regional Board as well as consumers of behavioral health services and their family members. During SFY 2011, five (5) additional CIT officers, in the Western part of the state, were certified as CIT instructors. Local CIT instructors were trained to provide the Memphis Model in their specific regional location and thus increase the number of officers receiving training. Several local trainings have occurred and this process is being supervised carefully, with excellent training being provided to more officers. To date, 1168 officers across Kentucky have been trained.

Goals for SFY 2014/2015 include:

1. **Continue to offer Specialized Training for Law Enforcement by means of a 40 hour Crisis Intervention Team (CIT) Training** currently being implemented by contract with a retired police lieutenant. State police officers as well as local police officers are trained using the Memphis Crisis Intervention Team model. Officers volunteer and are assigned by their supervisors for the training. CIT held their 4<sup>th</sup> annual CIT Conference for Law Enforcement in June of 2013, which provided additional opportunities to gain an understanding of mental health issues and their effects on individuals. Regions with CIT advisory committees nominate a CIT officer of the year and one is selected by NAMI and recognized at the annual NAMI Kentucky conference.
2. **Continue to increase the number of instructors and continue to increase the number of CIT trained officers across the state.** Several experienced CIT officers across the state have now been trained and qualify to be CIT instructors. Five (5) regions in Kentucky are utilizing local trainers to decrease costs and thereby increase the number of trainings available to local law enforcement agencies. Several local trainings occurred during SFY 2013 and are scheduled for SFY 2014. This process is being supervised closely by contract staff and DBHDID. To date 1168 law enforcement officers from agencies across Kentucky have been trained in the 40 hour Kentucky Law Enforcement Council (KLEC) certified CIT training class. This includes city police, county police, university campus police, sheriff departments and state police. In the statewide training, forty nine (49) CIT classes have been taught to date. To date officers

have been trained for 167 law enforcement agencies in Kentucky. Ten (10) regions currently have CIT Advisory Committees. The CIT Advisory Committees build upon the relationships between law enforcement, mental health professionals and mental health advocates, established in the 40 hour CIT class. However, these committees allow for long term and systemic improvements in services to persons with mental illness, developmental disabilities and substance use issues. Where there is a strong CIT Advisory Committee we have seen improvements in the “system” and in the response to those we serve.

3. **Continue to work on developing teams in rural eastern Kentucky mountain areas.** In April 2013, we offered the first CIT training in the Prestonsburg area. We continue to move this training into new areas and expect to have held training in every region by the end of SFY 2015.

The Division of Behavioral Health was awarded a two-year SAMSHA grant in June 2003 to develop regional behavioral health emergency disaster preparedness plans for each of the Regional MHMR Boards. As a continuation of that initiative, the Division continues to receive a small amount of funding (2005-2013) from the Kentucky Department for Public Health to help fund a statewide Mental Health/Mental Retardation Disaster Preparedness coordinator. This coordinator provides a behavioral health focus for Kentucky’s 14 regional ASPR (Assistant Secretary of Preparedness and Response) healthcare planning coalitions and ongoing interagency collaboration that have resulted in integrated and coordinated responses to emergencies and disasters. Regional CMHC plans continue to be updated annually and the Department continues to designate a program administrator to coordinate regional and statewide efforts.

The Regional CMHC’s will continue to participate in local/regional healthcare preparedness planning coalitions. CMHC staff shall assess, identify and monitor shelter needs for individuals with behavioral health, developmental, and intellectual disabilities during emergencies and disasters. CMHC staff shall assist in providing notification to behavioral health, developmental and intellectual disabilities populations and caregivers regarding response and recovery information.

The Program Coordinator continues to sit on the Kentucky Community Crisis Response Board (KCCRB) as the Commissioner Designee. The Kentucky Community Crisis Response Board provides assessments, crisis intervention, service collaboration, and system development following disasters. KCCRB, as the state lead disaster mental health agency, coordinates services, administers FEMA Crisis Counseling grants when necessary following a presidential Declaration, in collaboration with local and regional mental health providers. The KCCRB also provides multi-component crisis intervention services statewide, and is on call 24 hours a day, seven days a week. Regular incident responses include responding to crises with first responders, schools, businesses or community organizations, as invited.

## **Criterion 5: Management Systems**

### **2) Resources for Providers – Children’s Mental Health**

*Narrative Question: Describe training of providers of emergency health services regarding mental health.*

#### Crisis Intervention Team Training

Senate Bill 104, which was passed during the 2007 General Assembly, mandated KDBHDID with the development of a 40 hour Crisis Intervention Team (CIT) training curriculum to be utilized to train law enforcement officers to better respond to persons with mental illness. CIT

training began in Memphis, Tennessee and is now known as “The Memphis Model.” Kentucky’s CIT training curriculum includes modules regarding children’s mental health, suicide prevention, developmental disabilities, severe mental illness as well as substance use disorders. Included in this 40 hour training is a requirement for law enforcement officers to spend an entire day practicing skills taught during the week, while being critiqued from a panel of experts. KDBHDID currently contracts with a retired police lieutenant to organize and implement training of law enforcement officers across the state in the CIT model. This contract requires collaboration with the Kentucky Department of Criminal Justice Training, which approves the curriculum and trainers for each course. Training events also require the collaboration of the local Regional Board as well as consumers of behavioral health services and their family members. During SFY 2011, five (5) additional CIT officers, in the Western part of the state, were certified as CIT instructors. Local CIT instructors were trained to provide the Memphis Model in their specific regional location and thus increase the number of officers receiving training. Several local trainings have occurred and this process is being supervised carefully, with excellent training being provided to more officers. It is the goal of SFY 2014-2105 to continue statewide and local CIT trainings in order to increase the number of CIT officers in Kentucky. During SFY 2012, 287 officers were trained using the CIT model. To date, 1168 officers across Kentucky have been trained. In the Louisville Metro Area, 68 Louisville Metro Police Officers were trained during SFY 2012. The total officers in the Louisville Metro Area trained to date is 675, over 50% of their entire force of 1216 officers. The goal in the Louisville Metro Area is to have a least one (1) CIT officer on each shift.

Goals for SFY 2014/2015 include:

4. **Continue to offer Specialized Training for Law Enforcement by means of a 40 hour Crisis Intervention Team (CIT) Training** currently being implemented by contract with a retired police lieutenant. State police officers as well as local police officers are trained using the Memphis Crisis Intervention Team model. Officers volunteer and are assigned by their supervisors for the training. CIT held their 5<sup>th</sup> annual CIT Conference for Law Enforcement in June of 2013, which provided additional opportunities to gain an understanding of mental health issues and their effects on individuals. Regions with CIT advisory committees nominate a CIT officer of the year and one is selected by NAMI and recognized at the annual NAMI Kentucky conference.
5. **Continue to increase the number of instructors and continue to increase the number of CIT trained officers across the state.** Several experienced CIT officers across the state have now been trained and qualify to be CIT instructors. Five (5) regions in Kentucky are utilizing local trainers to decrease costs and thereby increase the number of trainings available to local law enforcement agencies. Several local trainings occurred during SFY 2012 and are scheduled for SFY 2013. This process is being supervised closely by contract staff and DBHDID. To date 1168 law enforcement officers from agencies across Kentucky have been trained in the 40 hour Kentucky Law Enforcement Council (KLEC) certified CIT training class. This includes city police, county police, university campus police, sheriff departments and state police. These totals exclude the Louisville Metro Police department (LMPD). The LMPD currently has over 600 trained CIT officers and also trains all new recruits in the full 40 hour CIT class. In the statewide training, thirty nine (39) CIT classes have been taught to date, with ten (10) scheduled for calendar year 2013. To date officers have been trained for 167 law enforcement agencies in Kentucky. Ten (10) regions currently have CIT Advisory Committees. The CIT Advisory Committees build upon the relationships between law enforcement, mental health professionals and mental health advocates, established in the 40 hour CIT class. However, these committees allow for long term and systemic improvements in services to persons with mental illness, developmental disabilities and

substance use issues. Where there is a strong CIT Advisory Committee we have seen improvements in the “system” and in the response to those we serve.

6. **Continue to work on developing teams in rural eastern Kentucky mountain areas.** In April 2013, we will be able to offer the first CIT training in the Prestonsburg area. We continue to move this training into new areas and expect to have held training in every region by the end of SFY 2015.

#### Emergency Disaster Preparedness

The Division of Behavioral Health was awarded a two-year SAMSHA grant in June 2003 to develop regional behavioral health emergency disaster preparedness plans for each of the Regional Boards. As a continuation of that initiative, the Division continues to receive a small amount of funding (2005-2013) from the Kentucky Department for Public Health to help fund a statewide Mental Health/Mental Retardation Disaster Preparedness coordinator. This coordinator provides a behavioral health focus for Kentucky’s 14 regional ASPR (Assistant Secretary of Preparedness and Response) healthcare planning coalitions and ongoing interagency collaboration that have resulted in integrated and coordinated responses to emergencies and disasters. Regional CMHC plans continue to be updated annually and the Department continues to designate a program administrator to coordinate regional and statewide efforts.

In July 2012 staff from the Division of Behavioral Health and the Kentucky Department for Public Health met for biannual planning purposes and agreed to collaborate in the following ways during emergencies and disasters.

- Designate staff to serve in the DPH’s Department Operation Center during Level 1 or Level 2 incidents.
- Designate DBHDID staff serving the DPH DOC to report Community Mental Health Center and Department facility assessments and on-going status to Emergency Support Function -8 (ESF-8) and to the Commonwealth Emergency Operations Center through the DOC.
- Designate DBHDID staff serving the DPH DOC to assist with identifying resources to secure services for individuals with behavioral health (mental and substance use) disorders and developmental/intellectual disabilities for shelter, day care, supervision, medication, transportation and housing.
- Develop a written plan/Continuity of Operations Plan (COOP) and train staff on implementation of the plan should it be needed during an event.
- Assist DPH in the development of statistical profiles of persons with functional and access needs by providing data on persons served by the agency.

The Regional CMHCs will continue to participate in local/regional healthcare preparedness planning coalitions. CMHC staff shall assess, identify and monitor shelter needs for individuals with behavioral health, developmental, and intellectual disabilities during emergencies and disasters. CMHC staff shall assist in providing notification to behavioral health, developmental and intellectual disabilities populations and caregivers regarding response and recovery information.

Each Regional Board Emergency Disaster Preparedness Coordinator, as well as the statewide coordinator, provides information and training materials for first responders in their Healthcare Planning Coalitions and as requested at other Public Health venues. This has included planning for special needs populations in sheltering and other disaster situations.

### Kentucky Community Crisis Response Board

The Program Coordinator continues to sit on the Kentucky Community Crisis Response Board (KCCRB) as the Commissioner Designee. The Kentucky Community Crisis Response Board provides assessments, crisis intervention, service collaboration, and system development following disasters. KCCRB, as the state lead disaster mental health agency, coordinates services, administers FEMA Crisis Counseling grants when necessary following a presidential Declaration, in collaboration with local and regional mental health providers. The KCCRB also provides multi-component crisis intervention services statewide, and is on call 24 hours a day, seven days a week. Regular incident responses include responding to crises with first responders, schools, businesses or community organizations, as invited.

The Kentucky Community Crisis Response Board (KCCRB) is recognized as the lead disaster behavioral health agency by the KDBHDID, Kentucky Division of Emergency Management (KyEM) and the American Red Cross (ARC). In a natural disaster or under national security conditions, many events will occur which will necessitate the coordination and delivery of crisis intervention and disaster behavioral health services. KCCRB credentials and maintains a statewide network of trained professional volunteer responders and deploys rapid response teams to crisis and disaster sites. Many of the KCCRB volunteers are Regional Board staff. Additionally, the regional mental health centers provide training for their staff to respond to their specific community needs in disaster.

Crisis intervention and disaster behavioral health services include the immediate and coordinated provision of consultation, assessment, risk assessment, referral, and psychological first aid to people affected by crisis or disaster including first responders.

### Mental Health First Aid

In 2010, KDBHDID was asked by the Department for Public Health to begin setting targets for our Healthy Kentucky 2020 objectives to submit to the Centers for Disease Control and Prevention. One of our objectives was to increase the number of individuals trained in Mental Health First Aid. The following is our state's plan for accomplishing the goal:

Objective 23.4: Increase the Number of Individuals Who Receive the Mental Health First Aid USA Training Course

Data Source: KDBHDID, Mental Health First Aid USA

Baseline: 200 Individuals Trained in Kentucky

HK 2020 Target: 8,000 Individuals Trained in Kentucky

Implementation Strategy:

- KDBHDID will collaborate with various health advocacy groups throughout the state to provide the training.
- KDBHDID will offer the course to staff at the regional community mental health centers.
- KDBHDID will collaborate with faith-based organizations and service organizations to provide trainings.
- Making the course available to first responders is a priority.

At this point, our state has eleven instructors trained in Mental Health First Aid USA and approximately 500 individuals have received the 2-day training. Youth Mental Health First Aid is an 8-hour course for individuals 16 and older. Kentucky currently has three certified Youth Mental Health First Aid USA instructors across the state, one in Frankfort at Kentucky

Partnership for Families and Children and two in Ashland. Instructors must provide the training at least three times per year to stay certified. Our goal at this point is to ensure that many more people receive the training so that we can reach our Healthy Kentucky 2020 goal.

## **Criterion 5: Management Systems**

### **3) Grant Expenditure Manner – Adult and Children’s Mental Health/Substance Abuse Prevention and Treatment**

*Narrative question: Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved.*

Per Section 1911 of the Title XIX Block Grants, the state will expend the grant funds only for the purposes of:

- Carrying out the plan submitted for the fiscal year;
- Evaluating programs and services carried out under the plan; and
- Planning, administering and educational activities related to providing services under the plan.

KDBHDID allocates mental health block grant funds to Regional Boards and to agencies that are either public or not-for-profit entities in accordance with Mental Health Block Grant requirements. No funds are used to satisfy any requirement for the expenditures of non-Federal funds. The funds are utilized by KDBHDID to provide direct services for adults with SMI and children with SED and to support statewide initiatives that promote the systems of care for these populations. A few Regional Boards also act as the fiscal management agent for the expenditure of a portion of the grant funds allocated for statewide activities. The Substance Abuse Prevention and Treatment funds are utilized by KDBHDID to provide services for persons at risk of having substance use and/or mental disorders, services for persons at risk of contracting communicable diseases, and services for persons in need of primary substance abuse prevention. A few Regional Boards also act as the fiscal management agent for the expenditure of a portion of the grant funds allocated for statewide activities.

# MENTAL HEALTH BLOCK GRANT ALLOCATIONS FOR STATE FISCAL YEAR 2014

## CONTRACTED TO THE REGIONS FOR SERVICES:

<u>Region</u>	<u>Adults</u>	<u>Children</u>	<u>Supported Employment Pilot Sites</u>	<u>SMI/SED Deaf &amp; HoH</u>	<u>TOTAL</u>
Four Rivers	135,139	67,210			227,777
Pennyroyal	169,967	74,379			249,804
RiverValley	186,882	79,685			275,678
LifeSkills	191,484	84,644			287,431
Communicare	163,047	98,653			275,084
Seven Counties	568,148	305,948		38,833	893,849
NorthKey	258,649	80,534			349,594
Comprehend	35,045	43,638			113,646
Pathways	212,421	224,295			483,581
Mountain	169,467	68,980			240,777
Kentucky River	85,096	34,518			109,822
Cumberland River	243,676	100,317			339,393
Adanta	135,747	73,084			195,474
Bluegrass	135,983	207,433		22,482	343,485
Supported Employment Sites			150,000		<u>150,000</u>
					<b>\$4,445,395</b>

## STATEWIDE PROJECTS:

<u>Regional Board</u>	<u>Program or Service</u>	<u>Amount</u>
LifeSkills	Statewide Case Management Training	20,000
LifeSkills	Children's Training Initiatives	20,000
LifeSkills	MH Training and TA, USPRA	20,000
LifeSkills	Recovery Initiative	20,000
LifeSkills	Peer Support Training	20,000
LifeSkills	Supported Employment Fidelity Initiative	21,000
Seven Counties	Office of Consumer Advocacy	53,000
Seven Counties	Mental Health and Aging	20,000
Bluegrass	SIAC Support	25,000
Bluegrass	Parent Advocacy Mini-Grants	20,000
Bluegrass	Opportunities for Family Leadership	30,362
Bluegrass	Suicide Prevention	15,000
Bluegrass	CIT	70,000
Bluegrass	Statewide Deaf & HOH	<u>46,787</u>
		<b>\$401,149</b>



**OTHER:**

Kentucky Housing Corporation	13,334
Department of Corrections	50,000
Behavioral Health Planning Council	15,000
University of Kentucky - Institute for Pharmaceutical Outcomes & Policy (IPOP)	100,000
State Travel	15,000
NAMI KY – Recovery Oriented Family Support	119,554
Eastern Kentucky University	147,224
Kentucky Partnership for Families & Children – Family Driven Youth Guided Training & Support	143,000
Office of Vocational Rehabilitation – Supported Employment Services	75,000
University of Kentucky - Dartmouth	95,000
NAMI of Lexington (Participation Station) – Recovery Oriented Training	150,190
Audit Reserve (Federal Cuts)	<u>1,458,269</u>
	<b>\$2,381,571</b>

**TOTAL SFY 14 MHBG ALLOCATIONS** **\$7,228,115**

## SUBSTANCE ABUSE BLOCK GRANT ALLOCATIONS FOR STATE FISCAL YEAR 2014

### CONTRACTED TO THE REGIONS FOR SERVICES:

	<u>Region</u>	<u>Treatment</u>	<u>Pregnant &amp; Postpartum</u>	<u>Prevention</u>	<u>TOTAL</u>
1	Four Rivers	423,960	72,896	147,187	644,043
2	Pennyroyal	431,518	75,305	223,626	730,449
3	RiverValley	426,673	79,297	212,653	718,623
4	LifeSkills	700,711	233,883	210,042	1,144,636
5	Communicare Seven Counties	530,128	188,746	242,397	961,271
6	NorthKey	3,082,835	1,145,316	332,538	4,560,689
7	Comprehend	498,924	630,729	212,993	1,342,646
8	Pathways	93,241	15,010	100,000	208,251
10	Mountain	549,059	95,123	242,107	986,289
11	Kentucky River	455,154	63,172	165,933	684,259
12	Cumberland River	379,274	90,494	230,109	699,877
13	River	654,456	178,790	193,390	1,026,636
14	Adanta	22,711	117,882	221,658	662,251
15	Bluegrass	1,603,352	445,727	451,717	<u>2,500,796</u>
					<b>\$16,870,716</b>

### STATEWIDE PROJECTS:

	<u>Region</u>	<u>Program or Service</u>	<u>Amount</u>
4	LifeSkills	NIATx Training Funds	35,000
4	LifeSkills	Prevention	10,000
4	LifeSkills	Treatment	10,000
4	LifeSkills	Kentucky Prevention Network	19,950
5	Communicare	Crisis Intervention	30,000
		Statewide Deaf & Hard of Hearing	
15	Bluegrass	Hearing	20,000
15	Bluegrass	Suicide Prevention	<u>15,000</u>
			<b>\$139,950</b>

**MISCELLANEOUS FUNDED WITH SAPT BLOCK GRANT:**

	<u>Treatment</u>	<u>Pregnant &amp; Postpartum</u>	<u>Prevention</u>	<u>TOTAL</u>
REACH of Louisville Recovery Oriented Training (People Advocating Recovery)	91,300		365,321	91,300
KPFC Kentucky Housing Corp	15,000			15,000
Louisville Metro Health Dept	13,333			13,333
NAMI Lexington Eastern Kentucky University	500,000		449,628	500,000
UK - CDAR	24,000	60,000	71,003	801,036
	594,680			<u>725,683</u>
				<b>\$2,511,673</b>
<b>Other:</b>				
Armed Services Treatment	80,000			80,000
Peer Services Initiative	60,000			60,000
Audit Reserve	131,254			<u>131,254</u>
				<b>\$271,254</b>
<b>TOTAL SFY 14 SABG ALLOCATIONS</b>				<b>\$19,793,593</b>

## II: Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

### Narrative Question:

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This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact [planningdata@samhsa.hhs.gov](mailto:planningdata@samhsa.hhs.gov).

### Footnotes:

## II. Planning Steps

### Step 2: Identify the unmet service needs and critical gaps within the current system

*Identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.*

*Priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.*

*In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the CMS or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact [planningdata@samhsa.hhs.gov](mailto:planningdata@samhsa.hhs.gov).*

In an effort to identify unmet needs and critical gaps in the publicly funded behavioral health system, the Department has drawn upon data and information from a variety of sources at the local, regional and state level and compared it with data available nationally. The Department and stakeholders have participated in a number of activities to address the need for comprehensive data to drive their planning efforts, including:

- Behavioral Health Planning and Advisory Council Priority Setting Sessions;
- Provider Forums;
- Out-of-State Children's Workgroup/ Children's System of Care Redesign;
- Technical Assistance from Multiple Consultants; and
- Priorities and Supporting Research from Federal Funders, including SAMHSA.

At present, there are a number of priorities that have been identified but there are also a number of different overarching influences to be considered as planning occurs, including:

- Implementation of the Patient Protection and Affordable Care Act (PPACA) and the Mental Health Parity and Addiction Equity Act (MHPAEA) –Particularly the State Health Exchange
- State Budget Restrictions and a Struggling State and National Economy
- Implementation of Managed Care Statewide (including behavioral healthcare)
- Legislative Actions (including unfunded mandates)
- A newly constructed State Psychiatric Facility to Replace Eastern State Hospital (due to open in September 2013)
- Returning Service Members, Veterans and their Families with Behavioral Health Needs
- Workforce Issues and Shortages
- Underfunded Pension System and Increased Retirement Contribution by CMHCs

### Division of Behavioral Health – Unmet Service Needs

## **Mental Health**

The Kentucky Planning and Advisory Council has recommended the following nine (9) priorities for Block Grant funding and chose the top three (3) as priorities:

- **Develop specialized services and supports for youth transitioning to adulthood.** *Council agreed this includes training for staff as well as direct services and supports for youth;*
- **Promotion of recovery-oriented services across all Regional Board programs;** *Particularly use carry over funds for this as they may be one-time expense projects;*
- **Increased funding for family member and consumer-run support programs;**
- Increased funding for an anti-stigma and anti-discrimination campaign to educate the public;
- Promotion of early intervention and increased access to community-based services (to prevent higher levels of care);
- A self-identified, active parent, youth & consumer representative on every Center's Board of Directors;
- Increased access to transportation services;
- Increased education about services available at the Regional Boards; and
- Increased training for staff on evidence-based practices and on cultural competency.

The Planning Council and the Department also participated in a Center for Mental Health Services (CMHS) monitoring visit (March 2009) and remain aware of their report that noted the following:

- A need to rebalance mental health system resources between State Hospital and community services;
- A need to be more effective in soliciting and responding to consumer and family input into the service system; and
- A need to hire a self-identified consumer as Recovery Services Coordinator within the Division of Behavioral Health. It was noted that this action would introduce a consumer perspective into policy making as well as serve as a role model for other agencies.

There is a CMHS monitoring visit anticipated in the Spring of 2014. SAMHSA has indicated items to be addressed during this visit and DBHDID staff are currently gathering information to be shared. The state welcomes this opportunity to gain clarity on the priorities and directives of CMHS during these visits and anticipates that additional priorities may be established for Kentucky's behavioral health system as a result

The Kentucky Legislative Research Commission's Program Review and Investigations Committee conducted a follow up study to revisit their Research Report (previously released in June 2007), entitled; *Kentucky's Community Mental Health System is Expanding and Would Benefit from Better Planning and Reporting*. The major objectives of the original study were to describe the Regional Boards' mission, activities, and resources; analyze needs and services; and examine the processes of treatment, monitoring and outcome evaluation. The follow-up report focuses on the progress made and potential changes due to the current environment (e.g., managed care implementation, ACA, budget cuts, etc.). Recommendations from both versions of this study include reestablishing the Kentucky Commission on Mental Illness, Alcohol and Other Drug Abuse Disorders, and Dual Diagnosis and the Regional Mental Health Planning Councils, (HB843 Commission), having each Regional Board develop a strategic plan each year to be an integral part of statewide planning decisions, and instituting a standardized method of calculating each Regional Board's amount of charity allowance.

In May 2011, Leslie Schwalbe, MPA, provided consultation to DBHDID regarding preparing for managed care in the public mental health system. Several recommendations were made focusing on these major areas: 1) DBHDID updating CMHC contract language to accommodate managed care concerns; 2) DBHDID oversight regarding Managed Care Organizations' (MCO) contracts with the Department for Medicaid Services and with the CMHCs; and 3) Maintaining a safety net for the remaining state behavioral health funds for persons in the public system who do not have Medicaid benefits or other/adequate insurance coverage, even if periodic.

A Gap Analysis was calculated by DBHDID based on 2010 Census numbers and certified 2013 KY MIS Client/Event data. This data was based on prevalence data regarding adults with SMI and children with SED. It was noted that about 51% of adults with SMI in Kentucky receive services from the Regional Boards, and about 11% of adults with SMI served by the Regional Boards received targeted case management services. It was also noted that about 59% of children with SED received services from the Regional Boards and about 20% of the children with SED served by the Regional Boards received targeted case management services.

In October 2012, as well as in January of 2013, Community Support Directors from all fourteen (14) regions were asked to list the top three (3) priorities in their regions with regards to serving adults with SMI. The top three (3) responses among this group were transportation, supportive housing services and peer support services. Other notable concerns were funding for therapeutic rehabilitation programs, funding for assertive community treatment programs, supported employment services, and access to more prescribers. DBH staff has been working with staff from the Department for Medicaid Services (DMS) on preparation of a 1915i State Plan Amendment to provide more intensive services for adults with SMI.

Kentucky's estimates of the prevalence of severe mental illness are based on national work but also take into account the applicable Kentucky law that defines severe mental illness. In a National Institute of Mental Health (June 2008) publication, it was stated that, "An estimated 26.2 percent of Americans ages 18 and older — about one in four adults — suffer from a diagnosable mental disorder in a given year." It went on to report that, "about 6 percent, or 1 in 17 — who suffer from a serious mental illness." ((NIMH June 2008: *The numbers count: mental disorders in America*)

In the May 2012 National Survey on Drug Use and Health (NSDUH) Report presented state level estimates of prevalence of "any mental illness" and SMI among adults (age 18 and above) based on data collected from the combined 2008 and 2009 surveys. The estimated percentage of adults with "any mental illness," in the past year, ranged from 17.2 in Maryland to 24.0 in Rhode Island. Kentucky's estimated prevalence for any mental illness is 20.19 percent. Kentucky's percentage of adults with SMI was estimated at 5.4 percent, among the range of 3.5 in South Dakota to 7.0 percent in Rhode Island.

### ***Prevalence Data for Adults with SMI***

With the passage in 1992 of P.L. 102-321, the Community Mental Health Services Block Grant, Congress required the Center for Mental Health Services (CMHS) to develop a national definition for "adults with severe mental illness." CMHS was further required to develop an "estimation methodology" based on the definition that state mental health agencies must use to estimate needs in their state plans. While P.L. 102-321 limits CMHS Block Grant spending to persons who meet the federal definition, it does not require states to serve everyone covered by

the definition. The federal definition of “adults with a severe mental illness” was published on May 20, 1993.

A work group comprised of consumers, family members, and providers reviewed the federal definition and Kentucky's statutory definition of “chronic mental illness”; its recommendations were reflected in Administrative Regulations published in 1994. The regulation provided for operational definitions of the target population of adults with severe mental illness consistent with national policy. Kentucky’s definition of “adult with severe mental illness,” as currently operationalized, uses the following criteria for age, diagnosis, disability, and duration: Kentucky’s definition is narrower than the definition promulgated in the federal register for “Adult with Severe and Persistent Mental Illness.” Historically, stakeholders have supported the Department’s desire to focus limited funding on adults who meet the state’s narrower definition.

<b>Variable</b>	<b>Criteria</b>
<b>Age</b>	Age 18 or older
<b>Diagnosis</b>	Major Mental Illness <ul style="list-style-type: none"> <li>• Schizophrenia and Other Psychotic Disorders</li> <li>• Mood Disorders</li> <li>• Personality Disorders (when information and history depict persistent disability and significant impairment in areas of community living)</li> </ul>
<b>Disability</b>	Clear evidence of functional impairment in two or more of the following domains: <ul style="list-style-type: none"> <li>• Societal/Role Functioning: Functioning in the role most relevant to his/her contribution to society and, in making that contribution, how well the person maintains conduct within societal limits prescribed by laws, rules and strong social mores.</li> <li>• Interpersonal Functioning: How well the person establishes and maintains personal relationships. Relationships include those made at work and in the family settings as well as those that exist in other settings.</li> <li>• Daily Living/Personal Care Functioning: How well the person is able to care for him/herself and provide for his/her own needs such as personal hygiene, food, clothing, shelter and transportation. The capabilities covered are mostly those of making reliable arrangements appropriate to the person’s age, gender and culture.</li> <li>• Physical Functioning: Person’s general physical health, nutrition, strength, abilities/disabilities and illnesses/injuries.</li> <li>• Cognitive/Intellectual Functioning: Person’s overall thought processes, capacity, style and memory in relation to what is common for the person’s age, gender, and culture. Person’s response to emotional and interpersonal pressures on judgments, beliefs and logical thinking should all be considered in making this rating.</li> </ul>
<b>Duration</b>	One or more of these conditions of duration: <ul style="list-style-type: none"> <li>• Clinically significant symptoms of mental illness have persisted in the individual for a continuous period of at least two- (2) years.</li> <li>• The individual has been hospitalized for mental illness more than once in the last two- (2) years.</li> <li>• There is a history of one or more episodes with marked disability and the illness is expected to continue for a two-year period of time</li> </ul>



The 1999 federal methodology for estimating adults with serious mental illness requires states to use the national estimate of 5.4 percent for the prevalence of adults with severe mental illness (SMI), and a rate of 2.6 percent for adults with severe and persistent mental illness (SPMI).

The following table uses the federal SPMI prevalence rate of 2.6% and the 2010 census data to estimate the percentage of the targeted population serviced by the Regional Board during SFY 2012.

Regional Boards	Adult Census 2010	Estimated Prevalence (2.6% of the Adult Census)	Kentucky Adults with SMI Served in SFY 2012	Penetration Rate - SMI Served
Four Rivers	161,545	4,200	2,478	59%
Pennyroyal	158,100	4,111	3,485	85%
RiverValley	161,977	4,211	2,285	54%
LifeSkills	217,231	5,648	2,041	36%
Communicare	200,640	5,217	2,883	55%
Seven Counties	730,843	19,002	8,718	46%
NorthKey	326,235	8,482	3,060	36%
Comprehend	42,757	1,112	726	65%
Pathways	170,601	4,436	2,592	58%
Mountain	119,756	3,114	3,050	98%
Kentucky River	89,550	2,328	2,088	90%
Cumberland River	181,110	4,709	3,226	69%
Adanta	160,202	4,165	2,291	55%
Bluegrass	595,449	15,482	4,513	29%
<b>TOTAL</b>	<b>3,315,996</b>	<b>86,216</b>	<b>43,436</b>	<b>50%</b>

*Note: The data for SFY 2013 is not certified until October 15<sup>th</sup> thus SFY 2012 data is used.*

### **Prevalence Data for Children with SED**

Using 2010 census data and the state's agreed upon prevalence rate estimate of five percent, Regional Boards are aware of the number of children in potential need of services. The Boards also rely heavily on indicators and recommendations from the local communities, parent networks and Regional Planning Councils. Kentucky Kids Count, the annual report distributed by Kentucky Youth Advocates is also helpful for program planning. ([www.kyouth.org](http://www.kyouth.org).)

The following denotes the child population and the estimated number of children with a severe emotional disability (SED) and thus percentage served.

Estimated 2010 Child Census – 1,023,371

Estimated Number of Children with SED (5%) – 51,169

Kentucky MH Children Served SFY 2012 – 59,317 or 6% (of Kentucky's child population)

Kentucky SED Children Served SFY 2012 – 28,578 or 56% (of the 5% SED population)

*Note: Data for 2013 are not certified until October 15, 2013 and thus SFY 2012 data was used.*

In Kentucky, criteria for determining whether a child has SED were included in the enabling legislation (KRS 200.503) for the Kentucky IMPACT program in 1990. These criteria include the following. A child who:

1) Is under age 18 or under age 21 and was receiving mental health services prior to age 18 and the services must be continued for therapeutic benefit; and

2) Has a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is listed in the current addition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders; and presents substantial limitations which have persisted for least one year, or are judged by a mental health professional to be at high risk of continuing for one year without professional intervention in at least two of these five areas:

- Self-Care
- Interpersonal Relationships
- Family Life
- Self-Direction
- Education

or

- Is a Kentucky resident and is receiving residential treatment for an emotional disability through the interstate compact; or
- Has been removed from the home by the Department for Community Based Services (Kentucky's child welfare agency) and has been unable to be maintained in a stable setting due to a behavioral or emotional disability.

Kentucky's estimated prevalence rate falls in the low range of estimates derived from local studies and cited in "Prevalence of Severe Emotional Disturbance in Children and Adolescence" (Friedman et. al, SAMHSA, 1996). This study acknowledges the lack of epidemiological data and concludes that regardless of the estimated prevalence rate that may be used, children with severe emotional disabilities are greatly under-served, a conclusion Kentucky planners share.

#### **Data Sources Used:**

- Kentucky MIS Client/Event Data Set
- Kentucky State Data Center/US Census Bureau 2010
- KY STARS 2011 Statewide Needs Assessment
- NAMI KY 2011 Statewide Needs Assessment
- [http://www.nasmhpd.org/general\\_files/publications/POPS%202010%20final.pdf](http://www.nasmhpd.org/general_files/publications/POPS%202010%20final.pdf) (2010 Pillars of Peer Support - 2 "Expanding the Role of Peer Support Services in Mental Health Systems of Care and Recovery."
- [http://www.nasmhpd.org/general\\_files/publications/med\\_directors\\_pubs/Technical%20Report%20on%20Morbidity%20and%20Mortality%20-%20Final%2011-06.pdf](http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Technical%20Report%20on%20Morbidity%20and%20Mortality%20-%20Final%2011-06.pdf) (2006 "Morbidity and Mortality in People with Serious Mental Illness".
- SAMHSA's Strategic Initiatives 2010-2014
- <http://www.mhmr.ky.gov/mhsas/files/Suicide%20Prevention%20Plan.pdf> (2007 Kentucky Suicide Prevention Plan)

- [http://www.mhmr.ky.gov/mhsas/HB843\\_Commission/Reports/2007%20Progress%20Report.pdf](http://www.mhmr.ky.gov/mhsas/HB843_Commission/Reports/2007%20Progress%20Report.pdf) HB 843 Commission On Services and Supports For Individuals with Mental Illness, Alcohol and Other Drug Abuse Disorders and Dual Diagnoses 2007 Report “Template for Change”.
- 2011 Gap Analysis of Adults with SMI served/Received Targeted Case Management
- Kentucky’s 10 Year Plan to End Homelessness
- [http://oas.samhsa.gov/2k11/025/WEB\\_SR\\_025.cfm](http://oas.samhsa.gov/2k11/025/WEB_SR_025.cfm) 2011 National Survey on Drug Use and Health (NSDUH) Report. “Sources of Payment for Mental Health Treatment for Adults.”
- Mental Health Planning and Advisory Council Recommendations (2007 & 2010)
- Healthy People 2020 <http://www.healthypeople.gov/2020/default.aspx>

### ***Co-occurring Disorders***

In 2004, the Division of Mental Health and the Division of Substance Abuse were merged into the Division of Mental Health and Substance Abuse. In 2005, a Co-Occurring Advisory Council was formed by the Commissioner of the Department. This Council developed recommendations that would help create the infrastructure within the state to assist with providing a comprehensive, continuous and integrated system of care for persons with co-occurring disorders. In 2009, the Division was renamed the Division of Behavioral Health. Formal steps have been taken by the KDBHDID towards the integration of mental health and substance abuse services across the Commonwealth. Currently, one staff position within the Division of Behavioral Health is dedicated solely to the development, implementation and monitoring of integrated mental health and substance abuse services across the Commonwealth.

Technical assistance was received from the Co-Occurring Center for Excellence (COCE) and from a Dual Diagnosis Capability in Addiction Treatment (DDCAT)/ Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) national trainer during SFY 09. A core team of integration specialists were trained to use the DDCAT/DDCMHT tools. Pilot sites were identified at four (4) Regional MH/MR Boards. These sites agreed to have their adult outpatient programs reviewed for co-occurring capabilities. During SFY 2010, four (4) baseline DDCMHT/DDCAT reviews were completed and three (3) follow-up assessments were done. In 2011 the Division moved on to the assessment of co-occurring capabilities in programs in the ten (10) remaining Regional Boards of the states fourteen (14) Regional Boards. The DDCMHT was used to evaluate nine (9) adult outpatient mental health programs and the DDCAT was used for two (2) adult outpatient substance use programs. One board chose to review both their adult mental health and adult substance abuse outpatient programs. All programs were offered the opportunity to use the data from their DDCAT/DDCMHT reviews to make changes using the Network for Improvement of Addiction Treatment (NIATx) process improvement model to raise any scores below the score of three (3), which is co-occurring capable. Each center formed a change team and submitted an implementation plan. During 2011-2012 all teams participated in monthly coaching calls with the Division co-occurring program administrator and a contracted NIATx coach. In May 2012 the participating programs presented their NIATx change projects in a meeting in Frankfort and received a \$6,000 incentive made possible by a Transformation Transfer Initiative (TTI) grant. At the final presentation meeting the teams were joined by Heather Gotham, co-creator of the DDCMHT, who worked with them to understand how to use the review data to become co-occurring capable in all seven (7) dimensions of the DDCMHT/DDCAT indexes.

In the current plan and budget applications for 2013 the Regional Boards are encouraged to complete a DDCAT assessment on at least one substance use disorder program and have a score of three (3), co-occurring capable, or adopt an action plan to raise their score to co-occurring capable.

One **unmet need** that has emerged from the DDCMHT/DDCAT reviews is a need for peer led mutual support groups specific to co-occurring disorders. The participating programs chose to concentrate their efforts on assessment, treatment, staffing, training and continuity of care and the Division offered to address the peer support and peer led group items on the DDCAT/DDCMHT indexes. An aspect of the TTI grant was to start three (3) Double Trouble in Recovery (DTR) groups in Kentucky. With grant funds the Division was able to support DTR groups with literature, meeting space and facilitation. Kentucky now has nine (9) DTR groups and has recently hired (for one year) a DTR peer support liaison to facilitate interested communities in starting DTR groups.

Fourteen (14) CMHCs have participated in DDCMHT/DDCAT reviews and two (2) Kentucky programs have been added to the National Focus on Recovery (FIT) treatment locator map. Two (2) DBHDID employees attended the International Reciprocity and Credentialing (IC&RC) conference on co-occurring disorders in Minneapolis in 2012. One (1) DBH employee participated in the CADC licensure workgroup crafting the bill to create a credential for recovery peer support specialists to work with individuals in recovery from addiction. That bill has been introduced in the current legislative session.

Plans/ goals for Co-occurring Disorders for SFY 2014/2015:

- To continue evaluating the capacity of state programs for providing co-occurring treatment in programs receiving behavioral health block grant funding. The current CMHC plan and budget applications require Regional Boards to become co-occurring capable and to use evidence based practices in their substance use and mental health programs;
- To require the Regional Boards report their use of validated screening and assessment tools as well as how they are applying the American Society of Addiction Medication – Patient Placement Criteria (ASAM-PPC) criteria. The ongoing DDCAT/DDCMHT review provide a means of mapping progress toward co-occurring capability;
- Continue using the DDCAT/DDCHMHT at the program level;
- Continue to support and facilitate new peer led mutual support groups;
- Continue to require the use of evidence based treatment practices;
- Support employment of registered peer support specialists for recovery; and
- Support co-occurring training for providers. Jeff Georgi will present on “co-mingling disorders” and treating specific co-occurring psychiatric disorders at the Kentucky School of Alcohol and other Drug Studies in July 2013.

**Unmet Needs** for this population include:

There is a gap between individual counseling for substance use disorders and group counseling for substance use disorders. None of the fourteen Regional Boards provide co-occurring intensive outpatient therapy and only one adult outpatient program has a co-occurring treatment group. Some programs are beginning to integrate substance use disorders and mental health disorders treatment and are finding a need for more cross training of staff and for more dually licensed staff.

Peer support for recovery from substance use disorders and co-occurring disorders is needed and beginning to be addressed with the filing of legislation to create a master's level license for substance abuse counselors that includes a new credential and process for registering peer support specialists for substance use disorder individuals.

**Data Sources Used:**

- SFY 2012/2013 Plan and Budget Documents
- DDCAT/DDCMHT <http://www.samhsa.gov/co-occurring/DDCMHT/index.html>  
<http://www.samhsa.gov/co-occurring/ddcat/>
- <https://nrepp.samhsa.gov/ViewIntervention.aspx?id=13>
- <http://www.niatx.net/Home/Home.aspx?CategorySelected=HOME>
- [www.integratedrecoverynow.org/resources/#IntegratedTreatmentDirectory](http://www.integratedrecoverynow.org/resources/#IntegratedTreatmentDirectory)

***Military Personnel and Their Families***

Soldiers/Veterans from the Kentucky National Guard are scattered across Kentucky's 120 counties and it is difficult for them to get behavioral health treatment when and where they need it. Most individuals are typically not located near a military base or a Veterans Administration (VA) Hospital. If Service members/Veterans live near a bordering state they may leave the state for treatment or they may seek treatment in Kentucky or hide their affiliation with the military while seeking treatment.

Service members and Veterans in Kentucky are seeking services at the Community Mental Health Centers (CMHCs) and private providers to keep the diagnosis and treatment information out of their military records. This is occurring because of the fear of stigma and hindering career advancement of the Service member. Often the individual is paying out of pocket and in cash to hide the visit from the military insurance.

Kentucky communities and behavioral health providers have recognized an increase in the number of Service members returning from Operation Enduring Freedom and Operation Iraqi Freedom with undiagnosed TBI and PTSD. As the need for TBI and PTSD treatment increases, the knowledge of resources will increase. As people become more aware of the resources, the assumption is that they will use the resources and get treatment. At the same time, as more resources are used, the service quality could experience a temporary decrease. As the resources are used, the resources become more fragmented which can decrease the service quality. Without new funding, resources and additional behavioral health staff in place to assist the Service members and Veterans as they return home our Heroes and their families will suffer.

At present military bases, military hospitals or the VA Hospitals are not able to share data or patient information with outside providers and sometimes with each other. If we want to reach the Service members or Veterans where they are we need to develop reciprocity between agencies. Some Service members and Veterans don't want to go to the VA Hospitals or military hospitals and therefore go untreated.

***Unmet Needs/Prevalence Data for this population:***

- Kentucky has 4.3 million residents with a Veteran population of 342,370.
- The Kentucky Veteran population under the age of 25 is approximately 9,000

- As of September 2012 there were 30,410 women Veterans in Kentucky that number is up 8,410 over the previous year of 22,000. Unfortunately women are not aggressive in seeking services as many do not consider themselves a Veteran.
- During the 2012 fiscal year, the Community Mental Health Centers (CMHCs) in Kentucky reported treating 766 active duty Service members.
- During the 2012 fiscal year, the CMHCs in Kentucky reported treating 2,151 Veterans.
- The Military and Veterans Administration Hospitals are under Presidential Order to increase the services and manpower needed to treat our Service members and Veterans. They have made great strides toward this goal but this is an **unmet need** Service members, Veterans and their families in Kentucky.

Veteran and Active Duty Counts by Region										
Region	FY2011					FY2012				
	Active Duty		Veterans		All Clients	Active Duty		Veterans		All Clients
	Count	Percent	Count	Percent		Count	Percent	Count	Percent	
01 - Four Rivers	56	0.61%	188	2.06%	9,124	50	0.54%	183	1.99%	9,191
02 - Pennyroyal	100	0.76%	221	1.68%	13,132	98	0.70%	313	2.24%	13,952
03 - River Valley	47	0.50%	39	0.41%	9,429	54	0.54%	50	0.50%	9,936
04 - Lifeskills	123	1.06%	46	0.40%	11,600	42	0.31%	59	0.44%	13,363
05 - Communicare	13	0.12%	138	1.26%	10,937	15	0.13%	139	1.17%	11,874
06 - Seven Counties	69	0.17%	269	0.68%	39,625	65	0.15%	290	0.69%	42,035
07 - NorthKey	43	0.43%	147	1.46%	10,064	40	0.38%	126	1.20%	10,470
08 - Comprehend	46	0.93%	59	1.19%	4,940	50	0.93%	82	1.52%	5,389
10 - Pathways	45	0.25%	281	1.59%	17,666	63	0.36%	285	1.63%	17,449
11 - Mountain	92	0.91%	63	0.62%	10,099	71	0.65%	63	0.58%	10,870
12 - Kentucky River	32	0.25%	39	0.31%	12,599	104	0.78%	76	0.57%	13,363
13 - Cumberland River	1	0.01%	164	0.91%	18,062	4	0.02%	7	0.04%	18,561
14 - Adanta	45	0.39%	200	1.73%	11,589	36	0.31%	166	1.43%	11,609
15 - Bluegrass	85	0.35%	366	1.53%	23,962	74	0.30%	312	1.26%	24,734
<b>State Totals*</b>	<b>797</b>	<b>0.39%</b>	<b>2,220</b>	<b>1.09%</b>	<b>202,828</b>	<b>766</b>	<b>0.36%</b>	<b>2,151</b>	<b>1.01%</b>	<b>212,796</b>
*State Totals may include duplicates when clients were seen in multiple regions.										
Report Date: August 22, 2012										

### **Operation Headed Home**

The Operation Headed Home (OHH) workgroup began in 2008 with a core group of just three (3) individuals and has grown to over one hundred (100+) members who are connected and committed to providing counseling, information, resources, and support to Service members, Veterans and their family members.

### **Operation Headed Home Conferences**

To date, DBH has hosted three (3) Operation Headed Home conferences and trained more than seven hundred (700+) individuals for FREE. We are currently working on the next OHH conference that will occur in October 2013. Conference participants and presenters include: Past and present military Service members, Veterans (all branches) and their families/caregivers, local, state and national leaders, subject matter experts, and those serving on the “front lines” of behavioral healthcare and supportive services. The conference will address the following identified needs: Traumatic Brain Injuries (TBI), Post Traumatic Stress

Disorder (PTSD), suicide prevention, reintegration, family and caregiver support, available resources and benefits, transitioning to work and school, polytrauma, polypharmacy, substance abuse prevention and treatment, and hearing loss and tinnitus from blast injuries. We estimate attracting over 300 attendees to this conference.

The upcoming conference will strive to strengthen the community-based resources for returning Service members, Veterans and their Families. We will focus on TBI, PTSD, suicide prevention and ways to identify additional access points for care. The resources, partnerships and funding opportunities gained after the previous conferences have helped to build relationships across the state and fill tremendous gaps. It has also laid the groundwork for future community collaboration around TBI, PTSD and suicide prevention in our state.

### ***Operation Immersion***

Operation Immersion will help to remove barriers and ease soldier apprehension to accessing treatment. The Kentucky Division of Behavioral Health and the Kentucky National Guard have teamed up to present a comprehensive four day training in military culture and issues unique to Service members, Veterans and their families. This training will immerse Behavioral Health Providers and Professionals in aspects of military culture and the deployment experience. Attendees will sleep in the barracks, participate in early morning physical training, chores and inspection, experience the Field Leadership Reaction Course, combat simulators unique to the military, network with military personnel and resource providers. In addition, workshops will be provided on TBI, PTSD, Suicide Prevention, Substance Abuse Prevention and Treatment, Trauma Informed Care and current best practices to treat military clients and their families.

Kentucky held its first Operation Immersion on November 14-16, 2012 at one of the Kentucky National Guard training sites. Seventy-five (75) behavioral health professionals attended this hands-on event to learn about military culture and learn about TBI, PTSD and suicide prevention. The event was so successful and meaningful that a second event was immediately planned for April 9-12, 2013.

### **Goals:**

1. Strengthen Kentucky's capacity to serve and support the military and Veteran population by increasing the number of clinical professionals trained in military/Veteran culture.
2. Equip behavioral health service providers and professionals with knowledge and skills that increase their ability to provide high quality care and support to military and Veteran populations.
3. Promote integrated care and support systems by connecting behavioral health providers and professionals with military and Veteran resources.

### ***Kentucky Policy Academy for Service Members, Veteran's and their Families***

Leaders from key agencies within Kentucky attended the Policy Academy for Service members, Veteran's and their families in Washington D.C. in September 2012. The Governor is promoting collaboration between all agencies in the Commonwealth to aid our Service members, Veterans and their families. This group meets on a regular basis and is working on legislation to aid our military and veteran populations in our state. One focus area is the lack of available data regarding the military populations and how they are being served in Kentucky.

### ***Kentucky's Military Data Workgroup -PARIS Match for Medicaid***

Kentucky's Military Data Workgroup was established as a sub group of the Kentucky Policy Academy with a charge to gather data and information. We knew that this would be a challenge to get all of the organizations to agree to share data due to HIPAA laws, and state and federal

regulations. However, we are drafting memorandums of understanding, memorandums of agreements and working across all levels of government to ensure that we will be able to share the data. The group has also identified ways to save state Medicaid dollars, possibly up to \$1.2 million dollars in the first year. This will be accomplished by using the Public Assistance Reporting Information System (PARIS) system. The PARIS system will allow us to identify Veterans that are receiving state Medicaid dollars and change their payer source to the Veterans Administration. Veterans should not notice a change in care, just a change in payer source.

### ***Garrett Lee Smith Suicide Prevention Grant***

As a result of the Garrett Lee Smith State/Tribal Youth Suicide Prevention grants, states, tribes and communities will:

- increase the number of persons in youth serving organizations such as schools, foster care systems, juvenile justice programs, trained to identify and refer youth at risk for suicide
- increase the number of health, mental health, and substance abuse providers trained to assess, manage and treat youth at risk for suicide
- increase the number of youth identified as at risk for suicide
- increase the number of youth at risk for suicide referred for behavioral health care services
- increase the number of youth at risk for suicide who receive behavioral health care services
- increase the promotion of the National Suicide Prevention Lifeline

State/Tribal Youth Suicide Prevention Grants are authorized under the Garrett Lee Smith Memorial Act (Section 520E-1 of the Public Health Service Act, as amended). This announcement addresses Healthy People 2020 Mental Health and Mental Disorders Topic Area HP 2020-28 and SAMHSA's Strategic Initiative: Prevention of Substance Abuse and Mental Illness - Goal 1.3 (Prevent suicides and attempted suicides among populations at high risk, especially military families, youth, and American Indians and Alaska Natives (AI/AN)).

The current plans for SFY 2014/2015 are to continue to expand the efforts mentioned above. As the base of knowledge increases and expands to treat TBI and PTSD, we will adapt accordingly to offer the current best practices to professionals and providers. Our plans include providing the OHH conference once per year and alternating the location between a military base (Fort Knox or Fort Campbell) and a public facility. We want to provide trainings to the different regions across Kentucky. Operation Immersion will be held two times per year once in the Fall and once in the Spring. We are hopeful that the bond between the Kentucky National Guard and our organization continues to grow in order to serve the Heroes that deserve our help.

### ***Preparations for a Website***

A central access point for resources in Kentucky is being considered and a website may serve as a possible solution. The site will provide information for State and National resources and possibly provide training for providers in Kentucky. This should be similar to the nationally known program called "Network of Care."

### ***Changing Provider Contract Language***

DBH will be inserting language into our Community Mental Health Centers contracts that require CMHC to send key employees to free military training events to gain perspective and insight into treating the Service members, Veterans and Military families.



**Data Sources Used:**

- [http://factfinder2.census.gov/faces/nav/jsf/pages/community\\_facts.xhtml](http://factfinder2.census.gov/faces/nav/jsf/pages/community_facts.xhtml) U.S. Census Bureau| American FactFinder
- [http://www.va.gov/vetdata/docs/Maps/VetPop11\\_Under25.pdf](http://www.va.gov/vetdata/docs/Maps/VetPop11_Under25.pdf) U.S. Department of Veterans Affairs
- <http://www.va.gov/vetdata/Maps.asp> U.S. Census Bureau
- [http://www.va.gov/vetdata/Veteran\\_Population.asp](http://www.va.gov/vetdata/Veteran_Population.asp),  
<http://www.va.gov/vetdata/Report.asp> U.S. Department of Veterans Affairs, The National Center for Veterans Analysis and Statistics (NCVAS)
- DBHDID Client Event Data Set

**Substance Abuse Prevention**

Many of the gaps identified in the last Prevention Block Grant Plan were either partially or wholly realized through our State Prevention Enhancement (SPE) Grant and the State Epidemiological Outcomes Workgroup (SEOW) grant. The SPE grant, aimed at strengthening state prevention capacity, ended in June 2012. The SEOW grant, scheduled to last until September 2013 was relinquished as a prerequisite to qualifying for SAMHSA's Partnership for Success (PFS) funding.\*

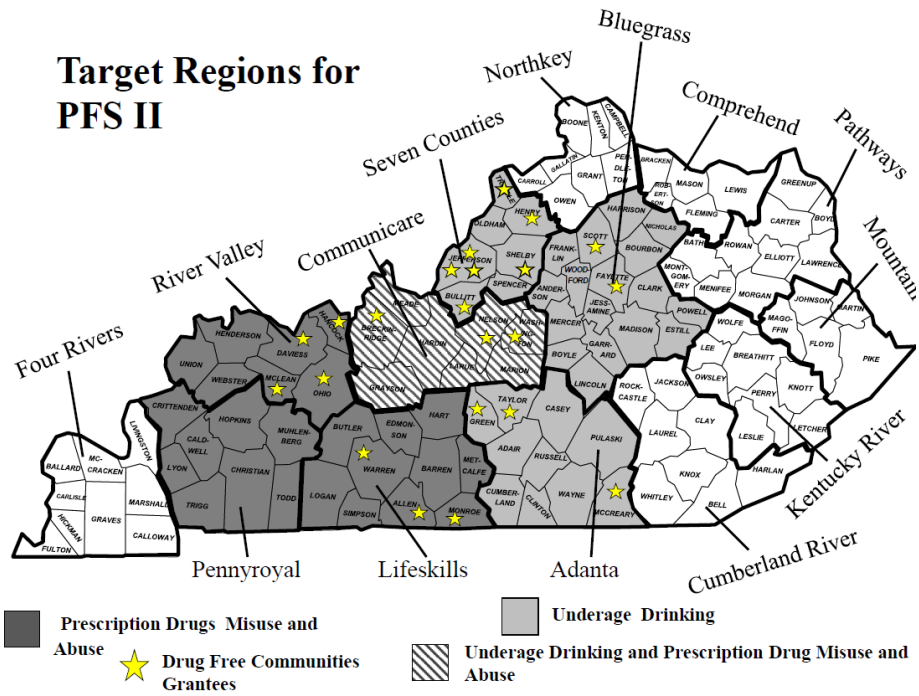
In October of 2012 the Substance Abuse Prevention Branch of the Division of Behavioral Health was one of 15 States/Territories to be awarded a SAMSHA's Partnership for Success (PFS) II grant. All PFS recipients are required by SAMSHA to utilize the Strategic Prevention Framework to plan and implement strategies aimed at reducing the consequences associated with underage drinking (UAD) and prescription drug (Rx) abuse. Since the focus of the PFS is very similar to pre-existing underage drinking and prescription drug components of our prevention block grant plan covered under our Changing Social Norms and Policy (CSNaP) initiative, there is much overlap between the two. The additional financial and technical assistance resources that the PFS affords will allow Kentucky to pursue these existing block grant goals more thoroughly and more systematically. If you will, the PFS is like a new motor in an old vehicle whose destination has already been set.

The PFS is a three year grant, scheduled to run until September 30, 2015, thus covering the time frame for this Block Grant planning period. Globally, the goal of the PFS and of our Rx and UAD block grant goals are to achieve a statewide reduction of past 30 day consumption of both of these substances. The information below provides more detail on the needs assessment activities, capacity building goals and types of activities and strategies that will be implemented.

As a requirement of the PFS application the SEOW was required to conduct a needs assessment to determine communities of high priority. Unlike past SAMSHA grants, where community was defined by the county boundaries, the PFS defines community on the much larger regional scale. The SEOW identified seven regions of need for UAD and Rx. These target regions are identified on the map below.

The SEOW utilized a number of data sources to determine regions of high need. The two principle sources that informed the SEOW findings were Kentucky Incentives for Prevention (KIP) Survey 2010 data and the 2011 Youth Risk Behavior Survey (YRBS).

## Target Regions for PFS II



**Table 2: Weighted prevalence of alcohol and prescription drug abuse among Kentucky high school students, YRBS 2011**

Characteristics	Any Alcohol	Binge	Prescription Drugs <sup>1</sup>
	%	%	%
<b>Total</b>	34.6	23.2	19.0
<b>Gender</b>			
Male	35.6	24.8	20.6
Female	33.4	21.2	17.0
<b>Grade</b>			
9 <sup>th</sup>	23.3	13.5	15.1
10 <sup>th</sup>	31.8	21.8	16.3
11 <sup>th</sup>	41.0	26.7	24.4
12 <sup>th</sup>	44.1	32.0	20.9
<b>Race/Ethnicity</b>			
White	35.2	24.2	20.4
Black	23.7	10.3	11.8
Hispanic	50.6	37.2	21.6
Other	34.9	21.3	24.2
<b>Mental Health<sup>2</sup></b>			
Depression	43.6	29.3	32.5
Bullied	40.1	26.8	29.6
Suicide Attempt	50.1	34.3	40.5

<sup>1</sup>Lifetime use of OxyContin, Percocet, Vicodin, Adderall, Ritalin, or Xanax

<sup>2</sup>Experienced in the past 12 months

The distribution of prevalence rates for alcohol intoxication and associated risk and protective factors from the 2010 KIP Survey are summarized in Table 3 by region. Table 4 provides similar data for prescription drug abuse.

**Table 3: Prevalence of alcohol-related indicators among Kentucky adolescents by Regional Prevention Center district, KIP 2010**

RPC Region	Type of Alcohol Abuse			Risk & Protective Factors		
	Intox	Binge <sup>1</sup>	Any	Early Abuse <sup>2</sup>	Access <sup>3</sup>	Disapproval <sup>4</sup>
	%	%	%	%	%	%
Kentucky	11.2	9.5	17.4	3.1	23.4	6.7
Adanta	11.4	9.5	17.5	3.4	24.7	7.6
Cumberland River	8.7	7.4	13.7	2.8	21.8	5.9
Bluegrass	12.0	9.8	18.0	2.6	23.3	7.8
Comprehend	10.6	9.9	17.0	4.1	24.4	6.4
Northkey	11.3	9.6	17.8	3.4	23.5	6.0
Communicare	13.0	11.1	20.8	3.4	26.0	7.5
Pathways	10.8	9.4	16.5	3.0	22.9	6.7
Seven Counties	13.2	11.0	21.0	2.7	24.1	7.2
Lifeskills	10.6	9.3	13.7	3.3	22.1	7.8

<sup>1</sup>Binge drinking during the past 2 weeks

<sup>2</sup>Began drinking regularly, at least one or twice a month, at age 12 or younger

<sup>3</sup>Reported very easy access to getting some beer, wine, or hard liquor

<sup>4</sup>Reported not wrong at all for someone their age to regularly drink beer, wine, or hard liquor

RPC Region	Prescription Drug Type <sup>1</sup>				Risk & Protective Factors	
	Oxy	Tranq	Speed	Any	Access <sup>2</sup>	Disapproval <sup>3</sup>
	%	%	%	%	%	%
Kentucky	1.0	1.5	0.9	2.8	5.6	1.7
Adanta	0.9	1.6	0.8	2.8	5.3	1.5
Cumberland River	1.0	1.4	0.7	2.6	5.8	1.4
Bluegrass	0.9	1.4	0.7	2.7	5.9	1.8
Comprehend	1.3	0.9	0.5	2.5	5.1	1.7
Northkey	1.3	1.6	1.0	2.7	6.0	1.8
Communicare	1.3	2.0	0.9	2.9	4.6	1.8
River Valley	0.9	1.7	1.2	3.5	5.3	1.9
Four Rivers	1.0	2.0	1.3	2.9	6.1	1.9
Pennyroyal	0.9	1.5	1.1	3.3	6.8	1.9
KY River	0.5	0.8	0.6	2.3	5.7	1.6
Mountain	0.5	0.8	0.4	1.7	6.0	1.4
Pathways	0.8	1.0	0.7	2.0	5.8	1.8
Seven Counties	1.1	1.8	1.1	3.2	4.1	1.6
Lifeskills	1.4	2.1	0.8	3.6	5.6	1.9

<sup>1</sup>Reported use on one or more occasions in the past month

<sup>2</sup>Reported very easy access to getting cocaine, LSD, or amphetamines

<sup>3</sup>Reported not wrong at all for someone their age to use LSD, cocaine, or other illegal drugs

Changing Social Norms and Policy, as the title suggests, focuses on environmental strategies that aim to change norms around acceptability of usage and limit availability of access. Regions that are concentrating on prescription drugs will concentrate their efforts primarily on:

- Correcting three (3) youth misperceptions about prescription drugs - that they are: 1.) safer than street drugs, 2.) less addictive than street drugs, 3.) OK to share among friends and family
- Safe storage and disposal of prescription drugs
- Support for new Kentucky legislation which licenses pain clinics and mandates the use of the Kentucky All Scheduled Prescription Electronic Drug Reporting (KASPER) system for all doctors in the state
- Conducting large scale informational efforts directed at parents, caregivers and prescribers of prescription drugs

Regions that are concentrating on Underage Drinking (UAD) binge drinking will focus primarily on:

- Limiting social and retail access of alcohol to underage youth through establishment of Social Host Ordinances, or strengthening enforcement of these ordinances in counties where they already exist.
- Retail access strategies such as shoulder taps and compliance checks.
- Expanding and intensifying the "I Won't Be the One" campaign – a large scale informational efforts at older adults about the legal and health consequences of providing alcohol to underage youth.

Additionally, the PFS will seek to strengthen prevention capacity/infrastructure at the State and community levels for addressing underage drinking, prescription drug misuse and abuse and for promoting mental health.

Kentucky's PFS proposal also embraces three (3) of the four (4) prevention goals of SAMSHA's Strategic Initiative # 1 which are already long term goals of our Block Grant plan. Briefly, those goals are:

- With primary prevention as the focus, build emotional health, prevent or delay onset of, and mitigate the symptoms and complications from substance abuse and mental illness
- Prevent or reduce the consequences of underage drinking
- Prevent or reduce the consequence of prescription drug misuse and abuse

\*As per the criteria of the PFS Request for Proposals (RFP), states awarded PFS funding must give up the remainder of the SEOW funding. SAMHSA's expectation is that PFS funding can be used to support the SEOW throughout the PFS grant cycle.

Many of the gaps that were identified in our prevention infrastructure will require long term effort to fill. Below is a list of the gaps that were included in last year's report and a bolded update on what has been done to address them.

Need to focus more efforts on diverted prescription drugs and underage drinking, both of which emerged as priorities in the most recent SEOW needs assessment;

**Status: As described above, a large part of our UAD and Rx efforts have been rolled into our PFS grant. Carry over block grant funding has also been provided to the Regional**

**Prevention Centers (RPC's) not covered in the PFS so that all counties of the state are served.**

The capacity for engaging with behavioral health issues (e.g. indicators of social, emotional, and behavioral well-being) is minimal and has not received emphasis heretofore;

**Status:** In 2012 the state offered three (3) Statewide trainings that addressed the integration of mental health and substance abuse. The Integration of Mental Health and Substance Abuse Prevention, facilitated by Michael Compton, drew 117 participants from Regional Prevention Centers, Community Mental Health Centers and private treatment providers. Seventeen (17) state staff from the Division of Behavioral Health also attended.

There is a need for a more systematic and comprehensive system for disseminating information about Evidence Based Practices (EBP) and Programs and for providing related training and technical support to the field. Kentucky proposes to form an Evidence-based workgroup to help translate the findings of the SEOW with meaningful and appropriate preventive interventions at community level;

**Status:** An Evidence-Based Practices Workgroup was formed last year and has met several times. The workgroup created two (2) very useful training tools related to community capacity building: 1) Understanding the Strategic Prevention Framework - an instructional poster explaining of the five (5) steps of the SPF in everyday language that volunteer community members are more likely to understand. 2) "The Process" a training DVD which elaborates and dramatizes the utility of community-level strategic planning with a particular focus on the SPF.

There is a need for renewed effort toward integrating and focusing limited resources in high-need communities. This will require broad systemic effort at the state level, but also focused coordination and planning at the community (regional) level with the full engagement of stakeholders;

**Status:** The SEOW identified seven (7) regions (55 counties) of high need in its PFS application. Resources have been directed to these regions to conduct additional needs assessments and to begin strategic planning. State prevention staff are looking at ways that block grant allocations to RPCs might be reformulated based on need and performance. Revision of the RPC work plans, which was just completed, is the first step in this process. We are also working with a team of out-of-state experts to see how other states have tackled this problem.

There remain some major gaps in terms of problems and populations, including the state's growing Hispanic population, adult substance abuse (especially older adults), emerging adults in the 18-24 age range, data on substance abuse and mental health difficulties in the workplace, LGBTQ youth and military families and children (Kentucky hosts two (2) of the nation's largest military posts: Fort Knox and Fort Campbell). There is a need for data development in these areas;

**Status:** In July of 2012 The Division of Behavioral Health hosted an LGBTQ2S Training which drew seventy-on (71) participants – ten (10) state staff from the Division of Behavioral Health, as well as a number of Regional Prevention Center staff and community coalition members. State staff participated in a LGBTQ2S work group which

conducted a needs and resource assessment for this population and drafted a work plan. Plans are currently underway to expand the workgroup to include branches of the entire Department.

The Faith Hope Future Conference which targeted risk factors for substance abuse and behavioral health among the military and their families drew seventy-seven (77) participants. The conference focused on such issues as mental and spiritual health injuries; Post Traumatic Stress Disorder; Post Traumatic Spiritual Disorder; Traumatic Brain Injuries; Military Sexual Trauma; spousal and child abuse; depression, substance abuse, and adjustment disorders. Eleven (11) RPC Staff and two (2) DBH staff attended.

There remain significant issues with respect to Appalachian life and culture that must be considered when targeting those geographic areas;

**Status: This issue has been discussed at Regional Prevention Center Directors meetings and at Evidence-based Work group meetings, but as of yet there are no milestones or outcomes to report.**

Need to update and expand the functionality of Kentucky's Data Warehouse (e.g., mapping and charting capacities), improve its attractiveness and usability (e.g., data visualization, infographics), and provide much more extensive training and support in its use within active planning processes;

**Status: This gap has been fully addressed. The data warehouse has been expanded to include mental health indicators, mapping and graphing features have been enhanced and three (3) training videos have been added "Public Health: Telling the Story Using Data", "Translating Data into Public Health Priorities", and "Introduction to Epidemiology".**

Several areas that need strengthening through workforce development and training include: (1) basic knowledge about the SPF framework; (2) knowledge and skills in planning processes, including data integration and goal formulation; (3) more knowledge about EBPs in prevention and the capacity to thoughtfully select strategies; (4) skill in data distillation and synthesis for the purposes of planning and evaluation; (5) skill in program management and implementation; (6) general knowledge and skills related to program evaluation, including instrument design, data analysis, and portrayal; (7) skills related to coalition-building; and, (8) skill in utilizing the enhanced data warehouse.

**Status: Gaps 4, 5, and 8 have been partially filled by the data warehouse training modules mentioned above. The PFS Project Director and Coordinator have scheduled training with the developers of the data warehouse to familiarize themselves with the new features. We are looking at the possibility of conducting a webinar for RPC staff and local coalitions on how to use the new data warehouse.**

**Prevention Goals for SFY 2014/2015**

Priority	Goal	Strategy	Performance Indicator	Target Population	Status
With primary prevention as the focus build emotional health, prevent or delay onset of, and mitigate symptoms and complications from substance abuse and mental illness.	Integrate the prevention of mental illness into state and local substance abuse prevention efforts as appropriate.	Provide training to Prevention staff state and regional regarding strategies/ resources to address the prevention of mental illness, including cultural training on high risk population, LGBTQ & military & Native American  Include relevant mental health data as indicated in the KY SEOW Epi-profile to the data warehouse	Number of trainings provided, number of state and RPC staff trained. Increased knowledge of mental illness prevention as measured by training evaluations.  The number of mental health promotion activities performed by the RPCs as measured by the prevention data set.	RPC Staff and Prevention Professionals	Ongoing In 2012 the state offered three (3) Statewide trainings that addressed the integration of mental Health and Substance Abuse. One hundred seventeen (117) RPC and CMHC staff attended. (SFY 2012)
Prevent or reduce consequences of underage drinking	Reduce state 10 <sup>th</sup> grade, 30 day binge drinking rate by at least 1% . KIP 2012 survey will be used as a baseline. KIP 2014 data will be used to measure outcomes.	Supporting/strengthening the enforcement of existing laws regarding adults providing alcohol to minors.  Implement local policies that target social access of alcohol to youth (social host & unruly gathering ordinances)	Increase in enforcement of UAD laws as measured by local law enforcement data and reports to coalitions  An increase in RPC time spent on UAD environmental strategies as measured by the prevention data set.  Number of policies developed	9 <sup>th</sup> -10 <sup>th</sup> grade youth in targeted counties  Parents & community at large.	Ongoing until September 30 <sup>th</sup> 2015. Applied for and was granted CSAP's PFS – a grant that specifically focuses on UAD and Rx. The PFS grant will be used to fund this goal. A needs assessment has been conducted which identified seven (7) regions of high need. Target regions are currently in the planning process. (SFY 2012)
Prevent suicides and attempted suicides among populations at high risk.	Integrate the prevention of suicide among high risk populations into state and local substance abuse prevention	Provide training to state and regional level prevention staff on the need for, and strategies and resources to address, suicide prevention, including cultural training on high risk population (LGBTQ, Native American and military families).	Number of trainings provided, number of state and RPC staff trained.  Increased knowledge of suicide prevention strategies and of the high risk populations as measured by training evaluations	RPC Staff and Prevention Professionals	Ongoing RPC staff have received QPR Suicide Prevention Training. Some RPCs have hosted this training for local coalitions. (SFY 2012)

Priority	Goal	Strategy	Performance Indicator	Target Population	Status
	efforts as appropriate.		Number of suicide awareness activities conducted by the RPCs as measured by the Prevention Data Set		
Reduce prescription drug misuse and abuse	Increase in parental awareness of youth Rx drug abuse  Reduce state 10 <sup>th</sup> grade 30 day Rx drug abuse. KIP 2012 survey will be used as a baseline. KIP 2014 will be used to measure outcomes.	Parental Rx education & awareness programs that stress proper storage, monitoring and disposal of Rx drugs.  Determine three (3) main misperceptions of students garnered from RPC Conducted focus group information around Rx drug misuse. Enlist the partnership of local high schools to participate in a youth contest that develops media messages that address of the three (3) identified misperceptions.	Number of flyers delivered, number of distribution points as measured in the prevention data set. Increase in RPC time of spent on environmental strategies relating to Rx drugs in selected counties, as measured by the Prevention Data Set.  Number of contest winners  Number of youth who see the media messages	Adults in the community  9 <sup>th</sup> Graders in targeted counties	Ongoing until September 30 <sup>th</sup> 2015. Applied for and was granted CSAP's PFS – a grant that specifically focuses on UAD and Rx. The PFS grant will be used to fund this goal. A needs assessment has been conducted which identified 7 regions of high need. Target regions are currently in the planning process. (SFY 2012)
Reduce prescription drug misuse and abuse	Expand indicators related to prescription drug abuse	Revise KIP Survey to include questions on perceived availability peer usage, perception of risk of Rx drugs and favorable attitudes toward Rx drugs.	# of new questions added to KIP concerning prescription drug abuse and misuse	6 <sup>th</sup> , 8 <sup>th</sup> , 10 <sup>th</sup> and 12 <sup>th</sup> graders	<b>Completed (SFY 2012)</b>
Reduce access of tobacco products to underage youth	A decrease of two (2) percentage points in perceived availability of tobacco products to underage youth in 6 <sup>th</sup> , 8 <sup>th</sup> , 10 <sup>th</sup> 12 <sup>th</sup>	Develop a tobacco vendor education program consistent with new FDA guidelines.  Begin phase I of tobacco retail licensing initiative  Issue report on Reward and Remind outcomes	Number of students who respond “very hard” or “sort of hard” to the question “ If you wanted to get some cigarettes how easy would it be for you to get some “ or (KIP Survey 2012)	Tobacco Retailers  Tobacco Retailers	KIP 2012 survey results are not yet available. Once they are made available we will compare tobacco availability data for 2010 and 2012. Tobacco Vendor Training was developed in SFY 2011 and launched in SFY 2012



Priority	Goal	Strategy	Performance Indicator	Target Population	Status
	Increased knowledge of Synar program, methodology goals and outcomes and KY youth tobacco use trends.	and lessons learned to RPC Staff and partner agencies  Organize an annual Synar conference ,  Regular e-mail updates to field	Distribution of report  Evaluation results from conference  # of participants at conference	State and RPC staff, and agency stakeholders  RPC staff and Prevention Professionals	<b>Completed (SFY 2012)</b>
Smokeless tobacco	Increase state-level smokeless tobacco prevention efforts	Update RPC's and prevention professionals on current smokeless data trends, and related information.  Increase resources to address Smokeless tobacco.  Work with ABC to increase number of smokeless tobacco compliance checks	Number of email updates  Number of smokeless tobacco presentations, made at RPC meetings, and other prevention venues  Number of Smokeless related e-mails sent to RPC staff and other prevention professionals.  Number of new resources created or existing resources made available to RPC's and Prevention Professionals.  Number of smokeless tobacco checks performed by ABC during FFY 2012	RPC Staff and Prevention Professionals  RPC Staff and Prevention Professionals  RPC Staff and Prevention Professionals  Tobacco Vendors	Ongoing (3 presentations given)  Tobacco Prevention Enhancement Site created "Smart Mouth," A prevention curriculum that targets youth smokeless tobacco use. (SFY 2012-13)
Make the data warehouse a more useful prevention	Update and expand the functionality of the KY data				<b>Completed (SFY2012)</b>

Priority	Goal	Strategy	Performance Indicator	Target Population	Status
planning tool	Warehouse				

### Prevention Block Grant Goals for 2014-2015

Priority	Goal	Strategy	Performance Indicator	Target Population	Status
Smokeless Tobacco Use	Increase the number of Synar inspections for smokeless tobacco.	Revise Synar inspection protocol smokeless tobacco and submit to CSAP for approval.	Number of Synar smokeless checks in 2012 compared to 2013	Tobacco vendors	
Smokeless Tobacco	Track # of smokeless checks done through ABC tobacco inspections and monitor retail violation rate	Modify ABC tobacco inspection form to distinguish smokeless inspections from cigarettes (Currently there is no information on the ABC inspection sheet to differentiate smokeless from cigarettes. .So we do not know how many violations are for smokeless)	Establishment of a baseline for number of smokeless checks performed  Establishment of a baseline retail violation rate for annual ABC smokeless checks.	Tobacco vendors	
Cigarettes and smokeless tobacco	Increase the number of Kentucky Tobacco retail clerks who have received TRUST training	Develop Marketing campaign to advertise TRUST.	Increase in number of tobacco retailers trained in 2013 compared to 2012.	Tobacco vendors	

Tobacco	Support Departmental efforts to implement smoking cessation in substance abuse and mental health treatment facilities	<p>Identify stakeholders, Compile the latest research on best practices for implementing smoking cessation in mental health and substance abuse treatment settings</p> <p>Collaborate with other departmental contacts to form a work group to synthesize research, and draft a work plan.</p>	<p>Formation of a mental health and substance abuse treatment smoking cessation workgroup.</p> <p>Compilation of research</p> <p>Formation of mental health substance abuse treatment smoking cessation workgroup</p> <p>Drafting of workgroup recommendations for addressing tobacco addiction among those with mental health and substance abuse problems.</p>	Persons suffering from mental health and substance abuse	
Strengthen state prevention infrastructure	Increase capacity of RPC staff to train communities on the Strategic Prevention Framework	Conduct workshops for all RPC's on the SPF process. Focus of the workshop will be how to overcome real life challenges that occur as communities implement the SPF.	<p>Number of RPC Staff and coalition members trained on the SPF.</p> <p>Number of RPC Staff who report they are comfortable using the SPF process. Number of counties that RPC staff report are using the SPF process effectively as compared to a 2012 baseline survey</p>	RPC Directors and Staff	

<p>Data Reporting</p>	<p>Improve quality of data reported into the Prevention Data System by RPC staff across the state</p>	<ol style="list-style-type: none"> <li>1. Convene a statewide work group of RPC representatives focused on Prevention Data, reviewing modules or themes of information collected in the Prevention Data System, making recommendations for improvements (Nov 2012 to Dec 2013)</li> <li>2. Address the number of elements used for capturing data into the prevention data system, ensuring a connection between elements and reporting purposes (Jan to Apr 2013)</li> <li>3. Review data (modules of services/activities, programs, participants) for clear understanding of barriers to reliable data, providing information and training sessions for branch staff and RPC staff (Nov 2012 to Dec 2013)</li> </ol> <p>Develop a series of</p>	<ol style="list-style-type: none"> <li>1. Data elements include ways to gather effective or short-term outcomes</li> <li>2. Process outcomes are more reliable and verifiable</li> <li>3. Data Manual is updated to reflect improvements</li> <li>4. RPC staff self-report improved</li> <li>5. Data review of modules or themes indicate improved use of the Prevention Data System by RPC staff through connecting data pieces, which indicate improved reliability of data</li> </ol> <p>Reports produced provide performance measures to RPC staff.</p>		
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		reports that are performance and process oriented for RPC staff to use in their strategic planning and work (July to December 2013)			
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**Data sources:**

- The (KIP) Kentucky Incentives for Prevention Survey (modeled after the Monitoring the Future Survey and conducted in grades 6,8,10,12). KIP is implemented every two years on even numbered years. Approximately 150 out of 170 school districts across the state participate in the KIP survey;
- Behavioral Risk Factor Surveillance System (BRFSS);
- CDC Wide-ranging Online Data for Epidemiologic Research;
- National Survey on Drugs and Health (NSDUH) is an annual survey that collects comprehensive information on substance abuse and mental health. Two-year prevalence rates from the NSDUH are used based on small area estimation procedures that combine state-level data with a national model. Like the KIP and MTF, the NSDUH asks respondents about past-month alcohol and tobacco use. For nonmedical use of pain relievers, illicit drug abuse/dependence, and alcohol abuse/dependence, prevalence rates are based on the past year;
- Kentucky All Scheduled Prescription Electronic Reporting System (KASPER) tracks controlled substances dispensed in Kentucky. Data are primarily intended for physicians, pharmacists and law enforcement officials;
- Kentucky Cancer Registry (KCR) is the centralized population-based cancer registry for the Commonwealth of Kentucky. Mandatory reporting to KCR began in 1991;
- Dartmouth Atlas of Healthcare (DAHC) documents variations in how medical resources are distributed and utilized;
- The Gallup-Healthways Well-Being Index Survey (WBI) surveys roughly 1,000 Americans a day, 350 days a year about health and well-being. Based on their responses individuals and communities receive an overall well-being composite score and a score for each of six sub-indices including life evaluation, emotional health, physical health, healthy behavior, work environment, and basic access; and
- The United States Census Bureau.

**Substance Abuse Treatment**

***Women who are pregnant and have a mental health and/or substance use disorder***

In Kentucky, pregnant women are the only adult population with a Medicaid benefit covering substance abuse treatment and prevention. Pregnant women are identified as a priority population in accordance with Center for Substance Abuse Treatment (CSAT) regulations. The CMHCs screen at initial contact and provide care within twenty-four (24) hours, the remainder within forty-eight (48) hours.

Kentucky has four (4) publicly funded substance abuse programs designed specifically for pregnant women.

1. KIDS NOW Plus (KN+) Substance Abuse and Pregnancy Program provides Universal and Selective Prevention education and identifies, assesses, and links pregnant and postpartum women to addiction and/or mental health treatment, case management, and other community resources. Engaging women in intensive case management provides an opportunity to increase readiness for treatment. Evidence Based Practices (EBP) used include Screening, Brief Intervention, Referral and Treatment (SBIRT), Intensive Case Management, Motivational Interviewing, and Motivational Incentives. In SFY 2012 the following services were delivered to pregnant women:
  - i. Universal prevention to 1,593 women;
  - ii. Selective and Indicated Prevention to 217 women;
  - iii. Intensive case management to 536 women.

KN+ staff are working with the MCOs to make their services more available to the women in the state.

2. **Project LINK** provides intensive case management to pregnant and postpartum women in the Louisville area. KIDS NOW Plus provides their services in the six surrounding counties. The program offers outreach and case management services designed to identify, assess, and link pregnant and postpartum women to addiction treatment, case management, and other community resources.
3. **PRIDE Program** provides outpatient services for pregnant women in Lexington/Fayette County.
4. **Independence House** provides long term residential substance abuse treatment and case management for women during pregnancy. Located in Corbin, in Southeastern Kentucky, it serves women from all over the state.

Four (4) additional long term residential treatment programs and eleven (11) short term (approximately 30 days) residential programs accept pregnant women. Only one (1) residential program accepts pregnant adolescents.

Intensive outpatient treatment is available in eleven (11) of the fourteen (14) regions for pregnant women and in four (4) regions for pregnant adolescents. Four (4) of the residential programs that accept pregnant women (including Independence House) also accept the woman's dependent children.

University of Kentucky Medical Center in Lexington has a high risk pregnancy clinic that provides medical detoxification and/or stabilization on methadone for those who will be able to continue in medication assisted treatment upon returning home. The University of Louisville Hospital also has a NICU for stabilization of babies. All eleven (11) Opiate Treatment Centers accept pregnant women and all (including the nine (9) private programs) consider pregnant women a priority population. They all coordinate well with hospitals that provide medical stabilization on methadone for pregnant women.

The CMHCs typically did not ask about pregnancy on first contact even though this is a priority population. This was changed with the SFY 2013 contract. Each CMHC now has a set protocol for asking about pregnancy at first contact with new female clients. This includes adolescents. Therefore the consistency of immediate admission has increased.

Due to increased monitoring of prescription drug sales through the KASPER program, there has been a reduction in **prescription opiate abuse**. The consequences have caused a significant

increase in the use of heroin. Epidemic levels of heroin use have caused an increase in overdoses. NAS, neonatal abstinence syndrome, has become a house hold term in the public due to media coverage. The NICUs in the state have seen an increase in the number of babies being served. Carry over funds from SFY 2013 will be used to provide additional medication assisted treatment for 25-30 pregnant women for SFY 2014. The Northern part of the state has been particularly hard hit with the heroin addiction. They have received funds this fiscal year and will next fiscal year to meet the need of pregnant women.

The Division of Behavioral Health (DBH) **Trauma Informed Care Initiative** is continuing in SFY 2014. Training for CMHCs will continue at the Kentucky School of Alcohol and Other Drug Studies. Seeking Safety, an EBP standardized trauma treatment for co-occurring trauma and substance abuse, continues to be emphasized in the CMHCs. It is primarily used with women.

An internal work group met to develop the goals/implementation strategies around SBIRT. The state recognizes that this is imperative in order to meet the needs of pregnant women in KY. Implementation will begin in SFY 14-15 in collaboration with the KY Guard.

The **Perinatal Depression Project** the Department for Public Health (DPH), and DBHDID initiated in 2007, continues to be successful and ongoing even with the end of the funding. The health departments are adding a pregnancy specialist at each center. They will assist with referrals for pregnant women. DBHDID programs described above have collaborative relationships with DPH, Administrative Office of the Courts (AOC), the Department of Education's Family Resource and Youth Services Centers (FRYSCs), Department for Community Based Services (child protective services) as well as private OB/GYNs.

***Unmet needs/prevalence data/sources for this population include:***

- Using **national prevalence estimates and outdated state surveys**, an estimated 11.6% of pregnant women use alcohol at some point in their pregnancies and approximately 3.9% use illicit drugs. There were 58,376 live births in Kentucky in 2008 (CDC). If 11.6% of pregnant women used alcohol or drugs, then approximately 6,772 infants were born prenatally exposed. The number of pregnant women who received substance abuse services at the fourteen (14) CMHCs during SFY 2013 was 1,120, or 16% of pregnant women who needed or are estimated to have needed services.
- A new statewide prevalence study for substance use during pregnancy continues to be needed. The most recent study was in 1990.
- Even with the pregnancy and postpartum Medicaid benefit, funding for residential substance abuse treatment is minimally available to pregnant women due the federal Medicaid regulation requiring facilities to have a maximum of sixteen (16) beds. The benefit also extends only to 60 days postpartum, leaving new mothers without resources for supportive services during the crucial first three (3) years of the child's life.
- Although effective screening of pregnant women for substance abuse by medical providers is minimal in Kentucky, the state, in collaboration with other agencies, has developed an implementation plan for SBIRT with pregnant women.
- Medicaid has changed to a managed care system. Medicaid billing for pregnant women has dropped in half during the first half of SFY 2013. The KIDS NOW Plus program is working with one of the Managed Care Organization (MCOs) to increase effective programming for pregnant women.

- Due to fears of losing custody of their children, as well as repeated incidences of arrests and efforts to enact legislation criminalizing substance use by pregnant women in Kentucky, many women do not feel safe disclosing their need for help.
- Public schools do not currently provide prevention education related to substance use during pregnancy.
- Substance Abuse treatment programs do not currently provide prevention education related to pregnancy and substance abuse.

**Unmet Needs:**

Additional treatment resources are needed for pregnant women, especially outside of the “Golden Triangle” of the three largest cities (Louisville, Lexington and Covington). Funding for the two specialized pregnancy programs that serve a wide geographic area, KIDS NOW Plus and Independence House, is not secure: 73% of KIDS NOW Plus funding is allocated annually by the Governor’s office of Early Childhood Development with Tobacco Settlement Funds. Independence House’s SAMHSA Pregnant and Postpartum Women grant ended in October, 2011. Current funding for KIDS NOW Plus is insufficient, affording only twelve (12) case management FTEs and five (5) Prevention FTEs who serve eight (8) of the twelve (12) CMHCs.

27.4% of pregnant women in Kentucky smoke. Other than the 1-800-Quit Now, a national help line for smokers, a minimal number of smoking cessation services are available to pregnant women in Kentucky.

***Priorities for SFY 2013/2014:***

- Continue to monitor and correct the CMHCs compliance with screening for pregnancy on the first contact, through site visits and sample intake phone calls;
- Expand the KIDS NOW Plus Substance Abuse and Pregnancy Program so that women in every county have access to specialized outreach, prevention and case management services;
- Provide continued funding for the Independence House residential program;
- Expand treatment capacity for pregnant women and strengthen the use of Evidence Based Practices in women’s treatment;
- In collaboration with the Department for Public Health, devise a strategy to address the issue of smoking during pregnancy;
- A statewide prevalence study is a priority. Kentucky’s cross-agency substance Exposed Infants workgroup has a committee chaired by a neonatal physician which is prepared to do such a study when funding is available;
- In collaboration with the Kentucky Chapters of the American College of Obstetrics and Gynecology, the American Medical Association, and a statewide initiative is needed to promote the use of a pregnancy specific SBIRT protocol by medical providers. The protocol should include specialized instruction on how to address the unique fears and barriers faced by pregnant women with substance use disorders;
- Seek a Medicaid waiver to reimburse for residential substance abuse treatment at facilities with more than sixteen (16) beds;
- Collaborate with the Department for Community Based Services (child welfare) to adopt a strategy for addressing pregnant women’s fears of having their children removed and their resulting reluctance to seek help for their substance use disorders;



- Identify or create a training module for clinicians on providing prevention education on pregnancy and substance abuse, and through the contract process and/or regulation, require providers to give this information to all clients; and
- In collaboration with DPH, provide adequate funding for the Perinatal Depression Project to increase treatment capacity and utilization for perinatal mood disorders statewide. At the same time, strategies for engagement need to be identified and implemented through existing programs such as KIDS NOW plus and DPH's HANDs (home visitation program).

**Data Sources:**

- Office of Drug Control Policy, Annual Report for 2012
- CDAR: Center for Drug and Alcohol Research
- KIDS NOW Plus Annual Report 2012
- SAMHSA: Data, Outcomes, and Quality (DOQ)
- Department for Public Health, Perinatal Depression Project

***Parents with Substance Abuse and/or Mental Health Disorders with Dependent Children***

DBHDID does not require the CMHCs to prioritize parents with dependent children and so they are provided with the same array of services as the general population. However, twelve (12) of our fourteen (14) CMHCs report that they prioritize referrals of parents from the child welfare system. Child protective services (provided by the Department of Community Based Services or DCBS) currently does not use a standardized method for screening parents for substance use disorders in order to know who to refer for assessment, though they have done a pilot project testing the use of the UNCOPE screener during investigations. DCBS also contracts with a program (the University of Kentucky Targeted Assessment Program) to provide in-depth holistic assessment for a subset of their population, usually clients who are having difficulty achieving self-sufficiency or child custody.

DCBS currently contracts with the CMHCs through DBHDID to provide substance use disorder and co-occurring mental health disorder services to the clients participating in a pilot program called Sobriety Treatment and Recovery Teams (START). In this pilot, Family Mentors (peer support specialists) team with child protective service workers to help engage clients in services and keep children in the home if possible. The CMHCs provide quick access to assessment and referral to the appropriate level of care. Since 2007, START has served 489 families in 4 sites: two urban, one small town, and one rural Appalachian county. While the population is small compared to the large number of families in need of services, it is hoped that the practices tested in these sites can be spread to other regions. In October of 2012, DCBS was awarded a 5 year ACF grant to spread START to another site with a small city. Outcome data from the START program shows the following:

- 72.4% of families has at least one parent with access to treatment within 4 days of referral;
- In 68% of the families, at least one parent was retained in treatment for 5 sessions or more;
- The average number of services for the mothers in the START program was 114.5;
- In 64.9% of the cases, both parents were provided substance use disorder services;
- Families served fell into the top 10% of DCBS clients in terms of number of risks for child maltreatment;

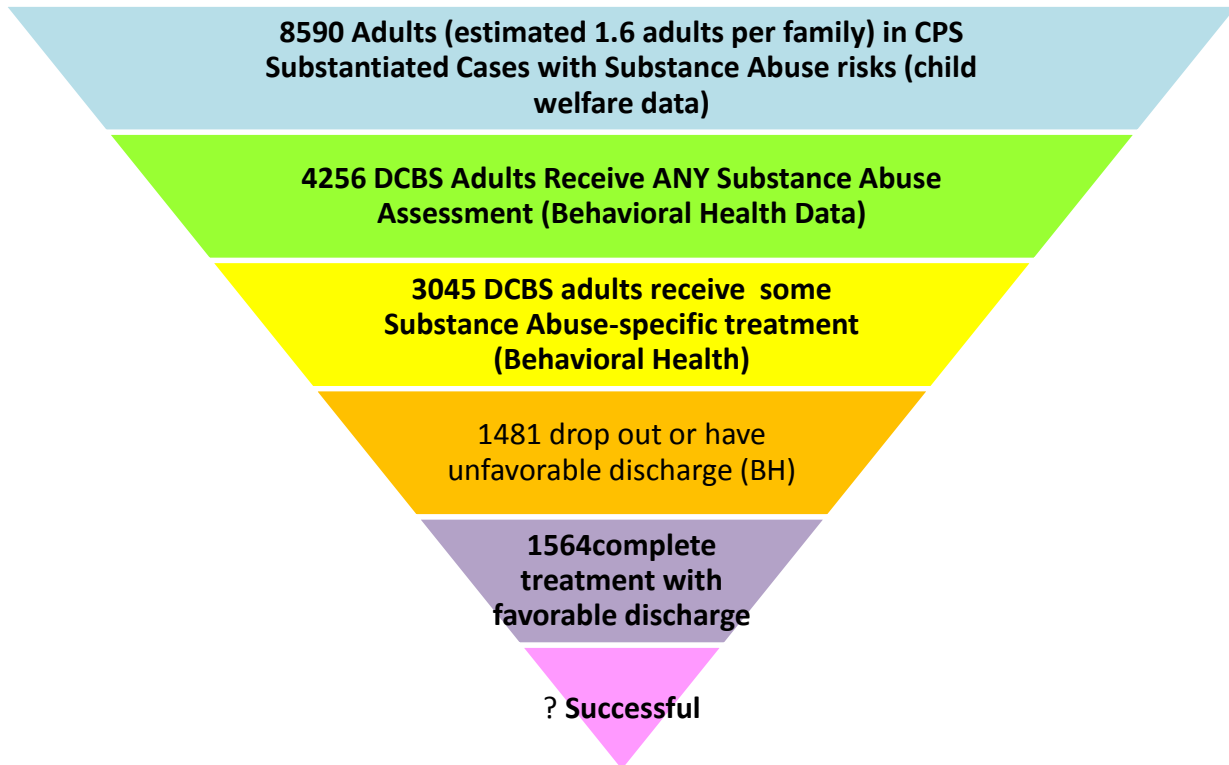
- Almost 70% of the families had at least one parent with a favorable discharge from treatment by case closure, compared to 18.2% of DCBS-referred clients in general who completed a treatment episode; and
- 20.2% of START clients are African American (mostly from the urban Louisville site), .3% are American Indian, 71.1% are Caucasian, .6% are Hispanic, and 7.8% are of mixed race. DCBS has an initiative to reduce racial disproportionality in foster care and child removals.

The Administrative Office of the Courts contracts with one CMHC through DBHDID to provide substance use and co-occurring mental health disorder services to parents involved in the courts and child protective services due to child maltreatment, a project called Families Moving Beyond Abuse (FMBA). Services will also be provided by the CMHC for children in SFY2013. As with START, DBHDID provides a Liaison to the project who provides technical assistance. Because of this collaborative project, progress has been made in increasing the intensity of treatment for parents when needed and breaking down barriers to the use of medication assisted treatment. In October 2012, DBHDID was awarded a SAMHSA Treatment Drug Court grant to enhance the treatment for FMBA. Treatment intensity will be increased to an intensive outpatient level in the community, and treatment will be trauma informed and co-occurring capable. Seeking Safety and Living in Balance will be implemented, and peer support specialists will be employed and co-supervised by the treatment provider and child protective services. No outcomes are available yet for this project.

In the Plan and Budget for SFY13, four CMHCs reported that they always screen for child maltreatment among parents with dependent children. Eight additional CMHCs reported that they sometimes screen. Three currently have a written policy on screening for child maltreatment, and eight reported that they planned to have one by the end of 2012.

***Unmet needs/Prevalence Data*** for this population include:

According to a drop-off assessment (see below) done by the Data and Information Sharing Workgroup of the In-Depth Technical Assistance project that DBHDID participates in with DCBS and the Administrative Office of the Courts, only about half of the possible parents being identified within child protective services as having substance abuse risk factors are receiving assessment services within the CMHCs, and of those who receive an assessment, fewer than half receive some substance use disorder specific treatment, and less than a quarter complete treatment with a favorable discharge.



- Based on feedback provided by DCBS and the courts in various regions, it seems that three distinct barriers exist for parents seeking services from CMHCs: 1) the assessment process frequently results in a recommendation of no treatment based on client self-report and denial of the need for services. This is frustrating to the referral source and possibly restricts clients in need of services from receiving them. 2) Inadequate services are available in some regions of the state, leaving some clients with long wait lists to enter treatment and sometimes a lower level of care and intensity than is helpful to them. 3) Communication between DCBS and the CMHCs is uneven across regions and providers, with information pertinent to child safety not always provided to DCBS. In addition, many of the CMHCs report that the majority of their clients are court ordered by drug courts or because of convictions for driving while intoxicated. The CMHCs do not have well-developed systems for accepting, assessing, providing services, and reporting on clients referred by DCBS, perhaps partly because there is no specific funding source associated with DCBS clients as there is for drug court and DUI clients. Making DCBS clients a priority population for the use of SAPT block grant funds might help to develop an adequate system for serving this population.
- The START evaluation indicates that around 80% of START clients receive intensive outpatient services, which include parenting, education about the disease of addiction, relapse prevention, and family sessions. An assessment by a Service Coordinator is used to determine the level of care required by the client, and the client's level of care may be adjusted based on their progress in treatment. START is only in 4 sites, and intensive outpatient services and quick access to assessments and treatment are not available in every region of the state. Several CMHCs have opted to close their residential treatment programs to concentrate on intensive outpatient programs in more communities.

- Women who are unemployed or those without an employed partner who contributes to the household are most likely to experience poverty and to have no means of health insurance. The 2009 American Community Survey data indicated almost one-fourth (23.5%) of Kentucky children were living in poverty. Current estimates of Kentucky children enrolled in Medicaid programs averaged 386,775 per month, while Kentucky's Children Health Insurance Program (KCHIP) enrollment averaged 60,778 children per month (2009). These state funded insurance programs help to provide women and children with necessary preventative health care and mental health services and are particularly important for families struggling with poverty. Until recently, Kentucky has not opted to include substance use disorder treatment in the state plan for services reimbursed by Medicaid, except for pregnant women. DBHDID and KY Medicaid currently have a state plan amendment in review with federal Medicaid which would increase funding available for substance abuse treatment by an estimated \$17,000,000. This SPA would allow for substance abuse services to be reimbursable for parents with dependent children, adolescents, and individuals with recent criminal justice involvement.

### ***Goal for SFY 2014/2015***

In the Plan and Budget for SFY 2014, the following language was included: Parents with dependent children referred by the Department for Community Based Services (DCBS) are defined as a priority population. DBHDID recommends that CMHCs begin planning for how these individuals can be provided with services for substance use and/or mental health disorders within one week of referral. Plans should include training of staff who works with parents with dependent children. One resource for such training is the free online course from the National Center on Substance Abuse and Child Welfare: <http://www.ncsacw.samhsa.gov/tutorials/tutorialDesc.aspx?id=1>.

In addition, in order to prepare for the expanded coverage of substance abuse treatment under Medicaid, DHBDID will work with DCBS on adopting the screening required for referral.

### **Data Sources:**

- DCBS TWIST (The Worker's Information System),
- the TEDS (Treatment Episode Data Set) and
- NOMS (National Outcome Measures) data set.

### ***Persons who are Intravenous Drug Users (IDU)***

#### ***Prevalence Data***

According to the Office of Applied Studies, there is a decreasing trend in injection drug use with more persons smoking or inhaling heroin and other drugs, rather than injecting them. This national trend is not being mirrored in Kentucky. Reports of injection drug use are slowly rising among individuals in the state substance abuse treatment sample. The change in the number of individuals reporting ever having injected drugs showed a significant increase ( $p < .001$ ) from SFY 2010 to SFY 2012. Of the 15,386 individuals treated for substance abuse in the Community Mental Health Centers (CMHCs) during SFY 2012, 2,954, or 19.2%, reported having used IV drugs. This is an increase from the SFY 2010 rate of 15.8%.

A total of 7,588 individuals who sought substance abuse treatment services at Kentucky Opiate Treatment Programs (OTP) between SFY 2008 and SFY 2011 reported having an injection drug use history compared to 3,957 individuals in the general substance abuse treatment centers between FY09-FY11 who had a history of injection drug use.

Overall, there were a total of 16,385 individuals over the course of about four years who sought addiction treatment in Kentucky and had a history of injection drug use. Only one-fourth of those individuals were in OTPs during that time period and the numbers across years did not change significantly among the OTP client sample. The increase in individuals reporting a history of injection drug use among the CMHC substance abuse treatment sample is statistically significant.

**Strengths:**

1. Kentucky has eleven (11) licensed OTPs, two (2) publically funded and nine (9) independently owned. Kentucky regulates and monitors its OTPs more stringently than many states, and as a result, the programs provide good quality care, both medical and psychosocial.
2. Kentucky has relatively low rates of HIV AIDS.

**Unmet Needs:**

1. Though the public is aware of the serious opiate addiction problem in the state, many Kentucky communities and CMHCs have been resistant to medication-assisted treatment (MAT). Although no data has been collected on this, CMHC site reviews have revealed that: 1) most CMHCs do not screen for IV drug use on first contact as required for the Block Grant; 2) MAT is seldom presented as a treatment option to patients; and 3) the majority of CHMC programs are abstinence-based and do not accept patients on MAT. Over the past 1-2 years, there has been some loosening of treatment program policies barring any psychotropic medication, so that most programs do now allow prescribed antidepressants, and some allow prescribed anti-anxiety medications.
2. There are very few medically-supported detoxification services in the state, and virtually none available to individuals without insurance. Individuals in the CMHC using IV drugs normally are detoxed in a social setting, without any pharmacological assistance.
3. Most substance abuse clients currently served through Block Grant funds are indigent, which puts the private OTPs out of reach. The two publically funded programs are in the main urban areas, and have such an extensive waiting list that there is normally over a year wait. Because the state is poor, rural, and mountainous, accessibility needs to be a part of any solution.
4. Although Kentucky has a serious Hepatitis C problem substance abuse Prevention efforts do not currently include any education about the dangers of IV drug use and needle sharing because such education is seen as a "harm reduction strategy." This is true of Prevention services provided to selective and indicated populations as well as universal. Treatment programs also do not offer education on the dangers of IV drug use and needle sharing.

### **Priorities for SFY 2014/2015**

1. All CMHCs should screen for IV drug use on initial contact in order to be in full compliance with Block Grant requirements. DBHDID needs to educate the CMHCs and hold them accountable through the onsite review process.
2. KY needs to follow national standards such as the *NQF Standard of Care regarding Withdrawal Management*. “Supportive pharmacotherapy should be available and provided to manage the symptoms and adverse consequences of withdrawal, based on a systematic assessment of the symptoms and risk of serious adverse consequences of the withdrawal process.” This could be accomplished by increasing the number of detox services so that there is a minimum of one medically supported detox center in each of the 14 CMHC regions, and more where population or geography requires.
3. KY should follow national standards such as the NQF Standard of Care regarding Pharmacotherapy: “Pharmacotherapy should be recommended and available to adult patients diagnosed with opioid dependence and without medical contraindications.” CMHCs should be required to recommend MAT when appropriate, and affordable MAT options need to be increased (see #4).
4. There needs to be a minimum of one publically-funded OTP program in each of the 14 CMHC regions. With the health care changes coming in 2014, some Block Grant funds should be used to provide MAT to indigent urban and rural residents.
5. KY SA Prevention and Treatment education needs to include information on the danger of IV drug use and needle sharing.
6. More data needs to be gathered about prevalence of IV drug use and treatment outcomes, and data needs to be shared between DBHDID and other agencies such as the Recovery Kentucky centers, Department for Public Health, Department of Juvenile Justice, Department of Corrections, and Administrative Offices of the Courts.

### **Data Sources**

- Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (July 19, 2007). The National Survey on Drug Use and Health (NSDUH) Report: Demographic and Geographic Variations in Injection Drug Use. Rockville, MD.
- Center on Drug and Alcohol Research (CDAR) University of KY.

### **Individuals with Tuberculosis**

The Kentucky Tuberculosis (TB) Control Program is operated through the Cabinet for Health and Family Services (CHFS), Department for Public Health (DPH), and is authorized by state law to coordinate TB control activities in Kentucky. The program’s overarching objective is to eliminate TB as a public health problem. The program works to achieve that objective by

focusing its efforts on rendering and maintaining all individuals who have TB disease as non-infectious, ensuring non-infected persons do not become infected, and ensuring that individuals who are infected but who do not have TB disease remain non-infectious.

State employees, local health department employees and private health care providers carry out TB control activities. Funds are allocated to designated local health departments which serve as local lead agencies for the TB Control Program. State level public health personnel provide program planning, implementation and evaluation, program performance standards, technical assistance and consultation including X-ray, nursing, medical, clerical, statistical, financial, and managerial support, and training and disease surveillance.

The Division of Behavioral Health continues to assess for compliance with both contractual and regulatory mandates through the comprehensive, onsite reviews that are conducted biennially at the CMHCs and annually at the licensed Opioid Treatment Programs. Review teams, which include a peer reviewer from the field, examine client service records for documentation of a referral for TB screening and evidence that the client was provided with information and the option to be tested for HIV. Review team members also interview clients and program staff and review personnel records and agency policies to ensure requirements are met and the appropriate services are provided. The DBHDID continues to ensure appropriate training is available to substance abuse staff and that continuing education is provided that offers the most current information on infectious diseases.

Kentucky continues to show a declining rate of TB, as reported by the DPH. A total of 71 cases of TB were reported for 2011, which is a rate of 1.6 per 100,000. This is lower than the 2008 rate of 2.4 per 100,000 and Kentucky has seen a nearly continual decline since 2000, when the rate was 3.7 per 100,000.

The Division of Behavioral Health continues to work with the DPH to obtain the most current data on Kentucky's rates of newly diagnosed cases of TB, so the most appropriate services may be coordinated.

**Data Sources:**

- Department for Public Health

***Persons with or at risk for HIV/AIDS and who are in treatment for substance abuse***

The Kentucky HIV/AIDS Program is operated by the Cabinet for Health and Family Services (CHFS), Department for Public Health (DPH), and is mandated by state law to document and maintain the HIV/AIDS case reports data. The HIV/AIDS Program's primary goal is to promote the prevention of HIV transmission and associated morbidity and mortality. The program works to accomplish this goal by ensuring that HIV/AIDS surveillance is a quality, secure system, ensuring that all people at risk for HIV infection know their sero-status, ensuring that those who are not infected with HIV remain uninfected, ensuring that those infected with HIV do not transmit HIV to others, ensuring that those infected with HIV have access to the most effective therapies possible, and ensuring a quality professional education program that includes the most current HIV/AIDS information.

According to the DPH reports, the number of new AIDS cases diagnosed in 2009 in Kentucky for persons ages 13 and older was 239. This translates to a rate of 7.9 per 100,000. This is comparatively lower than the US estimated rate of 12.2 per 100,000 for 2008. The reports for 2011 identify 150 cases that have been diagnosed for persons age 13 and older. Only 35

pediatric cases of AIDS have been diagnosed in Kentucky since 1989, with only 3 of those being diagnosed since 2004. The case of pediatric AIDS was diagnosed in 2005.

States that have a prevalence rate of 10 per 100,000 or higher must comply with 45 CFR Part 96.128 Requirements regarding Human Immunodeficiency Virus. Kentucky is exempt from the HIV early intervention set aside requirement due to the AIDS cases being less than 10 per 100,000 for the last several years.

The Division of Behavioral Health continues to assess for compliance with both contractual and regulatory mandates through the comprehensive, onsite reviews that are conducted biennially at the CMHCs and annually at the licensed Opioid Treatment Programs. Review teams, which include a peer reviewer from the field, examine client service records for documentation of a referral for TB screening and evidence that the client was provided with information and the option to be tested for HIV. Review team members also interview clients and program staff and review personnel records and agency policies to ensure requirements are met and the appropriate services are provided. The DBHDID continues to ensure appropriate training is available to substance abuse staff and that continuing education is provided that offers the most current information on infectious diseases.

The Division of Behavioral Health continues to work with the DPH to obtain the most current data on Kentucky's rates of newly diagnosed cases of HIV/AIDS so the most appropriate services may be coordinated. Although Kentucky has been a lower risk state for HIV/AIDS for several years, DBHDID staff has recognized that there is a need to address Hepatitis C more intensively in substance abuse services as well as increasing education about Hepatitis A and B. Currently there are no free testing services for Hepatitis C in Kentucky and there are very few affordable treatment services. Due to these needs, Kentucky is also beginning to coordinate more with the DPH Viral Hepatitis Prevention Coordinator.

**Data Sources:**

- Department for Public Health

***Adolescents with substance abuse and/or mental health problems***

In Kentucky some of the main barriers to improving adolescent substance abuse services are a lack of state funds, a lack of service options, and a lack of community awareness about the problem.

Currently, youth are being assessed for mental health and substance abuse issues by the Administrative Office of the Courts (AOC) as well as the Department for Juvenile Justice (DJJ). There have been clinical staff trained in assessment methods/tools in most every CMHC and there are state and national trainers within Kentucky to continue to provide training and coaching on the use of the Global Assessment of Individual Needs (GAIN) family of screening and assessment tools. Due to turnover and difficulty with adoption of the GAIN within some treatment provider agencies, the momentum of the assessment has waned. There is a need to encourage the use of the assessment tool as it is not being utilized by the CMHSs consistently.

The need to enhance treatment options for adolescents with juvenile justice involvement is especially pronounced. While some adolescents will engage in troubling behavior, appropriate and consistently-applied discipline can ensure youth have opportunities to learn from mistakes and become successful contributing adults. Unfortunately, Kentucky, like many states has responded to such troubling behavior by detaining youth, including those who commit status



offenses, an approach shown to be ineffective and highly expensive (Nelson, 2008). In fact, Kentucky detains youth charged with status offenses at the second highest rate in the nation, even though the most populous county in the state does not use this practice (KYA, 2011). With national estimates of approximately 70% of youth with juvenile justice involvement meet criteria for a diagnosable mental health disorder and about 61% have a co-occurring substance use disorder (National Center for Mental Health and Juvenile Justice, 2006), adolescents with juvenile justice involvement present a unique challenge to the system of care. Not only is the intensity of their needs likely to be greater, but proper response to their multiple needs requires increased collaboration, continuity of care, and the ability to recruit and retain providers who are equipped to treat multiple needs. Unfortunately, many of the youth do not receive much needed behavioral health treatment that could prevent initial involvement with the juvenile justice system or reduce the likelihood of recidivism. The Kentucky Department of Juvenile Justice (DJJ), one of five departments under the Kentucky Justice and Public Safety Cabinet within the Executive Branch, is responsible for statewide detention services, residential placement/treatment services, probation, community aftercare/reintegration programs and youth awaiting adult placement or court. Of Kentucky youth coming into contact with the juvenile justice system, 32% are committed to the DJJ, 28% are informally adjusted (diverted), and 40% of cases are probated (Kentucky Department for Juvenile Justice, 2006). Thus, the need for accessible and effective treatment is paramount throughout the system.

A fairly comprehensive array of services for youth with emotional disorders is available to varying degrees across Kentucky. This is less the case for youth identified with substance abuse treatment needs. While Kentucky has over twenty (20) years of experience in providing behavioral health services to children, youth and their families through a system of care interagency infrastructure called Kentucky IMPACT and utilization of the State Interagency Council (SIAC). SIAC meets monthly to oversee coordinated policy development, comprehensive planning and collaborative budgeting for Kentucky's system of care for children. In addition to representatives from sister agencies from within the Cabinet, there are representatives from AOC, DJJ, Department of Education and parents and youth. SIAC has developed formal recommendations for state and local community changes to support youth with substance use and co-occurring disorders and within the realm of case management services. The SIAC has established a workgroup to focus on adolescent substance abuse and juvenile justice. The purpose of this workgroup is to promote comprehensive, integrated services for youth with substance use or co-occurring substance use and mental disorders.

There are two (2) nationally recognized Reclaiming Futures sites and two (2) sites that are working as state Reclaiming Future sites. Reclaiming Futures is a proven national model working toward systems change to address youth with substance abuse and juvenile justice issues. Working with the National Reclaiming Futures Office and Kentucky Youth Advocates a "Kentuckyized" version of the model and implementation guide has been completed to address youth with complex issues, who may be status offenders that are being detained and the disproportionate minority contact of youth within our juvenile justice system. A third Reclaiming Futures site established through a SAMHSA/MacArthur Policy Academy/Action Network grant has been established using the KY version of the Reclaiming Futures implementation guide. This third site has focused on working with youth in a pre-diversion status that has focused efforts on screening, assessing, and treating youth on "the front end" of the juvenile justice system as a means of avoiding net widening into the juvenile justice system.

A significant service gap is the limited array of available services for adolescent substance use treatment, both community-based and residential. In fact, in some regions of the state, there is an absence of treatment options, requiring youth to be served outside their home communities,

and the use of evidence-based screening, assessment, and intervention options are likewise limited. Finally, and perhaps, most difficult to address, is a pervasive cultural lack of understanding of the potential benefits of community-based treatment options grounded in a belief that substance use challenges require residential treatment. A survey of residential treatment facilities was initially conducted between December 4, 2009 and December 7, 2009, by the University of Kentucky Center on Drug and Alcohol Research. The information on residential treatment and recovery beds was then updated to include all facilities in operation by August 2010. Data showed 223 inpatient psychiatric beds available for adolescent substance abuse treatment and are included in this report since they constitute the majority of publicly funded inpatient care for adolescents. There are 231 non-medical residential beds for adolescent substance abuse in the state. The male/female distribution is flexible depending on admission needs. The state does not operate any inpatient facilities for children and youth under eighteen (18) years of age. There are no Recovery Center beds for adolescents. (2010 Report from Center for Drug and Alcohol Research at University of Kentucky, *Residential Treatment Bed Capacity for Kentucky: Adult Substance Abuse Residential Treatment*).

Services for adolescents are provided by CMHCs, private providers, and Psychiatric Residential Treatment Facilities. The juvenile justice system also frequently serves as a de facto treatment provider in response to identified gaps in the service array.

Kentucky has made strides in promoting evidence based practices and has implemented an evidence based practice, Seven Challenges, across the state in various treatment milieus with both public and private providers. This was done with the assistance of Kentucky Youth First (SAC grant) for infrastructure building and Reclaiming Futures. Additionally, statewide trainings to treatment providers and other youth-serving staff in the use of motivational interviewing skills with adolescents were offered through Kentucky Youth First. Training for trainers as well as developing coaches for MI for adolescents have subsequently continued and sustained among a variety of child- and family-serving agencies across the state. However this limited use of evidence based treatment needs to be enhanced so that there is more options for evidence-based interventions for youth with substance use or co-occurring mental health and substance use needs and their families. Kentucky recently was awarded a SAMHSA State Adolescent Treatment Enhancement and Dissemination Grant (SAT-ED). Through this cooperative agreement, a learning laboratory with two sites working toward certification of the Adolescent Community Reinforcement Approach (ACRA) evidence based treatment model will provide a feedback loop that will allow for identification of barriers and testing of solutions regarding implementation policy and program information/recommendation and expansion of evidence based treatment models.

**Unmet Needs/Prevalence Data/Data Sources** for this population include:

- Based on the National Survey on Drug Use and Health, 2008 (<https://www.oas.samhsa.gov/nsduh.htm>) , Ages 12-25 49,000 youth needed but did not receive treatment for illicit drug use and ages 12-25 64,000 youth needed but did not receive treatment for alcohol use.
- On March 31, 2009, only 1,386 youth under the age of 18 were in treatment for substance abuse or mix of mental health and substance abuse services.
- The definition of a person needing but not receiving treatment for an illicit drug problem is that the person meets the criteria for abuse of or dependence on illicit drugs according to the DSM-IV, but has not received specialty treatment for an illicit drug problem in the

past year. Specialty treatment is treatment received at a drug and alcohol rehabilitation facility (inpatient or outpatient), hospital (inpatient only), or mental health center

**Table B.1 Illicit Drug Use in Past Month, by Age Group and State: Percentages, Annual Averages Based on 2004 and 2005 National Survey on Drug Use and Health (NSDUH)**  
<https://www.oas.samhsa.gov/nsduh.htm>.

State	Total		AGE GROUP (Years)					
			12-17		18-25		26 or Older	
	Estimate	95% Prediction Interval	Estimate	95% Prediction Interval	Estimate	95% Prediction Interval	Estimate	95% Prediction Interval
Kentucky	8.39	(7.09 - 9.90)	11.30	(9.40 - 13.54)	18.21	(15.27 - 21.57)	6.35	(4.91 - 8.17)

- In terms of adolescent services, the Division of Behavioral Health conducted a survey in February, 2002, of licensed Alcohol and Drug Entities (AODEs) in the state and found that, of the 300+ licensed programs in Kentucky, only 55-or less than 20%- had ongoing structured programming for adolescents. This hasn't changed in any great leaps for better or for worse. A structured program was defined as, at minimum, a weekly therapy group. Other examples included intensive outpatient programs, residential and inpatient treatment. In short, structured programs for adults were found to be more consistently available in the state than programs for adolescents.
- Kentucky detains youth charged with status offenses at the second highest rate in the nation,
- Some 1,746 youth charged with status offenses were locked up in secure detention facilities in 2009, accounting for nearly 20% of all youth incarcerated in Kentucky. ([http://kyyouth.org/issue\\_areas/Juvenile\\_Justice/](http://kyyouth.org/issue_areas/Juvenile_Justice/))
- Secure detention is the most expensive option available. Counties pay \$94 per day for each youth detained for a status offense and added to that is the cost for the Sheriff to transport the youth to the regional facilities. ([https://kyyouth.org/issue\\_areas/Juvenile\\_Justice/](https://kyyouth.org/issue_areas/Juvenile_Justice/))
- While the access to community based services for adolescents with substance use disorders has improved slightly, the recognition and concern for parity with child and adolescent Medicaid reimbursed mental health services is recognized and a focus for change.

Along with the social determinants of health often driven by poverty, Kentuckians face many health-related problems associated with lifestyle choices, community culture, and industries driving Kentucky's economy. Two industries, in particular alcohol and tobacco, have heavily influenced agriculture, economics, politics, and public health in the Commonwealth for many years. Kentucky has the largest number of distilleries in the nation, accounting for over \$1 billion in annual revenues, and industry-wide revenues related to tobacco production and consumption account for approximately \$500 million. While causal statements cannot be made, data on tobacco and alcohol use indicate rates exceeding national averages:

- Approximately 26% of Kentucky high school students are current smokers compared to 18.2% nationally (YRBS, 2009).

- Significantly more Kentucky residents (40%) report having a family member who smokes tobacco compared to 26% nationally (NSCH, 2007).
- Among youth, 21% of Kentucky 10th graders report being drunk in the past month compared to 14.7% nationally (KIP, 2010; MTF, 2010).
- Among those 18 and older, Kentucky had the highest frequency of past-month binge drinking in the nation, with an average of 5.9 episodes compared to 4.4 episodes nationally (BRFSS, 2010).

Additionally, increased abuse of prescription drugs is taking a toll on Kentucky's families and communities. Myriad factors have been attributed to the emergence of this problem, including a population of laborers (e.g., coal miners) who seek relief from pain, a culture in which the sharing of prescription medications is acceptable, an interstate highway system that promotes the transport of medicines across state lines, and persistent poverty that leads to the generation of income through illegal means (Kentucky State Epidemiological Outcomes Workgroup, 2012). The following data depict the extent of prescription drug abuse in Kentucky:

- Past-year nonmedical use of opioids was highest among transition-age youth (18-25 year olds), with approximately 15.4% reporting use compared to 11.9% nationally (NSDUH, 2008-2009).

**Goals for SFY 2014/2015:**

- Support the statewide use (especially the CMHCs) of a common tool for their initial screening/assessment process i.e., the GAIN Family of instruments—since this is already being used in some form by other child serving agencies. With all CMCHs using and conducting standard screening and assessment for trauma and substance use/abuse on all youth whom enter their doors
- Continue to work with the Reclaiming Futures National Program Office and AOC, DJJ and communities across the state to move towards Kentucky becoming a “Reclaiming Futures State” with implementing the “Kentucky-ized” version with having a statewide judicial training on Reclaiming Futures and the judges role in becoming a collaborator in system change and engaging mental health and substance abuse treatment and the community to work together to help adolescents and their families who may have substance use disorders and co-occurring substance use and mental health disorders.
- Kentucky has provided access to training/coaching in the GAIN, Cannabis Youth Treatment (CYT), and Seven Challenges. Kentucky has provided training to partner agencies in adolescent development, stages of change, and trends in adolescent substance abuse through Motivational Interviewing basics. We would like to enhance/strengthen the infrastructure to use evidence based treatment and assessment by developing a training plan that will look at expansion of additional ACRA sites and clinicians and address any need to train/coach/support already in place evidence based models
- Continue to provide specific training and coaching on the identification, diagnosis and treatment planning for adolescents with substance use and co-occurring disorders to

CMHCs as a cross training for child/adolescent mental health staff as well as for substance abuse clinicians who treat adolescents, then increase the amount of programming in the state for adolescents with co-occurring so that each CMHC will feel competent to develop at least one IOP and feel competent to treat adolescent substance abuse and co-occurring issues. We would like to continue to provide support and coaching as well as begin to move the adolescent programs more toward a co-occurring model by use of the Dual Diagnosis Capability family of instruments, including the DDCYT. The DDCYT assesses an agency's ability to provide high quality co-occurring disorder (COD) services through an objective evaluation of strengths and weaknesses in the areas of Program Environment, Clinical Processes, Continuity of Care, Program Structure, Staffing, and Training. We would like to pilot the use of the DDCYT assessment and assess at least 6 sites and train DDCYT assessors within the CMHC system. Through the assessment process, specific avenues for change are identified to expand an organization's capability to effectively treat adolescents with co-occurring disorders by providing a baseline

- Conduct a new survey in an effort to ascertain views on the strengths, as well as the needs and barriers to more effective adolescent services in local communities and in the state and to look at tying in prevention efforts with Adolescent treatment needs.
- Strengthen training and consultation resources so that there is a greater clinical presence regarding adolescent treatment in state-funded programs. In addition, gather and use intake and follow-up data to help clinicians and policy makers better understand the characteristics of clients entering treatment and their needs.
- Need to more clearly identify adolescents as a priority treatment population in the state and clearly target expectations for adolescent treatment providers by mandating the use of best practices
- Continue to provide clinicians with adolescent specific client-level data on characteristics of adolescents entering treatment as well as follow-up outcomes on clients who have received treatment to strengthen the use of data in guiding treatment efforts and to compare outcomes for adolescents with those of adults.
- Continue to assist with the ongoing work of the Kentucky Adolescent Substance Abuse Consortium (KASAC). KASAC currently has a Board of Directors, bylaws and regional contacts in each of the 14 Regional Mental Health/Mental Retardation regions of the state. In the past, Consortium meetings have been held bi-monthly at varying locations around the state so that providers could more easily attend a meeting. KASAC's annual meeting is held in conjunction with the Kentucky School of Alcohol and Other Drug Studies. Now the Consortium provides an Annual Adolescent Specific Two day Conference supporting evidence based adolescent specific practices and DBHDID could provide a "boost" to the Consortium by providing technical assistance, some limited financial support and by introducing new opportunities to carry out their mission.
- One of the most significant service gaps pertains to the lack of a specific funding stream for adolescent substance use services in the state. Current efforts are underway to explore the use of EPSDT, Medicaid Waivers, and Medicaid SPAs as a means of increasing funding for substance use treatment. Through the requirements of the SAT-ED cooperative agreement, Kentucky is planning to develop a cross-agency State/

financial map of Federal and State/ financial resources which include but are not limited to Medicaid/CHIP, SAPT Block Grant, and other funding streams available to deliver evidence-informed substance use and co-occurring substance use and mental disorders treatment and recovery support services to adolescents and their families, with the intention of providing information to those agencies on options for redeployment of financial resources and ways to expand the continuum of treatment/recovery services and supports

- Look at performing workforce mapping of the available clinicians that provide services to adolescents with substance use and co-occurring substance use and mental health disorders and continue to work on KASACs previous work on development of State standards for endorsement of adolescent and family substance use and co-occurring mental disorders treatment counselors.

**Data Sources:**

Substance Abuse and Mental Health Services Administration. (2010), Description of a Modern Addictions and Mental Health Delivery system, Office of Policy, Planning and Innovation, Rockville, MD <http://www.samhsa.gov/healthreform/docs/AddictionMHSsystemBrief.pdf>

Substance Abuse and Mental Health Services Administration, *Results from the 2011 National Survey on Drug Use and Health: Summary of National Findings*, NSDUH Series H-44, HHS Publication No. (SMA) 12-4713. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012.

## II. Planning Steps

### Step 2: Identify the unmet service needs and critical gaps within the current system

*Identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.*

*Priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.*

*In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the CMS or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact [planningdata@samhsa.hhs.gov](mailto:planningdata@samhsa.hhs.gov).*

In an effort to identify unmet needs and critical gaps in the publicly funded behavioral health system, the Department has drawn upon data and information from a variety of sources at the local, regional and state level and compared it with data available nationally. The Department and stakeholders have participated in a number of activities to address the need for comprehensive data to drive their planning efforts, including:

- Behavioral Health Planning and Advisory Council Priority Setting Sessions;
- Provider Forums;
- Out-of-State Children's Workgroup/ Children's System of Care Redesign;
- Technical Assistance from Multiple Consultants; and
- Priorities and Supporting Research from Federal Funders, including SAMHSA.

At present, there are a number of priorities that have been identified but there are also a number of different overarching influences to be considered as planning occurs, including:

- Implementation of the Patient Protection and Affordable Care Act (PPACA) and the Mental Health Parity and Addiction Equity Act (MHPAEA) –Particularly the State Health Exchange
- State Budget Restrictions and a Struggling State and National Economy
- Implementation of Managed Care Statewide (including behavioral healthcare)
- Legislative Actions (including unfunded mandates)
- A newly constructed State Psychiatric Facility to Replace Eastern State Hospital (due to open in September 2013)
- Returning Service Members, Veterans and their Families with Behavioral Health Needs
- Workforce Issues and Shortages
- Underfunded Pension System and Increased Retirement Contribution by CMHCs

### Division of Behavioral Health – Unmet Service Needs

## **Mental Health**

The Kentucky Planning and Advisory Council has recommended the following nine (9) priorities for Block Grant funding and chose the top three (3) as priorities:

- **Develop specialized services and supports for youth transitioning to adulthood.** *Council agreed this includes training for staff as well as direct services and supports for youth;*
- **Promotion of recovery-oriented services across all Regional Board programs;** *Particularly use carry over funds for this as they may be one-time expense projects;*
- **Increased funding for family member and consumer-run support programs;**
- Increased funding for an anti-stigma and anti-discrimination campaign to educate the public;
- Promotion of early intervention and increased access to community-based services (to prevent higher levels of care);
- A self-identified, active parent, youth & consumer representative on every Center's Board of Directors;
- Increased access to transportation services;
- Increased education about services available at the Regional Boards; and
- Increased training for staff on evidence-based practices and on cultural competency.

The Planning Council and the Department also participated in a Center for Mental Health Services (CMHS) monitoring visit (March 2009) and remain aware of their report that noted the following:

- A need to rebalance mental health system resources between State Hospital and community services;
- A need to be more effective in soliciting and responding to consumer and family input into the service system; and
- A need to hire a self-identified consumer as Recovery Services Coordinator within the Division of Behavioral Health. It was noted that this action would introduce a consumer perspective into policy making as well as serve as a role model for other agencies.

There is a CMHS monitoring visit anticipated in the Spring of 2014. SAMHSA has indicated items to be addressed during this visit and DBHDID staff are currently gathering information to be shared. The state welcomes this opportunity to gain clarity on the priorities and directives of CMHS during these visits and anticipates that additional priorities may be established for Kentucky's behavioral health system as a result

The Kentucky Legislative Research Commission's Program Review and Investigations Committee conducted a follow up study to revisit their Research Report (previously released in June 2007), entitled; *Kentucky's Community Mental Health System is Expanding and Would Benefit from Better Planning and Reporting*. The major objectives of the original study were to describe the Regional Boards' mission, activities, and resources; analyze needs and services; and examine the processes of treatment, monitoring and outcome evaluation. The follow-up report focuses on the progress made and potential changes due to the current environment (e.g., managed care implementation, ACA, budget cuts, etc.). Recommendations from both versions of this study include reestablishing the Kentucky Commission on Mental Illness, Alcohol and Other Drug Abuse Disorders, and Dual Diagnosis and the Regional Mental Health Planning Councils, (HB843 Commission), having each Regional Board develop a strategic plan each year to be an integral part of statewide planning decisions, and instituting a standardized method of calculating each Regional Board's amount of charity allowance.



In May 2011, Leslie Schwalbe, MPA, provided consultation to DBHDID regarding preparing for managed care in the public mental health system. Several recommendations were made focusing on these major areas: 1) DBHDID updating CMHC contract language to accommodate managed care concerns; 2) DBHDID oversight regarding Managed Care Organizations' (MCO) contracts with the Department for Medicaid Services and with the CMHCs; and 3) Maintaining a safety net for the remaining state behavioral health funds for persons in the public system who do not have Medicaid benefits or other/adequate insurance coverage, even if periodic.

A Gap Analysis was calculated by DBHDID based on 2010 Census numbers and certified 2013 KY MIS Client/Event data. This data was based on prevalence data regarding adults with SMI and children with SED. It was noted that about 51% of adults with SMI in Kentucky receive services from the Regional Boards, and about 11% of adults with SMI served by the Regional Boards received targeted case management services. It was also noted that about 59% of children with SED received services from the Regional Boards and about 20% of the children with SED served by the Regional Boards received targeted case management services.

In October 2012, as well as in January of 2013, Community Support Directors from all fourteen (14) regions were asked to list the top three (3) priorities in their regions with regards to serving adults with SMI. The top three (3) responses among this group were transportation, supportive housing services and peer support services. Other notable concerns were funding for therapeutic rehabilitation programs, funding for assertive community treatment programs, supported employment services, and access to more prescribers. DBH staff has been working with staff from the Department for Medicaid Services (DMS) on preparation of a 1915i State Plan Amendment to provide more intensive services for adults with SMI.

Kentucky's estimates of the prevalence of severe mental illness are based on national work but also take into account the applicable Kentucky law that defines severe mental illness. In a National Institute of Mental Health (June 2008) publication, it was stated that, "An estimated 26.2 percent of Americans ages 18 and older — about one in four adults — suffer from a diagnosable mental disorder in a given year." It went on to report that, "about 6 percent, or 1 in 17 — who suffer from a serious mental illness." ((NIMH June 2008: *The numbers count: mental disorders in America*)

In the May 2012 National Survey on Drug Use and Health (NSDUH) Report presented state level estimates of prevalence of "any mental illness" and SMI among adults (age 18 and above) based on data collected from the combined 2008 and 2009 surveys. The estimated percentage of adults with "any mental illness," in the past year, ranged from 17.2 in Maryland to 24.0 in Rhode Island. Kentucky's estimated prevalence for any mental illness is 20.19 percent. Kentucky's percentage of adults with SMI was estimated at 5.4 percent, among the range of 3.5 in South Dakota to 7.0 percent in Rhode Island.

### ***Prevalence Data for Adults with SMI***

With the passage in 1992 of P.L. 102-321, the Community Mental Health Services Block Grant, Congress required the Center for Mental Health Services (CMHS) to develop a national definition for "adults with severe mental illness." CMHS was further required to develop an "estimation methodology" based on the definition that state mental health agencies must use to estimate needs in their state plans. While P.L. 102-321 limits CMHS Block Grant spending to persons who meet the federal definition, it does not require states to serve everyone covered by

the definition. The federal definition of “adults with a severe mental illness” was published on May 20, 1993.

A work group comprised of consumers, family members, and providers reviewed the federal definition and Kentucky's statutory definition of “chronic mental illness”; its recommendations were reflected in Administrative Regulations published in 1994. The regulation provided for operational definitions of the target population of adults with severe mental illness consistent with national policy. Kentucky’s definition of “adult with severe mental illness,” as currently operationalized, uses the following criteria for age, diagnosis, disability, and duration: Kentucky’s definition is narrower than the definition promulgated in the federal register for “Adult with Severe and Persistent Mental Illness.” Historically, stakeholders have supported the Department’s desire to focus limited funding on adults who meet the state’s narrower definition.

<b>Variable</b>	<b>Criteria</b>
<b>Age</b>	Age 18 or older
<b>Diagnosis</b>	Major Mental Illness <ul style="list-style-type: none"> <li>• Schizophrenia and Other Psychotic Disorders</li> <li>• Mood Disorders</li> <li>• Personality Disorders (when information and history depict persistent disability and significant impairment in areas of community living)</li> </ul>
<b>Disability</b>	Clear evidence of functional impairment in two or more of the following domains: <ul style="list-style-type: none"> <li>• Societal/Role Functioning: Functioning in the role most relevant to his/her contribution to society and, in making that contribution, how well the person maintains conduct within societal limits prescribed by laws, rules and strong social mores.</li> <li>• Interpersonal Functioning: How well the person establishes and maintains personal relationships. Relationships include those made at work and in the family settings as well as those that exist in other settings.</li> <li>• Daily Living/Personal Care Functioning: How well the person is able to care for him/herself and provide for his/her own needs such as personal hygiene, food, clothing, shelter and transportation. The capabilities covered are mostly those of making reliable arrangements appropriate to the person’s age, gender and culture.</li> <li>• Physical Functioning: Person’s general physical health, nutrition, strength, abilities/disabilities and illnesses/injuries.</li> <li>• Cognitive/Intellectual Functioning: Person’s overall thought processes, capacity, style and memory in relation to what is common for the person’s age, gender, and culture. Person’s response to emotional and interpersonal pressures on judgments, beliefs and logical thinking should all be considered in making this rating.</li> </ul>
<b>Duration</b>	One or more of these conditions of duration: <ul style="list-style-type: none"> <li>• Clinically significant symptoms of mental illness have persisted in the individual for a continuous period of at least two- (2) years.</li> <li>• The individual has been hospitalized for mental illness more than once in the last two- (2) years.</li> <li>• There is a history of one or more episodes with marked disability and the illness is expected to continue for a two-year period of time</li> </ul>

The 1999 federal methodology for estimating adults with serious mental illness requires states to use the national estimate of 5.4 percent for the prevalence of adults with severe mental illness (SMI), and a rate of 2.6 percent for adults with severe and persistent mental illness (SPMI).

The following table uses the federal SPMI prevalence rate of 2.6% and the 2010 census data to estimate the percentage of the targeted population serviced by the Regional Board during SFY 2012.

Regional Boards	Adult Census 2010	Estimated Prevalence (2.6% of the Adult Census)	Kentucky Adults with SMI Served in SFY 2012	Penetration Rate - SMI Served
Four Rivers	161,545	4,200	2,478	59%
Pennyroyal	158,100	4,111	3,485	85%
RiverValley	161,977	4,211	2,285	54%
LifeSkills	217,231	5,648	2,041	36%
Communicare	200,640	5,217	2,883	55%
Seven Counties	730,843	19,002	8,718	46%
NorthKey	326,235	8,482	3,060	36%
Comprehend	42,757	1,112	726	65%
Pathways	170,601	4,436	2,592	58%
Mountain	119,756	3,114	3,050	98%
Kentucky River	89,550	2,328	2,088	90%
Cumberland River	181,110	4,709	3,226	69%
Adanta	160,202	4,165	2,291	55%
Bluegrass	595,449	15,482	4,513	29%
<b>TOTAL</b>	<b>3,315,996</b>	<b>86,216</b>	<b>43,436</b>	<b>50%</b>

*Note: The data for SFY 2013 is not certified until October 15<sup>th</sup> thus SFY 2012 data is used.*

### **Prevalence Data for Children with SED**

Using 2010 census data and the state's agreed upon prevalence rate estimate of five percent, Regional Boards are aware of the number of children in potential need of services. The Boards also rely heavily on indicators and recommendations from the local communities, parent networks and Regional Planning Councils. Kentucky Kids Count, the annual report distributed by Kentucky Youth Advocates is also helpful for program planning. ([www.kyouth.org](http://www.kyouth.org).)

The following denotes the child population and the estimated number of children with a severe emotional disability (SED) and thus percentage served.

Estimated 2010 Child Census – 1,023,371

Estimated Number of Children with SED (5%) – 51,169

Kentucky MH Children Served SFY 2012 – 59,317 or 6% (of Kentucky's child population)

Kentucky SED Children Served SFY 2012 – 28,578 or 56% (of the 5% SED population)

*Note: Data for 2013 are not certified until October 15, 2013 and thus SFY 2012 data was used.*

In Kentucky, criteria for determining whether a child has SED were included in the enabling legislation (KRS 200.503) for the Kentucky IMPACT program in 1990. These criteria include the following. A child who:

1) Is under age 18 or under age 21 and was receiving mental health services prior to age 18 and the services must be continued for therapeutic benefit; and

2) Has a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is listed in the current addition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders; and presents substantial limitations which have persisted for least one year, or are judged by a mental health professional to be at high risk of continuing for one year without professional intervention in at least two of these five areas:

- Self-Care
- Interpersonal Relationships
- Family Life
- Self-Direction
- Education

or

- Is a Kentucky resident and is receiving residential treatment for an emotional disability through the interstate compact; or
- Has been removed from the home by the Department for Community Based Services (Kentucky's child welfare agency) and has been unable to be maintained in a stable setting due to a behavioral or emotional disability.

Kentucky's estimated prevalence rate falls in the low range of estimates derived from local studies and cited in "Prevalence of Severe Emotional Disturbance in Children and Adolescence" (Friedman et. al, SAMHSA, 1996). This study acknowledges the lack of epidemiological data and concludes that regardless of the estimated prevalence rate that may be used, children with severe emotional disabilities are greatly under-served, a conclusion Kentucky planners share.

#### **Data Sources Used:**

- Kentucky MIS Client/Event Data Set
- Kentucky State Data Center/US Census Bureau 2010
- KY STARS 2011 Statewide Needs Assessment
- NAMI KY 2011 Statewide Needs Assessment
- [http://www.nasmhpd.org/general\\_files/publications/POPS%202010%20final.pdf](http://www.nasmhpd.org/general_files/publications/POPS%202010%20final.pdf) (2010 Pillars of Peer Support - 2 "Expanding the Role of Peer Support Services in Mental Health Systems of Care and Recovery."
- [http://www.nasmhpd.org/general\\_files/publications/med\\_directors\\_pubs/Technical%20Report%20on%20Morbidity%20and%20Mortality%20-%20Final%2011-06.pdf](http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Technical%20Report%20on%20Morbidity%20and%20Mortality%20-%20Final%2011-06.pdf) (2006 "Morbidity and Mortality in People with Serious Mental Illness".
- SAMHSA's Strategic Initiatives 2010-2014
- <http://www.mhmr.ky.gov/mhsas/files/Suicide%20Prevention%20Plan.pdf> (2007 Kentucky Suicide Prevention Plan)

- [http://www.mhmr.ky.gov/mhsas/HB843\\_Commission/Reports/2007%20Progress%20Report.pdf](http://www.mhmr.ky.gov/mhsas/HB843_Commission/Reports/2007%20Progress%20Report.pdf) HB 843 Commission On Services and Supports For Individuals with Mental Illness, Alcohol and Other Drug Abuse Disorders and Dual Diagnoses 2007 Report “Template for Change”.
- 2011 Gap Analysis of Adults with SMI served/Received Targeted Case Management
- Kentucky’s 10 Year Plan to End Homelessness
- [http://oas.samhsa.gov/2k11/025/WEB\\_SR\\_025.cfm](http://oas.samhsa.gov/2k11/025/WEB_SR_025.cfm) 2011 National Survey on Drug Use and Health (NSDUH) Report. “Sources of Payment for Mental Health Treatment for Adults.”
- Mental Health Planning and Advisory Council Recommendations (2007 & 2010)
- Healthy People 2020 <http://www.healthypeople.gov/2020/default.aspx>

### ***Co-occurring Disorders***

In 2004, the Division of Mental Health and the Division of Substance Abuse were merged into the Division of Mental Health and Substance Abuse. In 2005, a Co-Occurring Advisory Council was formed by the Commissioner of the Department. This Council developed recommendations that would help create the infrastructure within the state to assist with providing a comprehensive, continuous and integrated system of care for persons with co-occurring disorders. In 2009, the Division was renamed the Division of Behavioral Health. Formal steps have been taken by the KDBHDID towards the integration of mental health and substance abuse services across the Commonwealth. Currently, one staff position within the Division of Behavioral Health is dedicated solely to the development, implementation and monitoring of integrated mental health and substance abuse services across the Commonwealth.

Technical assistance was received from the Co-Occurring Center for Excellence (COCE) and from a Dual Diagnosis Capability in Addiction Treatment (DDCAT)/ Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) national trainer during SFY 09. A core team of integration specialists were trained to use the DDCAT/DDCMHT tools. Pilot sites were identified at four (4) Regional MH/MR Boards. These sites agreed to have their adult outpatient programs reviewed for co-occurring capabilities. During SFY 2010, four (4) baseline DDCMHT/DDCAT reviews were completed and three (3) follow-up assessments were done. In 2011 the Division moved on to the assessment of co-occurring capabilities in programs in the ten (10) remaining Regional Boards of the states fourteen (14) Regional Boards. The DDCMHT was used to evaluate nine (9) adult outpatient mental health programs and the DDCAT was used for two (2) adult outpatient substance use programs. One board chose to review both their adult mental health and adult substance abuse outpatient programs. All programs were offered the opportunity to use the data from their DDCAT/DDCMHT reviews to make changes using the Network for Improvement of Addiction Treatment (NIATx) process improvement model to raise any scores below the score of three (3), which is co-occurring capable. Each center formed a change team and submitted an implementation plan. During 2011-2012 all teams participated in monthly coaching calls with the Division co-occurring program administrator and a contracted NIATx coach. In May 2012 the participating programs presented their NIATx change projects in a meeting in Frankfort and received a \$6,000 incentive made possible by a Transformation Transfer Initiative (TTI) grant. At the final presentation meeting the teams were joined by Heather Gotham, co-creator of the DDCMHT, who worked with them to understand how to use the review data to become co-occurring capable in all seven (7) dimensions of the DDCMHT/DDCAT indexes.

In the current plan and budget applications for 2013 the Regional Boards are encouraged to complete a DDCAT assessment on at least one substance use disorder program and have a score of three (3), co-occurring capable, or adopt an action plan to raise their score to co-occurring capable.

One **unmet need** that has emerged from the DDCMHT/DDCAT reviews is a need for peer led mutual support groups specific to co-occurring disorders. The participating programs chose to concentrate their efforts on assessment, treatment, staffing, training and continuity of care and the Division offered to address the peer support and peer led group items on the DDCAT/DDCMHT indexes. An aspect of the TTI grant was to start three (3) Double Trouble in Recovery (DTR) groups in Kentucky. With grant funds the Division was able to support DTR groups with literature, meeting space and facilitation. Kentucky now has nine (9) DTR groups and has recently hired (for one year) a DTR peer support liaison to facilitate interested communities in starting DTR groups.

Fourteen (14) CMHCs have participated in DDCMHT/DDCAT reviews and two (2) Kentucky programs have been added to the National Focus on Recovery (FIT) treatment locator map. Two (2) DBHDID employees attended the International Reciprocity and Credentialing (IC&RC) conference on co-occurring disorders in Minneapolis in 2012. One (1) DBH employee participated in the CADC licensure workgroup crafting the bill to create a credential for recovery peer support specialists to work with individuals in recovery from addiction. That bill has been introduced in the current legislative session.

Plans/ goals for Co-occurring Disorders for SFY 2014/2015:

- To continue evaluating the capacity of state programs for providing co-occurring treatment in programs receiving behavioral health block grant funding. The current CMHC plan and budget applications require Regional Boards to become co-occurring capable and to use evidence based practices in their substance use and mental health programs;
- To require the Regional Boards report their use of validated screening and assessment tools as well as how they are applying the American Society of Addiction Medication – Patient Placement Criteria (ASAM-PPC) criteria. The ongoing DDCAT/DDCMHT review provide a means of mapping progress toward co-occurring capability;
- Continue using the DDCAT/DDCHMHT at the program level;
- Continue to support and facilitate new peer led mutual support groups;
- Continue to require the use of evidence based treatment practices;
- Support employment of registered peer support specialists for recovery; and
- Support co-occurring training for providers. Jeff Georgi will present on “co-mingling disorders” and treating specific co-occurring psychiatric disorders at the Kentucky School of Alcohol and other Drug Studies in July 2013.

**Unmet Needs** for this population include:

There is a gap between individual counseling for substance use disorders and group counseling for substance use disorders. None of the fourteen Regional Boards provide co-occurring intensive outpatient therapy and only one adult outpatient program has a co-occurring treatment group. Some programs are beginning to integrate substance use disorders and mental health disorders treatment and are finding a need for more cross training of staff and for more dually licensed staff.

Peer support for recovery from substance use disorders and co-occurring disorders is needed and beginning to be addressed with the filing of legislation to create a master's level license for substance abuse counselors that includes a new credential and process for registering peer support specialists for substance use disorder individuals.

**Data Sources Used:**

- SFY 2012/2013 Plan and Budget Documents
- DDCAT/DDCMHT <http://www.samhsa.gov/co-occurring/DDCMHT/index.html>  
<http://www.samhsa.gov/co-occurring/ddcat/>
- <https://nrepp.samhsa.gov/ViewIntervention.aspx?id=13>
- <http://www.niatx.net/Home/Home.aspx?CategorySelected=HOME>
- [www.integratedrecoverynow.org/resources/#IntegratedTreatmentDirectory](http://www.integratedrecoverynow.org/resources/#IntegratedTreatmentDirectory)

***Military Personnel and Their Families***

Soldiers/Veterans from the Kentucky National Guard are scattered across Kentucky's 120 counties and it is difficult for them to get behavioral health treatment when and where they need it. Most individuals are typically not located near a military base or a Veterans Administration (VA) Hospital. If Service members/Veterans live near a bordering state they may leave the state for treatment or they may seek treatment in Kentucky or hide their affiliation with the military while seeking treatment.

Service members and Veterans in Kentucky are seeking services at the Community Mental Health Centers (CMHCs) and private providers to keep the diagnosis and treatment information out of their military records. This is occurring because of the fear of stigma and hindering career advancement of the Service member. Often the individual is paying out of pocket and in cash to hide the visit from the military insurance.

Kentucky communities and behavioral health providers have recognized an increase in the number of Service members returning from Operation Enduring Freedom and Operation Iraqi Freedom with undiagnosed TBI and PTSD. As the need for TBI and PTSD treatment increases, the knowledge of resources will increase. As people become more aware of the resources, the assumption is that they will use the resources and get treatment. At the same time, as more resources are used, the service quality could experience a temporary decrease. As the resources are used, the resources become more fragmented which can decrease the service quality. Without new funding, resources and additional behavioral health staff in place to assist the Service members and Veterans as they return home our Heroes and their families will suffer.

At present military bases, military hospitals or the VA Hospitals are not able to share data or patient information with outside providers and sometimes with each other. If we want to reach the Service members or Veterans where they are we need to develop reciprocity between agencies. Some Service members and Veterans don't want to go to the VA Hospitals or military hospitals and therefore go untreated.

***Unmet Needs/Prevalence Data for this population:***

- Kentucky has 4.3 million residents with a Veteran population of 342,370.
- The Kentucky Veteran population under the age of 25 is approximately 9,000

- As of September 2012 there were 30,410 women Veterans in Kentucky that number is up 8,410 over the previous year of 22,000. Unfortunately women are not aggressive in seeking services as many do not consider themselves a Veteran.
- During the 2012 fiscal year, the Community Mental Health Centers (CMHCs) in Kentucky reported treating 766 active duty Service members.
- During the 2012 fiscal year, the CMHCs in Kentucky reported treating 2,151 Veterans.
- The Military and Veterans Administration Hospitals are under Presidential Order to increase the services and manpower needed to treat our Service members and Veterans. They have made great strides toward this goal but this is an **unmet need** Service members, Veterans and their families in Kentucky.

Veteran and Active Duty Counts by Region										
Region	FY2011					FY2012				
	Active Duty		Veterans		All Clients	Active Duty		Veterans		All Clients
	Count	Percent	Count	Percent		Count	Percent	Count	Percent	
01 - Four Rivers	56	0.61%	188	2.06%	9,124	50	0.54%	183	1.99%	9,191
02 - Pennyroyal	100	0.76%	221	1.68%	13,132	98	0.70%	313	2.24%	13,952
03 - River Valley	47	0.50%	39	0.41%	9,429	54	0.54%	50	0.50%	9,936
04 - Lifeskills	123	1.06%	46	0.40%	11,600	42	0.31%	59	0.44%	13,363
05 - Communicare	13	0.12%	138	1.26%	10,937	15	0.13%	139	1.17%	11,874
06 - Seven Counties	69	0.17%	269	0.68%	39,625	65	0.15%	290	0.69%	42,035
07 - NorthKey	43	0.43%	147	1.46%	10,064	40	0.38%	126	1.20%	10,470
08 - Comprehend	46	0.93%	59	1.19%	4,940	50	0.93%	82	1.52%	5,389
10 - Pathways	45	0.25%	281	1.59%	17,666	63	0.36%	285	1.63%	17,449
11 - Mountain	92	0.91%	63	0.62%	10,099	71	0.65%	63	0.58%	10,870
12 - Kentucky River	32	0.25%	39	0.31%	12,599	104	0.78%	76	0.57%	13,363
13 - Cumberland River	1	0.01%	164	0.91%	18,062	4	0.02%	7	0.04%	18,561
14 - Adanta	45	0.39%	200	1.73%	11,589	36	0.31%	166	1.43%	11,609
15 - Bluegrass	85	0.35%	366	1.53%	23,962	74	0.30%	312	1.26%	24,734
<b>State Totals*</b>	<b>797</b>	<b>0.39%</b>	<b>2,220</b>	<b>1.09%</b>	<b>202,828</b>	<b>766</b>	<b>0.36%</b>	<b>2,151</b>	<b>1.01%</b>	<b>212,796</b>
*State Totals may include duplicates when clients were seen in multiple regions.										
Report Date: August 22, 2012										

### **Operation Headed Home**

The Operation Headed Home (OHH) workgroup began in 2008 with a core group of just three (3) individuals and has grown to over one hundred (100+) members who are connected and committed to providing counseling, information, resources, and support to Service members, Veterans and their family members.

### **Operation Headed Home Conferences**

To date, DBH has hosted three (3) Operation Headed Home conferences and trained more than seven hundred (700+) individuals for FREE. We are currently working on the next OHH conference that will occur in October 2013. Conference participants and presenters include: Past and present military Service members, Veterans (all branches) and their families/caregivers, local, state and national leaders, subject matter experts, and those serving on the “front lines” of behavioral healthcare and supportive services. The conference will address the following identified needs: Traumatic Brain Injuries (TBI), Post Traumatic Stress



Disorder (PTSD), suicide prevention, reintegration, family and caregiver support, available resources and benefits, transitioning to work and school, polytrauma, polypharmacy, substance abuse prevention and treatment, and hearing loss and tinnitus from blast injuries. We estimate attracting over 300 attendees to this conference.

The upcoming conference will strive to strengthen the community-based resources for returning Service members, Veterans and their Families. We will focus on TBI, PTSD, suicide prevention and ways to identify additional access points for care. The resources, partnerships and funding opportunities gained after the previous conferences have helped to build relationships across the state and fill tremendous gaps. It has also laid the groundwork for future community collaboration around TBI, PTSD and suicide prevention in our state.

### ***Operation Immersion***

Operation Immersion will help to remove barriers and ease soldier apprehension to accessing treatment. The Kentucky Division of Behavioral Health and the Kentucky National Guard have teamed up to present a comprehensive four day training in military culture and issues unique to Service members, Veterans and their families. This training will immerse Behavioral Health Providers and Professionals in aspects of military culture and the deployment experience. Attendees will sleep in the barracks, participate in early morning physical training, chores and inspection, experience the Field Leadership Reaction Course, combat simulators unique to the military, network with military personnel and resource providers. In addition, workshops will be provided on TBI, PTSD, Suicide Prevention, Substance Abuse Prevention and Treatment, Trauma Informed Care and current best practices to treat military clients and their families.

Kentucky held its first Operation Immersion on November 14-16, 2012 at one of the Kentucky National Guard training sites. Seventy-five (75) behavioral health professionals attended this hands-on event to learn about military culture and learn about TBI, PTSD and suicide prevention. The event was so successful and meaningful that a second event was immediately planned for April 9-12, 2013.

### **Goals:**

1. Strengthen Kentucky's capacity to serve and support the military and Veteran population by increasing the number of clinical professionals trained in military/Veteran culture.
2. Equip behavioral health service providers and professionals with knowledge and skills that increase their ability to provide high quality care and support to military and Veteran populations.
3. Promote integrated care and support systems by connecting behavioral health providers and professionals with military and Veteran resources.

### ***Kentucky Policy Academy for Service Members, Veteran's and their Families***

Leaders from key agencies within Kentucky attended the Policy Academy for Service members, Veteran's and their families in Washington D.C. in September 2012. The Governor is promoting collaboration between all agencies in the Commonwealth to aid our Service members, Veterans and their families. This group meets on a regular basis and is working on legislation to aid our military and veteran populations in our state. One focus area is the lack of available data regarding the military populations and how they are being served in Kentucky.

### ***Kentucky's Military Data Workgroup -PARIS Match for Medicaid***

Kentucky's Military Data Workgroup was established as a sub group of the Kentucky Policy Academy with a charge to gather data and information. We knew that this would be a challenge to get all of the organizations to agree to share data due to HIPAA laws, and state and federal

regulations. However, we are drafting memorandums of understanding, memorandums of agreements and working across all levels of government to ensure that we will be able to share the data. The group has also identified ways to save state Medicaid dollars, possibly up to \$1.2 million dollars in the first year. This will be accomplished by using the Public Assistance Reporting Information System (PARIS) system. The PARIS system will allow us to identify Veterans that are receiving state Medicaid dollars and change their payer source to the Veterans Administration. Veterans should not notice a change in care, just a change in payer source.

### ***Garrett Lee Smith Suicide Prevention Grant***

As a result of the Garrett Lee Smith State/Tribal Youth Suicide Prevention grants, states, tribes and communities will:

- increase the number of persons in youth serving organizations such as schools, foster care systems, juvenile justice programs, trained to identify and refer youth at risk for suicide
- increase the number of health, mental health, and substance abuse providers trained to assess, manage and treat youth at risk for suicide
- increase the number of youth identified as at risk for suicide
- increase the number of youth at risk for suicide referred for behavioral health care services
- increase the number of youth at risk for suicide who receive behavioral health care services
- increase the promotion of the National Suicide Prevention Lifeline

State/Tribal Youth Suicide Prevention Grants are authorized under the Garrett Lee Smith Memorial Act (Section 520E-1 of the Public Health Service Act, as amended). This announcement addresses Healthy People 2020 Mental Health and Mental Disorders Topic Area HP 2020-28 and SAMHSA's Strategic Initiative: Prevention of Substance Abuse and Mental Illness - Goal 1.3 (Prevent suicides and attempted suicides among populations at high risk, especially military families, youth, and American Indians and Alaska Natives (AI/AN)).

The current plans for SFY 2014/2015 are to continue to expand the efforts mentioned above. As the base of knowledge increases and expands to treat TBI and PTSD, we will adapt accordingly to offer the current best practices to professionals and providers. Our plans include providing the OHH conference once per year and alternating the location between a military base (Fort Knox or Fort Campbell) and a public facility. We want to provide trainings to the different regions across Kentucky. Operation Immersion will be held two times per year once in the Fall and once in the Spring. We are hopeful that the bond between the Kentucky National Guard and our organization continues to grow in order to serve the Heroes that deserve our help.

### ***Preparations for a Website***

A central access point for resources in Kentucky is being considered and a website may serve as a possible solution. The site will provide information for State and National resources and possibly provide training for providers in Kentucky. This should be similar to the nationally known program called "Network of Care."

### ***Changing Provider Contract Language***

DBH will be inserting language into our Community Mental Health Centers contracts that require CMHC to send key employees to free military training events to gain perspective and insight into treating the Service members, Veterans and Military families.

### **Data Sources Used:**

- [http://factfinder2.census.gov/faces/nav/jsf/pages/community\\_facts.xhtml](http://factfinder2.census.gov/faces/nav/jsf/pages/community_facts.xhtml) U.S. Census Bureau| American FactFinder
- [http://www.va.gov/vetdata/docs/Maps/VetPop11\\_Under25.pdf](http://www.va.gov/vetdata/docs/Maps/VetPop11_Under25.pdf) U.S. Department of Veterans Affairs
- <http://www.va.gov/vetdata/Maps.asp> U.S. Census Bureau
- [http://www.va.gov/vetdata/Veteran\\_Population.asp](http://www.va.gov/vetdata/Veteran_Population.asp),  
<http://www.va.gov/vetdata/Report.asp> U.S. Department of Veterans Affairs, The National Center for Veterans Analysis and Statistics (NCVAS)
- DBHDID Client Event Data Set

### **Substance Abuse Prevention**

Many of the gaps identified in the last Prevention Block Grant Plan were either partially or wholly realized through our State Prevention Enhancement (SPE) Grant and the State Epidemiological Outcomes Workgroup (SEOW) grant. The SPE grant, aimed at strengthening state prevention capacity, ended in June 2012. The SEOW grant, scheduled to last until September 2013 was relinquished as a prerequisite to qualifying for SAMHSA's Partnership for Success (PFS) funding.\*

In October of 2012 the Substance Abuse Prevention Branch of the Division of Behavioral Health was one of 15 States/Territories to be awarded a SAMSHA's Partnership for Success (PFS) II grant. All PFS recipients are required by SAMSHA to utilize the Strategic Prevention Framework to plan and implement strategies aimed at reducing the consequences associated with underage drinking (UAD) and prescription drug (Rx) abuse. Since the focus of the PFS is very similar to pre-existing underage drinking and prescription drug components of our prevention block grant plan covered under our Changing Social Norms and Policy (CSNaP) initiative, there is much overlap between the two. The additional financial and technical assistance resources that the PFS affords will allow Kentucky to pursue these existing block grant goals more thoroughly and more systematically. If you will, the PFS is like a new motor in an old vehicle whose destination has already been set.

The PFS is a three year grant, scheduled to run until September 30, 2015, thus covering the time frame for this Block Grant planning period. Globally, the goal of the PFS and of our Rx and UAD block grant goals are to achieve a statewide reduction of past 30 day consumption of both of these substances. The information below provides more detail on the needs assessment activities, capacity building goals and types of activities and strategies that will be implemented.

As a requirement of the PFS application the SEOW was required to conduct a needs assessment to determine communities of high priority. Unlike past SAMSHA grants, where community was defined by the county boundaries, the PFS defines community on the much larger regional scale. The SEOW identified seven regions of need for UAD and Rx. These target regions are identified on the map below.

The SEOW utilized a number of data sources to determine regions of high need. The two principle sources that informed the SEOW findings were Kentucky Incentives for Prevention (KIP) Survey 2010 data and the 2011 Youth Risk Behavior Survey (YRBS).

### **Additional Unmet Needs**

- 1) One of the critical unmet needs facing our prevention system as we move forward with our efforts to curb prescription drug misuse and abuse is a lack of documented research on effective strategies. Some facets of this problem were discussed at a break out session at the national PFS Grantee meeting last year. The efficacy of strategies such as permanent prescription drug drop boxes and one day community prescription drug drop offs were discussed at length. The only conclusion that was drawn was that, while these strategies sound promising, there is, currently at least, no way to know if they are effective because: 1) no one really knows what total the quantity of prescription pain killers are in a given community, hence there is no way to measure what effect drop boxes and the like have on reducing that quantity and; 2) medication from drop boxes is generally measured in weight, not in types of pills returned. So there is no way to know if the drugs that the drop boxes are targeted to reduce are actually being disposed of.
- 2) In order to more effectively measure the outcomes of our Regional Prevention Center System we need to develop a standard set of performance indicators. This is problematic given the regional differences in culture, readiness of the counties served, and skill levels of staff.
- 3) Enhancements are needed to our Prevention Data Set that will allow us to compare the activities entered into the data system with the goals and activities of the RPC work plans so that we can generate some type of "work plan status" report that will give us a snapshot of what progress has been made on the RPC work plans. The data system was in place well before the work plans were developed and is not designed to generate these kind of reports. We are not even sure if the data system is capable of being upgraded to perform this type of task. We do not have the resources to develop/purchase a new data system.
- 4) Due to state budget cut backs our Early Intervention Program (EIP) was discontinued. The EIP program allowed schools, The Administrative Office of the Courts, the Department for Juvenile Justice and other organizations serving youth to screen high risk youth that resulted in either a referral to treatment or provided these youth with an evidence based prevention program. The loss of EIP means that we no longer have a systematic way to serve the selected population. Some RPC's have managed to fund limited EIP programs within their region. But the scope has been vastly reduced, leaving a huge need for services to address this population.

### **Additional Epidemiological Data for the Ranking of Alcohol, Tobacco and Other Drugs**

Drugs other than alcohol and prescription drugs were not included in this section because they were not state priorities. Additional SEOW data can be found on tobacco and other drugs in the Kentucky SEOW State Profile available at the link below:

<http://sig.reachoflouisville.com/LinkFiles/KY%20SEOW%20State%20Profile.pdf>

Also, the SEOW in conjunction with REACH of Louisville as part of its ongoing needs assessment produced regional ATOD profiles from 2012 KIP data. This report has not been posted on the SEOW link to the Data Warehouse but is available upon request.

The Composition of the SEOW is as follows:

Participant	Organization/Entity
Irene Centers	Dept. for Public Health
Steve Cambron	Div. Behavioral Health
Dr. Richard Clayton	University of Kentucky
Ron Crouch	State Workforce Cabinet
Mike Razor	Alcoholic Bev. Control
Bob Illback	REACH of Louisville
Van Ingram	Off. Drug Control Policy
Connie Neal	Office of the Courts
Nick Peiper	REACH of Louisville
Dr. Vestena Robbins	Div. Behavioral Health
Connie Smith Div.	Behavioral Health
Libby Taylor	Dept. of Education
Jan Ulrich	Div. Behavioral Health
Dr. Richard Wilson	University of Louisville

### **The SEOW's Process for Primary Prevention Planning**

The epidemiologist (Nick Peiper) will communicate directly with the SEOW Chairs (Connie Smith and Steve Cambron), and be responsible for managing tasks and deliverables. The SEOW Chairs and the epidemiologist will be responsible for maintaining involvement with state agencies, relevant state advisory groups, and the network of regional prevention centers (RPC). The SEOW Chairs will provide regular updates to the Director of the Division of Behavioral Health and the Commissioner of the DBHDID. The epidemiologist will be included in these briefings to provide additional detail about the process and deliverables.

The SEOW will systematically evaluate the correlates and consequences of Alcohol, Tobacco, and Other Drug (ATOD) usage throughout Kentucky. These evaluations will serve to advise the BHDID as well as facilitate the continued surveillance, analysis, and reporting of ATOD usage. The SEOW will function to:

1. Suggest appropriate data analyses, facilitate appropriate interpretation of findings, suggest methods for sharing data across disciplines, determine underutilized data sources, and promote new forms of data collection.
2. Ensure that relevant state and community planners have useable survey, demographic, risk/resilience, enforcement, morbidity/mortality, and treatment data.
3. Expand the data warehouse managed by REACH of Louisville, Inc. to further facilitate the dissemination of relevant ATOD and mental health data.

4. Serve as a technical resource for the Division of Behavioral Health and any other relevant organization or entity.

## **DATA COLLECTION AND METHODOLOGY**

The SEOW will conduct state and community assessments that will include the following:

1. Assessment of the incidence and prevalence of substance abuse and mental health disorders within specific populations and across the lifespan.
2. Determination of the nature, magnitude, and problems associated with substance abuse and mental illness.
3. Establishment and management of relevant data systems, including systems used to conduct archival, evaluative, ethnographic, and prospective studies as well as those designed to serve as an early warning network.
4. Coordination with appropriate decision-making entities within the state or community to provide data in formats useful for guiding effective and efficient use of prevention resources, including the development of templates, reports, and other products for dissemination.
5. Promotion of ongoing, in-depth exchange of data and learning among the SEOW and state/community leaders who have extensive knowledge of local substance abuse and mental health problems.

## **Additional Data Sources From Other State Agencies That Provide or Purchase Behavioral Health Services**

### **KENTUCKY STATE POLICE (KSP)**

Description: The KSP archives data regarding alcohol and drug-related collisions, adult and juvenile arrests, and other illegal activity.

Sponsor(s): Commonwealth of Kentucky

Geographic level: State, County

Frequency: Data collected and reported annually

Years Used: 2009

Indicators: Fatal collisions; Alcohol and drug arrests

Strengths: County-level estimates

Weaknesses: Small samples

Link: <http://www.kentuckystatepolice.org>

### **KENTUCKY DEPARTMENT FOR COMMUNITY BASED SERVICES (DCBS)**

Description: DCBS was formed within the Cabinet for Families and Children in 1998 to give local offices more decision-making authority and the ability to collaborate more effectively with other community service providers. DCBS services are administered through our network of nine service regions and offices in each of Kentucky's 120 counties. In addition, DCBS utilizes a

network of contract officials to deliver services, such as child care. The provision of services is enhanced through a close relationship and coordination with local community partners.

Sponsor(s): Kentucky Cabinet for Health and Family Services

Geographic level: State, County

Frequency: Data collected and reported annually

Years Used: 2010

Indicators: Substance abuse cited and substantiated as risk factor among newborns

Strengths: County-level estimates

Weaknesses: Estimates based on small samples

Link: <http://chfs.ky.gov/dcbs/>

#### KENTUCKY CENTER FOR SCHOOL SAFETY (KCSS)

Description: The KCSS brings together a collaborative partnership to facilitate training and technical assistance to education, human service and justice professionals, teacher preparation, applied research, electronic communication, and school and community needs assessment.

Sponsor(s): Kentucky Department of Education

Eastern Kentucky University

Geographic level: State, County

Frequency: Data collected and reported biennially

Years Used: 2010

Indicators: Disciplinary actions for drug possession, use, and distribution

Strengths: County-level estimates

Weaknesses: Inconsistent drug and substance definitions

Link: <http://www.kysafeschools.org>

#### KENTUCKY OFFICE OF VITAL STATISTICS

Description: Kentucky's Vital Statistics Law, enacted by the General Assembly in 1910, provides for and legalizes the registration of births and deaths.

Sponsor(s): Kentucky Cabinet for Health and Family Services

Geographic level: State, County

Frequency: Data collected and reported annually

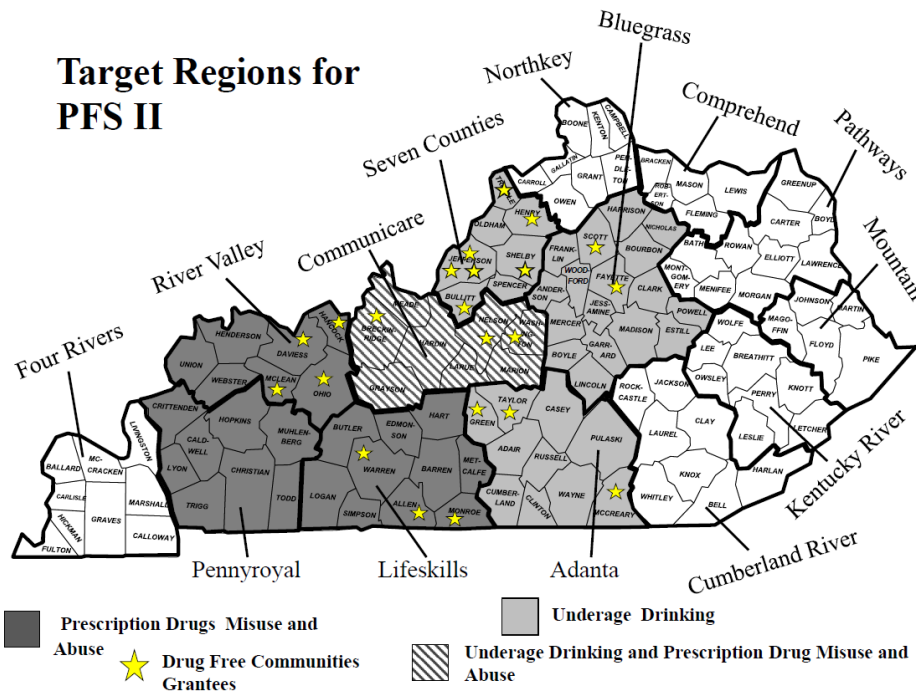
Years Used: 2006

Indicators: Births to mothers who smoked during pregnancy

Strengths: County-level estimates

Weaknesses: Small samples; Data not comparable to years prior to 2004

Link: <http://chfs.ky.gov/dph/vital/>



**Table 2: Weighted prevalence of alcohol and prescription drug abuse among Kentucky high school students, YRBS 2011**

Characteristics	Any Alcohol	Binge	Prescription Drugs <sup>1</sup>
	%	%	%
<b>Total</b>	34.6	23.2	19.0
<b>Gender</b>			
Male	35.6	24.8	20.6
Female	33.4	21.2	17.0
<b>Grade</b>			
9 <sup>th</sup>	23.3	13.5	15.1
10 <sup>th</sup>	31.8	21.8	16.3
11 <sup>th</sup>	41.0	26.7	24.4
12 <sup>th</sup>	44.1	32.0	20.9
<b>Race/Ethnicity</b>			
White	35.2	24.2	20.4
Black	23.7	10.3	11.8
Hispanic	50.6	37.2	21.6
Other	34.9	21.3	24.2
<b>Mental Health<sup>2</sup></b>			
Depression	43.6	29.3	32.5
Bullied	40.1	26.8	29.6
Suicide Attempt	50.1	34.3	40.5

<sup>1</sup>Lifetime use of OxyContin, Percocet, Vicodin, Adderall, Ritalin, or Xanax



The distribution of prevalence rates for alcohol intoxication and associated risk and protective factors from the 2010 KIP Survey are summarized in Table 3 by region. Table 4 provides similar data for prescription drug abuse.

**Table 3: Prevalence of alcohol-related indicators among Kentucky adolescents by Regional Prevention Center district, KIP 2010**

RPC Region	Type of Alcohol Abuse			Risk & Protective Factors		
	Intox	Binge <sup>1</sup>	Any	Early Abuse <sup>2</sup>	Access <sup>3</sup>	Disapproval <sup>4</sup>
	%	%	%	%	%	%
Kentucky	11.2	9.5	17.4	3.1	23.4	6.7
Adanta	11.4	9.5	17.5	3.4	24.7	7.6
Cumberland River	8.7	7.4	13.7	2.8	21.8	5.9
Bluegrass	12.0	9.8	18.0	2.6	23.3	7.8
Comprehend	10.6	9.9	17.0	4.1	24.4	6.4
Northkey	11.3	9.6	17.8	3.4	23.5	6.0
Communicare	13.0	11.1	20.8	3.4	26.0	7.5
River Valley	12.0	10.2	17.9	3.0	22.8	7.0
Four Rivers	10.5	9.0	17.3	3.5	23.6	6.4
Pennyroyal	11.0	9.1	17.3	3.2	25.1	6.7
KY River	9.9	8.9	14.4	3.1	20.3	6.5
Mountain	9.3	8.5	14.5	2.5	22.1	6.8
Pathways	10.8	9.4	16.5	3.0	22.9	6.7
Seven Counties	13.2	11.0	21.0	2.7	24.1	7.2
Lifeskills	10.6	9.3	13.7	3.3	22.1	7.8

<sup>1</sup>Binge drinking during the past 2 weeks

<sup>2</sup>Began drinking regularly, at least one or twice a month, at age 12 or younger

<sup>3</sup>Reported very easy access to getting some beer, wine, or hard liquor

<sup>4</sup>Reported not wrong at all for someone their age to regularly drink beer, wine, or hard liquor

**Table 4: Prevalence of prescription drug-related indicators among Kentucky adolescents by Regional Prevention Center district, KIP 2010**

RPC Region	Prescription Drug Type <sup>1</sup>				Risk & Protective Factors	
	Oxy	Tranq	Speed	Any	Access <sup>2</sup>	Disapproval <sup>3</sup>
	%	%	%	%	%	%
Kentucky	1.0	1.5	0.9	2.8	5.6	1.7
Adanta	0.9	1.6	0.8	2.8	5.3	1.5
Cumberland River	1.0	1.4	0.7	2.6	5.8	1.4
Bluegrass	0.9	1.4	0.7	2.7	5.9	1.8
Comprehend	1.3	0.9	0.5	2.5	5.1	1.7
Northkey	1.3	1.6	1.0	2.7	6.0	1.8
Communicare	1.3	2.0	0.9	2.9	4.6	1.8
River Valley	0.9	1.7	1.2	3.5	5.3	1.9
Four Rivers	1.0	2.0	1.3	2.9	6.1	1.9
Pennyroyal	0.9	1.5	1.1	3.3	6.8	1.9
KY River	0.5	0.8	0.6	2.3	5.7	1.6
Mountain	0.5	0.8	0.4	1.7	6.0	1.4
Pathways	0.8	1.0	0.7	2.0	5.8	1.8
Seven Counties	1.1	1.8	1.1	3.2	4.1	1.6
Lifeskills	1.4	2.1	0.8	3.6	5.6	1.9

<sup>1</sup>Reported use on one or more occasions in the past month

<sup>2</sup>Reported very easy access to getting cocaine, LSD, or amphetamines

<sup>3</sup>Reported not wrong at all for someone their age to use LSD, cocaine, or other illegal drugs

Changing Social Norms and Policy, as the title suggests, focuses on environmental strategies that aim to change norms around acceptability of usage and limit availability of access. Regions that are concentrating on prescription drugs will concentrate their efforts primarily on:

- Correcting three (3) youth misperceptions about prescription drugs - that they are: 1.) safer than street drugs, 2.) less addictive than street drugs, 3.) OK to share among friends and family
- Safe storage and disposal of prescription drugs
- Support for new Kentucky legislation which licenses pain clinics and mandates the use of the Kentucky All Scheduled Prescription Electronic Drug Reporting (KASPER) system for all doctors in the state
- Conducting large scale informational efforts directed at parents, caregivers and prescribers of prescription drugs

Regions that are concentrating on Underage Drinking (UAD) binge drinking will focus primarily on:

- Limiting social and retail access of alcohol to underage youth through establishment of Social Host Ordinances, or strengthening enforcement of these ordinances in counties where they already exist.
- Retail access strategies such as shoulder taps and compliance checks.

- Expanding and intensifying the “I Won’t Be the One” campaign – a large scale informational efforts at older adults about the legal and health consequences of providing alcohol to underage youth.

Additionally, the PFS will seek to strengthen prevention capacity/infrastructure at the State and community levels for addressing underage drinking, prescription drug misuse and abuse and for promoting mental health.

Kentucky’s PFS proposal also embraces three (3) of the four (4) prevention goals of SAMSHA’s Strategic Initiative # 1 which are already long term goals of our Block Grant plan. Briefly, those goals are:

- With primary prevention as the focus, build emotional health, prevent or delay onset of, and mitigate the symptoms and complications from substance abuse and mental illness
- Prevent or reduce the consequences of underage drinking
- Prevent or reduce the consequence of prescription drug misuse and abuse

\*As per the criteria of the PFS Request for Proposals (RFP), states awarded PFS funding must give up the remainder of the SEOW funding. SAMHSA’s expectation is that PFS funding can be used to support the SEOW throughout the PFS grant cycle.

Many of the gaps that were identified in our prevention infrastructure will require long term effort to fill. Below is a list of the gaps that were included in last year’s report and a bolded update on what has been done to address them.

Need to focus more efforts on diverted prescription drugs and underage drinking, both of which emerged as priorities in the most recent SEOW needs assessment;

**Status: As described above, a large part of our UAD and Rx efforts have been rolled into our PFS grant. Carry over block grant funding has also been provided to the Regional Prevention Centers (RPC’s) not covered in the PFS so that all counties of the state are served.**

The capacity for engaging with behavioral health issues (e.g. indicators of social, emotional, and behavioral well-being) is minimal and has not received emphasis heretofore;

**Status: In 2012 the state offered three (3) Statewide trainings that addressed the integration of mental health and substance abuse. The Integration of Mental Health and Substance Abuse Prevention, facilitated by Michael Compton, drew 117 participants from Regional Prevention Centers, Community Mental Health Centers and private treatment providers. Seventeen (17) state staff from the Division of Behavioral Health also attended.**

There is a need for a more systematic and comprehensive system for disseminating information about Evidence Based Practices (EBP) and Programs and for providing related training and technical support to the field. Kentucky proposes to form an Evidence-based workgroup to help translate the findings of the SEOW with meaningful and appropriate preventive interventions at community level;

**Status:** An Evidence-Based Practices Workgroup was formed last year and has met several times. The workgroup created two (2) very useful training tools related to community capacity building: 1) Understanding the Strategic Prevention Framework - an instructional poster explaining of the five (5) steps of the SPF in everyday language that volunteer community members are more likely to understand. 2) “The Process” a training DVD which elaborates and dramatizes the utility of community-level strategic planning with a particular focus on the SPF.

There is a need for renewed effort toward integrating and focusing limited resources in high-need communities. This will require broad systemic effort at the state level, but also focused coordination and planning at the community (regional) level with the full engagement of stakeholders;

**Status:** The SEOW identified seven (7) regions (55 counties) of high need in its PFS application. Resources have been directed to these regions to conduct additional needs assessments and to begin strategic planning. State prevention staff are looking at ways that block grant allocations to RPCs might be reformulated based on need and performance. Revision of the RPC work plans, which was just completed, is the first step in this process. We are also working with a team of out-of-state experts to see how other states have tackled this problem.

There remain some major gaps in terms of problems and populations, including the state’s growing Hispanic population, adult substance abuse (especially older adults), emerging adults in the 18-24 age range, data on substance abuse and mental health difficulties in the workplace, LGBTQ youth and military families and children (Kentucky hosts two (2) of the nation’s largest military posts: Fort Knox and Fort Campbell). There is a need for data development in these areas;

**Status:** In July of 2012 The Division of Behavioral Health hosted an LGBTQ2S Training which drew seventy-one (71) participants – ten (10) state staff from the Division of Behavioral Health, as well as a number of Regional Prevention Center staff and community coalition members. State staff participated in a LGBTQ2S work group which conducted a needs and resource assessment for this population and drafted a work plan. Plans are currently underway to expand the workgroup to include branches of the entire Department.

The Faith Hope Future Conference which targeted risk factors for substance abuse and behavioral health among the military and their families drew seventy-seven (77) participants. The conference focused on such issues as mental and spiritual health injuries; Post Traumatic Stress Disorder; Post Traumatic Spiritual Disorder; Traumatic Brain Injuries; Military Sexual Trauma; spousal and child abuse; depression, substance abuse, and adjustment disorders. Eleven (11) RPC Staff and two (2) DBH staff attended.

There remain significant issues with respect to Appalachian life and culture that must be considered when targeting those geographic areas;

**Status:** This issue has been discussed at Regional Prevention Center Directors meetings and at Evidence-based Work group meetings, but as of yet there are no milestones or outcomes to report.

Need to update and expand the functionality of Kentucky's Data Warehouse (e.g., mapping and charting capacities), improve its attractiveness and usability (e.g., data visualization, infographics), and provide much more extensive training and support in its use within active planning processes;

**Status: This gap has been fully addressed. The data warehouse has been expanded to include mental health indicators, mapping and graphing features have been enhanced and three (3) training videos have been added "Public Health: Telling the Story Using Data", "Translating Data into Public Health Priorities", and "Introduction to Epidemiology".**

Several areas that need strengthening through workforce development and training include: (1) basic knowledge about the SPF framework; (2) knowledge and skills in planning processes, including data integration and goal formulation; (3) more knowledge about EBPs in prevention and the capacity to thoughtfully select strategies; (4) skill in data distillation and synthesis for the purposes of planning and evaluation; (5) skill in program management and implementation; (6) general knowledge and skills related to program evaluation, including instrument design, data analysis, and portrayal; (7) skills related to coalition-building; and, (8) skill in utilizing the enhanced data warehouse.

**Status: Gaps 4, 5, and 8 have been partially filled by the data warehouse training modules mentioned above. The PFS Project Director and Coordinator have scheduled training with the developers of the data warehouse to familiarize themselves with the new features. We are looking at the possibility of conducting a webinar for RPC staff and local coalitions on how to use the new data warehouse.**

**Prevention Goals for SFY 2014/2015**

Priority	Goal	Strategy	Performance Indicator	Target Population	Status
With primary prevention as the focus build emotional health, prevent or delay onset of, and mitigate symptoms and complications from substance abuse and mental illness.	Integrate the prevention of mental illness into state and local substance abuse prevention efforts as appropriate.	Provide training to Prevention staff state and regional regarding strategies/ resources to address the prevention of mental illness, including cultural training on high risk population, LGBTQ & military & Native American  Include relevant mental health data as indicated in the KY SEOW Epi-profile to the data warehouse	Number of trainings provided, number of state and RPC staff trained. Increased knowledge of mental illness prevention as measured by training evaluations.  The number of mental health promotion activities performed by the RPCs as measured by the prevention data set.	RPC Staff and Prevention Professionals	Ongoing In 2012 the state offered three (3) Statewide trainings that addressed the integration of mental Health and Substance Abuse. One hundred seventeen (117) RPC and CMHC staff attended. (SFY 2012)
Prevent or reduce consequences of underage drinking	Reduce state 10 <sup>th</sup> grade, 30 day binge drinking rate by at least 1% . KIP 2012 survey will be used as a baseline. KIP 2014 data will be used to measure outcomes.	Supporting/strengthening the enforcement of existing laws regarding adults providing alcohol to minors.  Implement local policies that target social access of alcohol to youth (social host & unruly gathering ordinances)	Increase in enforcement of UAD laws as measured by local law enforcement data and reports to coalitions  An increase in RPC time spent on UAD environmental strategies as measured by the prevention data set.  Number of policies developed	9 <sup>th</sup> -10 <sup>th</sup> grade youth in targeted counties  Parents & community at large.	Ongoing until September 30 <sup>th</sup> 2015. Applied for and was granted CSAP's PFS – a grant that specifically focuses on UAD and Rx. The PFS grant will be used to fund this goal. A needs assessment has been conducted which identified seven (7) regions of high need. Target regions are currently in the planning process. (SFY 2012)
Prevent suicides and attempted suicides among populations at high risk.	Integrate the prevention of suicide among high risk populations into state and local substance abuse prevention	Provide training to state and regional level prevention staff on the need for, and strategies and resources to address, suicide prevention, including cultural training on high risk population (LGBTQ, Native American and military families).	Number of trainings provided, number of state and RPC staff trained.  Increased knowledge of suicide prevention strategies and of the high risk populations as measured by training evaluations	RPC Staff and Prevention Professionals	Ongoing RPC staff have received QPR Suicide Prevention Training. Some RPCs have hosted this training for local coalitions. (SFY 2012)

Priority	Goal	Strategy	Performance Indicator	Target Population	Status
	efforts as appropriate.		Number of suicide awareness activities conducted by the RPCs as measured by the Prevention Data Set		
Reduce prescription drug misuse and abuse	<p>Increase in parental awareness of youth Rx drug abuse</p> <p>Reduce state 10<sup>th</sup> grade 30 day Rx drug abuse. KIP 2012 survey will be used as a baseline. KIP 2014 will be used to measure outcomes.</p>	<p>Parental Rx education &amp; awareness programs that stress proper storage, monitoring and disposal of Rx drugs.</p> <p>Determine three (3) main misperceptions of students garnered from RPC Conducted focus group information around Rx drug misuse. Enlist the partnership of local high schools to participate in a youth contest that develops media messages that address of the three (3) identified misperceptions.</p>	<p>Number of flyers delivered, number of distribution points as measured in the prevention data set. Increase in RPC time of spent on environmental strategies relating to Rx drugs in selected counties, as measured by the Prevention Data Set.</p> <p>Number of contest winners</p> <p>Number of youth who see the media messages</p>	<p>Adults in the community</p> <p>9<sup>th</sup> Graders in targeted counties</p>	<p>Ongoing until September 30<sup>th</sup> 2015. Applied for and was granted CSAP's PFS – a grant that specifically focuses on UAD and Rx. The PFS grant will be used to fund this goal. A needs assessment has been conducted which identified 7 regions of high need. Target regions are currently in the planning process. (SFY 2012)</p>
Reduce prescription drug misuse and abuse	Expand indicators related to prescription drug abuse	Revise KIP Survey to include questions on perceived availability peer usage, perception of risk of Rx drugs and favorable attitudes toward Rx drugs.	# of new questions added to KIP concerning prescription drug abuse and misuse	6 <sup>th</sup> , 8 <sup>th</sup> , 10 <sup>th</sup> and 12 <sup>th</sup> graders	<b>Completed (SFY 2012)</b>
Reduce access of tobacco products to underage youth	A decrease of two (2) percentage points in perceived availability of tobacco products to underage youth in 6 <sup>th</sup> , 8 <sup>th</sup> , 10 <sup>th</sup> 12 <sup>th</sup>	<p>Develop a tobacco vendor education program consistent with new FDA guidelines.</p> <p>Begin phase I of tobacco retail licensing initiative</p> <p>Issue report on Reward and Remind outcomes</p>	Number of students who respond “very hard” or “sort of hard” to the question “ If you wanted to get some cigarettes how easy would it be for you to get some “ or (KIP Survey 2012)	<p>Tobacco Retailers</p> <p>Tobacco Retailers</p>	<p>KIP 2012 survey results are not yet available. Once they are made available we will compare tobacco availability data for 2010 and 2012. Tobacco Vendor Training was developed in SFY 2011 and launched in SFY 2012</p>

Priority	Goal	Strategy	Performance Indicator	Target Population	Status
	Increased knowledge of Synar program, methodology goals and outcomes and KY youth tobacco use trends.	and lessons learned to RPC Staff and partner agencies  Organize an annual Synar conference ,  Regular e-mail updates to field	Distribution of report  Evaluation results from conference  # of participants at conference	State and RPC staff, and agency stakeholders  RPC staff and Prevention Professionals	<b>Completed (SFY 2012)</b>
Smokeless tobacco	Increase state-level smokeless tobacco prevention efforts	Update RPC's and prevention professionals on current smokeless data trends, and related information.  Increase resources to address Smokeless tobacco.  Work with ABC to increase number of smokeless tobacco compliance checks	Number of email updates  Number of smokeless tobacco presentations, made at RPC meetings, and other prevention venues  Number of Smokeless related e-mails sent to RPC staff and other prevention professionals.  Number of new resources created or existing resources made available to RPC's and Prevention Professionals.  Number of smokeless tobacco checks performed by ABC during FFY 2012	RPC Staff and Prevention Professionals  RPC Staff and Prevention Professionals  RPC Staff and Prevention Professionals  Tobacco Vendors	Ongoing (3 presentations given)  Tobacco Prevention Enhancement Site created "Smart Mouth," A prevention curriculum that targets youth smokeless tobacco use. (SFY 2012-13)
Make the data warehouse a more useful prevention	Update and expand the functionality of the KY data				<b>Completed (SFY2012)</b>



Priority	Goal	Strategy	Performance Indicator	Target Population	Status
planning tool	Warehouse				

### Prevention Block Grant Goals for 2014-2015

Priority	Goal	Strategy	Performance Indicator	Target Population	Status
Smokeless Tobacco Use	Increase the number of Synar inspections for smokeless tobacco.	Revise Synar inspection protocol smokeless tobacco and submit to CSAP for approval.	Number of Synar smokeless checks in 2012 compared to 2013	Tobacco vendors	
Smokeless Tobacco	Track # of smokeless checks done through ABC tobacco inspections and monitor retail violation rate	Modify ABC tobacco inspection form to distinguish smokeless inspections from cigarettes (Currently there is no information on the ABC inspection sheet to differentiate smokeless from cigarettes. .So we do not know how many violations are for smokeless)	Establishment of a baseline for number of smokeless checks performed  Establishment of a baseline retail violation rate for annual ABC smokeless checks.	Tobacco vendors	
Cigarettes and smokeless tobacco	Increase the number of Kentucky Tobacco retail clerks who have received TRUST training	Develop Marketing campaign to advertise TRUST.	Increase in number of tobacco retailers trained in 2013 compared to 2012.	Tobacco vendors	

Tobacco	Support Departmental efforts to implement smoking cessation in substance abuse and mental health treatment facilities	<p>Identify stakeholders, Compile the latest research on best practices for implementing smoking cessation in mental health and substance abuse treatment settings</p> <p>Collaborate with other departmental contacts to form a work group to synthesize research, and draft a work plan.</p>	<p>Formation of a mental health and substance abuse treatment smoking cessation workgroup.</p> <p>Compilation of research</p> <p>Formation of mental health substance abuse treatment smoking cessation workgroup</p> <p>Drafting of workgroup recommendations for addressing tobacco addiction among those with mental health and substance abuse problems.</p>	Persons suffering from mental health and substance abuse	
Strengthen state prevention infrastructure	Increase capacity of RPC staff to train communities on the Strategic Prevention Framework	Conduct workshops for all RPC's on the SPF process. Focus of the workshop will be how to overcome real life challenges that occur as communities implement the SPF.	<p>Number of RPC Staff and coalition members trained on the SPF.</p> <p>Number of RPC Staff who report they are comfortable using the SPF process. Number of counties that RPC staff report are using the SPF process effectively as compared to a 2012 baseline survey</p>	RPC Directors and Staff	

<p>Data Reporting</p>	<p>Improve quality of data reported into the Prevention Data System by RPC staff across the state</p>	<ol style="list-style-type: none"> <li>1. Convene a statewide work group of RPC representatives focused on Prevention Data, reviewing modules or themes of information collected in the Prevention Data System, making recommendations for improvements (Nov 2012 to Dec 2013)</li> <li>2. Address the number of elements used for capturing data into the prevention data system, ensuring a connection between elements and reporting purposes (Jan to Apr 2013)</li> <li>3. Review data (modules of services/activities, programs, participants) for clear understanding of barriers to reliable data, providing information and training sessions for branch staff and RPC staff (Nov 2012 to Dec 2013)</li> </ol> <p>Develop a series of</p>	<ol style="list-style-type: none"> <li>1. Data elements include ways to gather effective or short-term outcomes</li> <li>2. Process outcomes are more reliable and verifiable</li> <li>3. Data Manual is updated to reflect improvements</li> <li>4. RPC staff self-report improved</li> <li>5. Data review of modules or themes indicate improved use of the Prevention Data System by RPC staff through connecting data pieces, which indicate improved reliability of data</li> </ol> <p>Reports produced provide performance measures to RPC staff.</p>		
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		reports that are performance and process oriented for RPC staff to use in their strategic planning and work (July to December 2013)			
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**Data sources:**

- The (KIP) Kentucky Incentives for Prevention Survey (modeled after the Monitoring the Future Survey and conducted in grades 6,8,10,12). KIP is implemented every two years on even numbered years. Approximately 150 out of 170 school districts across the state participate in the KIP survey;
- Behavioral Risk Factor Surveillance System (BRFSS);
- CDC Wide-ranging Online Data for Epidemiologic Research;
- National Survey on Drugs and Health (NSDUH) is an annual survey that collects comprehensive information on substance abuse and mental health. Two-year prevalence rates from the NSDUH are used based on small area estimation procedures that combine state-level data with a national model. Like the KIP and MTF, the NSDUH asks respondents about past-month alcohol and tobacco use. For nonmedical use of pain relievers, illicit drug abuse/dependence, and alcohol abuse/dependence, prevalence rates are based on the past year;
- Kentucky All Scheduled Prescription Electronic Reporting System (KASPER) tracks controlled substances dispensed in Kentucky. Data are primarily intended for physicians, pharmacists and law enforcement officials;
- Kentucky Cancer Registry (KCR) is the centralized population-based cancer registry for the Commonwealth of Kentucky. Mandatory reporting to KCR began in 1991;
- Dartmouth Atlas of Healthcare (DAHC) documents variations in how medical resources are distributed and utilized;
- The Gallup-Healthways Well-Being Index Survey (WBI) surveys roughly 1,000 Americans a day, 350 days a year about health and well-being. Based on their responses individuals and communities receive an overall well-being composite score and a score for each of six sub-indices including life evaluation, emotional health, physical health, healthy behavior, work environment, and basic access; and
- The United States Census Bureau.

**Substance Abuse Treatment**

***Women who are pregnant and have a mental health and/or substance use disorder***

In Kentucky, pregnant women are the only adult population with a Medicaid benefit covering substance abuse treatment and prevention. Pregnant women are identified as a priority population in accordance with Center for Substance Abuse Treatment (CSAT) regulations. The CMHCs screen at initial contact and provide care within twenty-four (24) hours, the remainder within forty-eight (48) hours.

Kentucky has four (4) publicly funded substance abuse programs designed specifically for pregnant women.

1. KIDS NOW Plus (KN+) Substance Abuse and Pregnancy Program provides Universal and Selective Prevention education and identifies, assesses, and links pregnant and postpartum women to addiction and/or mental health treatment, case management, and other community resources. Engaging women in intensive case management provides an opportunity to increase readiness for treatment. Evidence Based Practices (EBP) used include Screening, Brief Intervention, Referral and Treatment (SBIRT), Intensive Case Management, Motivational Interviewing, and Motivational Incentives. In SFY 2012 the following services were delivered to pregnant women:
  - i. Universal prevention to 1,593 women;
  - ii. Selective and Indicated Prevention to 217 women;
  - iii. Intensive case management to 536 women.

KN+ staff are working with the MCOs to make their services more available to the women in the state.

2. **Project LINK** provides intensive case management to pregnant and postpartum women in the Louisville area. KIDS NOW Plus provides their services in the six surrounding counties. The program offers outreach and case management services designed to identify, assess, and link pregnant and postpartum women to addiction treatment, case management, and other community resources.
3. **PRIDE Program** provides outpatient services for pregnant women in Lexington/Fayette County.
4. **Independence House** provides long term residential substance abuse treatment and case management for women during pregnancy. Located in Corbin, in Southeastern Kentucky, it serves women from all over the state.

Four (4) additional long term residential treatment programs and eleven (11) short term (approximately 30 days) residential programs accept pregnant women. Only one (1) residential program accepts pregnant adolescents.

Intensive outpatient treatment is available in eleven (11) of the fourteen (14) regions for pregnant women and in four (4) regions for pregnant adolescents. Four (4) of the residential programs that accept pregnant women (including Independence House) also accept the woman's dependent children.

University of Kentucky Medical Center in Lexington has a high risk pregnancy clinic that provides medical detoxification and/or stabilization on methadone for those who will be able to continue in medication assisted treatment upon returning home. The University of Louisville Hospital also has a NICU for stabilization of babies. All eleven (11) Opiate Treatment Centers accept pregnant women and all (including the nine (9) private programs) consider pregnant women a priority population. They all coordinate well with hospitals that provide medical stabilization on methadone for pregnant women.

The CMHCs typically did not ask about pregnancy on first contact even though this is a priority population. This was changed with the SFY 2013 contract. Each CMHC now has a set protocol for asking about pregnancy at first contact with new female clients. This includes adolescents. Therefore the consistency of immediate admission has increased.

Due to increased monitoring of prescription drug sales through the KASPER program, there has been a reduction in **prescription opiate abuse**. The consequences have caused a significant

increase in the use of heroin. Epidemic levels of heroin use have caused an increase in overdoses. NAS, neonatal abstinence syndrome, has become a house hold term in the public due to media coverage. The NICUs in the state have seen an increase in the number of babies being served. Carry over funds from SFY 2013 will be used to provide additional medication assisted treatment for 25-30 pregnant women for SFY 2014. The Northern part of the state has been particularly hard hit with the heroin addiction. They have received funds this fiscal year and will next fiscal year to meet the need of pregnant women.

The Division of Behavioral Health (DBH) **Trauma Informed Care Initiative** is continuing in SFY 2014. Training for CMHCs will continue at the Kentucky School of Alcohol and Other Drug Studies. Seeking Safety, an EBP standardized trauma treatment for co-occurring trauma and substance abuse, continues to be emphasized in the CMHCs. It is primarily used with women.

An internal work group met to develop the goals/implementation strategies around SBIRT. The state recognizes that this is imperative in order to meet the needs of pregnant women in KY. Implementation will begin in SFY 14-15 in collaboration with the KY Guard.

The **Perinatal Depression Project** the Department for Public Health (DPH), and DBHDID initiated in 2007, continues to be successful and ongoing even with the end of the funding. The health departments are adding a pregnancy specialist at each center. They will assist with referrals for pregnant women. DBHDID programs described above have collaborative relationships with DPH, Administrative Office of the Courts (AOC), the Department of Education's Family Resource and Youth Services Centers (FRYSCs), Department for Community Based Services (child protective services) as well as private OB/GYNs.

***Unmet needs/prevalence data/sources for this population include:***

- Using **national prevalence estimates and outdated state surveys**, an estimated 11.6% of pregnant women use alcohol at some point in their pregnancies and approximately 3.9% use illicit drugs. There were 58,376 live births in Kentucky in 2008 (CDC). If 11.6% of pregnant women used alcohol or drugs, then approximately 6,772 infants were born prenatally exposed. The number of pregnant women who received substance abuse services at the fourteen (14) CMHCs during SFY 2013 was 1,120, or 16% of pregnant women who needed or are estimated to have needed services.
- A new statewide prevalence study for substance use during pregnancy continues to be needed. The most recent study was in 1990.
- Even with the pregnancy and postpartum Medicaid benefit, funding for residential substance abuse treatment is minimally available to pregnant women due the federal Medicaid regulation requiring facilities to have a maximum of sixteen (16) beds. The benefit also extends only to 60 days postpartum, leaving new mothers without resources for supportive services during the crucial first three (3) years of the child's life.
- Although effective screening of pregnant women for substance abuse by medical providers is minimal in Kentucky, the state, in collaboration with other agencies, has developed an implementation plan for SBIRT with pregnant women.
- Medicaid has changed to a managed care system. Medicaid billing for pregnant women has dropped in half during the first half of SFY 2013. The KIDS NOW Plus program is working with one of the Managed Care Organization (MCOs) to increase effective programming for pregnant women.

- Due to fears of losing custody of their children, as well as repeated incidences of arrests and efforts to enact legislation criminalizing substance use by pregnant women in Kentucky, many women do not feel safe disclosing their need for help.
- Public schools do not currently provide prevention education related to substance use during pregnancy.
- Substance Abuse treatment programs do not currently provide prevention education related to pregnancy and substance abuse.

**Unmet Needs:**

Additional treatment resources are needed for pregnant women, especially outside of the “Golden Triangle” of the three largest cities (Louisville, Lexington and Covington). Funding for the two specialized pregnancy programs that serve a wide geographic area, KIDS NOW Plus and Independence House, is not secure: 73% of KIDS NOW Plus funding is allocated annually by the Governor’s office of Early Childhood Development with Tobacco Settlement Funds. Independence House’s SAMHSA Pregnant and Postpartum Women grant ended in October, 2011. Current funding for KIDS NOW Plus is insufficient, affording only twelve (12) case management FTEs and five (5) Prevention FTEs who serve eight (8) of the twelve (12) CMHCs.

27.4% of pregnant women in Kentucky smoke. Other than the 1-800-Quit Now, a national help line for smokers, a minimal number of smoking cessation services are available to pregnant women in Kentucky.

**Priorities for SFY 2013/2014:**

- Continue to monitor and correct the CMHCs compliance with screening for pregnancy on the first contact, through site visits and sample intake phone calls;
- Expand the KIDS NOW Plus Substance Abuse and Pregnancy Program so that women in every county have access to specialized outreach, prevention and case management services;
- Provide continued funding for the Independence House residential program;
- Expand treatment capacity for pregnant women and strengthen the use of Evidence Based Practices in women’s treatment;
- In collaboration with the Department for Public Health, devise a strategy to address the issue of smoking during pregnancy;
- A statewide prevalence study is a priority. Kentucky’s cross-agency substance Exposed Infants workgroup has a committee chaired by a neonatal physician which is prepared to do such a study when funding is available;
- In collaboration with the Kentucky Chapters of the American College of Obstetrics and Gynecology, the American Medical Association, and a statewide initiative is needed to promote the use of a pregnancy specific SBIRT protocol by medical providers. The protocol should include specialized instruction on how to address the unique fears and barriers faced by pregnant women with substance use disorders;
- Seek a Medicaid waiver to reimburse for residential substance abuse treatment at facilities with more than sixteen (16) beds;
- Collaborate with the Department for Community Based Services (child welfare) to adopt a strategy for addressing pregnant women’s fears of having their children removed and their resulting reluctance to seek help for their substance use disorders;

- Identify or create a training module for clinicians on providing prevention education on pregnancy and substance abuse, and through the contract process and/or regulation, require providers to give this information to all clients; and
- In collaboration with DPH, provide adequate funding for the Perinatal Depression Project to increase treatment capacity and utilization for perinatal mood disorders statewide. At the same time, strategies for engagement need to be identified and implemented through existing programs such as KIDS NOW plus and DPH's HANDs (home visitation program).

**Data Sources:**

- Office of Drug Control Policy, Annual Report for 2012
- CDAR: Center for Drug and Alcohol Research
- KIDS NOW Plus Annual Report 2012
- SAMHSA: Data, Outcomes, and Quality (DOQ)
- Department for Public Health, Perinatal Depression Project

***Parents with Substance Abuse and/or Mental Health Disorders with Dependent Children***

DBHDID does not require the CMHCs to prioritize parents with dependent children and so they are provided with the same array of services as the general population. However, twelve (12) of our fourteen (14) CMHCs report that they prioritize referrals of parents from the child welfare system. Child protective services (provided by the Department of Community Based Services or DCBS) currently does not use a standardized method for screening parents for substance use disorders in order to know who to refer for assessment, though they have done a pilot project testing the use of the UNCOPE screener during investigations. DCBS also contracts with a program (the University of Kentucky Targeted Assessment Program) to provide in-depth holistic assessment for a subset of their population, usually clients who are having difficulty achieving self-sufficiency or child custody.

DCBS currently contracts with the CMHCs through DBHDID to provide substance use disorder and co-occurring mental health disorder services to the clients participating in a pilot program called Sobriety Treatment and Recovery Teams (START). In this pilot, Family Mentors (peer support specialists) team with child protective service workers to help engage clients in services and keep children in the home if possible. The CMHCs provide quick access to assessment and referral to the appropriate level of care. Since 2007, START has served 489 families in 4 sites: two urban, one small town, and one rural Appalachian county. While the population is small compared to the large number of families in need of services, it is hoped that the practices tested in these sites can be spread to other regions. In October of 2012, DCBS was awarded a 5 year ACF grant to spread START to another site with a small city. Outcome data from the START program shows the following:

- 72.4% of families has at least one parent with access to treatment within 4 days of referral;
- In 68% of the families, at least one parent was retained in treatment for 5 sessions or more;
- The average number of services for the mothers in the START program was 114.5;
- In 64.9% of the cases, both parents were provided substance use disorder services;
- Families served fell into the top 10% of DCBS clients in terms of number of risks for child maltreatment;



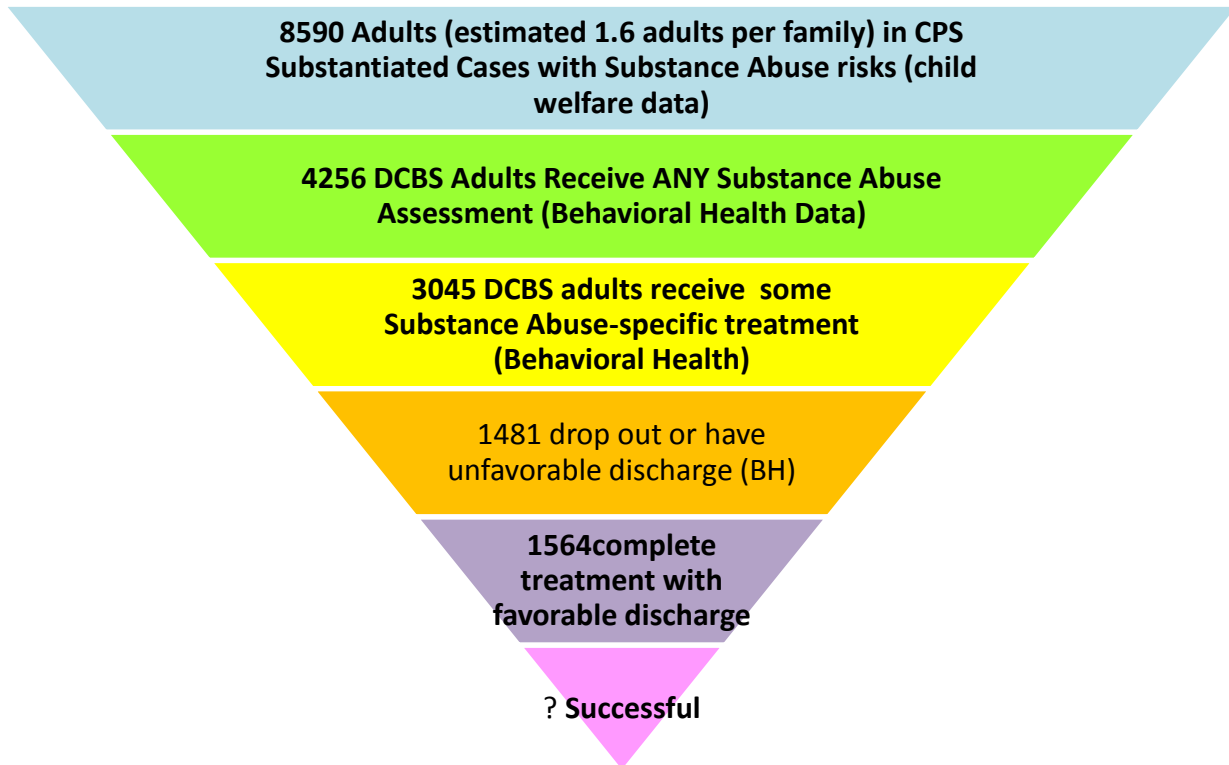
- Almost 70% of the families had at least one parent with a favorable discharge from treatment by case closure, compared to 18.2% of DCBS-referred clients in general who completed a treatment episode; and
- 20.2% of START clients are African American (mostly from the urban Louisville site), .3% are American Indian, 71.1% are Caucasian, .6% are Hispanic, and 7.8% are of mixed race. DCBS has an initiative to reduce racial disproportionality in foster care and child removals.

The Administrative Office of the Courts contracts with one CMHC through DBHDID to provide substance use and co-occurring mental health disorder services to parents involved in the courts and child protective services due to child maltreatment, a project called Families Moving Beyond Abuse (FMBA). Services will also be provided by the CMHC for children in SFY2013. As with START, DBHDID provides a Liaison to the project who provides technical assistance. Because of this collaborative project, progress has been made in increasing the intensity of treatment for parents when needed and breaking down barriers to the use of medication assisted treatment. In October 2012, DBHDID was awarded a SAMHSA Treatment Drug Court grant to enhance the treatment for FMBA. Treatment intensity will be increased to an intensive outpatient level in the community, and treatment will be trauma informed and co-occurring capable. Seeking Safety and Living in Balance will be implemented, and peer support specialists will be employed and co-supervised by the treatment provider and child protective services. No outcomes are available yet for this project.

In the Plan and Budget for SFY13, four CMHCs reported that they always screen for child maltreatment among parents with dependent children. Eight additional CMHCs reported that they sometimes screen. Three currently have a written policy on screening for child maltreatment, and eight reported that they planned to have one by the end of 2012.

***Unmet needs/Prevalence Data*** for this population include:

According to a drop-off assessment (see below) done by the Data and Information Sharing Workgroup of the In-Depth Technical Assistance project that DBHDID participates in with DCBS and the Administrative Office of the Courts, only about half of the possible parents being identified within child protective services as having substance abuse risk factors are receiving assessment services within the CMHCs, and of those who receive an assessment, fewer than half receive some substance use disorder specific treatment, and less than a quarter complete treatment with a favorable discharge.



- Based on feedback provided by DCBS and the courts in various regions, it seems that three distinct barriers exist for parents seeking services from CMHCs: 1) the assessment process frequently results in a recommendation of no treatment based on client self-report and denial of the need for services. This is frustrating to the referral source and possibly restricts clients in need of services from receiving them. 2) Inadequate services are available in some regions of the state, leaving some clients with long wait lists to enter treatment and sometimes a lower level of care and intensity than is helpful to them. 3) Communication between DCBS and the CMHCs is uneven across regions and providers, with information pertinent to child safety not always provided to DCBS. In addition, many of the CMHCs report that the majority of their clients are court ordered by drug courts or because of convictions for driving while intoxicated. The CMHCs do not have well-developed systems for accepting, assessing, providing services, and reporting on clients referred by DCBS, perhaps partly because there is no specific funding source associated with DCBS clients as there is for drug court and DUI clients. Making DCBS clients a priority population for the use of SAPT block grant funds might help to develop an adequate system for serving this population.
- The START evaluation indicates that around 80% of START clients receive intensive outpatient services, which include parenting, education about the disease of addiction, relapse prevention, and family sessions. An assessment by a Service Coordinator is used to determine the level of care required by the client, and the client's level of care may be adjusted based on their progress in treatment. START is only in 4 sites, and intensive outpatient services and quick access to assessments and treatment are not available in every region of the state. Several CMHCs have opted to close their residential treatment programs to concentrate on intensive outpatient programs in more communities.

- Women who are unemployed or those without an employed partner who contributes to the household are most likely to experience poverty and to have no means of health insurance. The 2009 American Community Survey data indicated almost one-fourth (23.5%) of Kentucky children were living in poverty. Current estimates of Kentucky children enrolled in Medicaid programs averaged 386,775 per month, while Kentucky's Children Health Insurance Program (KCHIP) enrollment averaged 60,778 children per month (2009). These state funded insurance programs help to provide women and children with necessary preventative health care and mental health services and are particularly important for families struggling with poverty. Until recently, Kentucky has not opted to include substance use disorder treatment in the state plan for services reimbursed by Medicaid, except for pregnant women. DBHDID and KY Medicaid currently have a state plan amendment in review with federal Medicaid which would increase funding available for substance abuse treatment by an estimated \$17,000,000. This SPA would allow for substance abuse services to be reimbursable for parents with dependent children, adolescents, and individuals with recent criminal justice involvement.

### ***Goal for SFY 2014/2015***

In the Plan and Budget for SFY 2014, the following language was included: Parents with dependent children referred by the Department for Community Based Services (DCBS) are defined as a priority population. DBHDID recommends that CMHCs begin planning for how these individuals can be provided with services for substance use and/or mental health disorders within one week of referral. Plans should include training of staff who works with parents with dependent children. One resource for such training is the free online course from the National Center on Substance Abuse and Child Welfare: <http://www.ncsacw.samhsa.gov/tutorials/tutorialDesc.aspx?id=1>.

In addition, in order to prepare for the expanded coverage of substance abuse treatment under Medicaid, DHBDID will work with DCBS on adopting the screening required for referral.

### **Data Sources:**

- DCBS TWIST (The Worker's Information System),
- the TEDS (Treatment Episode Data Set) and
- NOMS (National Outcome Measures) data set.

### ***Persons who are Intravenous Drug Users (IDU)***

#### ***Prevalence Data***

According to the Office of Applied Studies, there is a decreasing trend in injection drug use with more persons smoking or inhaling heroin and other drugs, rather than injecting them. This national trend is not being mirrored in Kentucky. Reports of injection drug use are slowly rising among individuals in the state substance abuse treatment sample. The change in the number of individuals reporting ever having injected drugs showed a significant increase ( $p < .001$ ) from SFY 2010 to SFY 2012. Of the 15,386 individuals treated for substance abuse in the Community Mental Health Centers (CMHCs) during SFY 2012, 2,954, or 19.2%, reported having used IV drugs. This is an increase from the SFY 2010 rate of 15.8%.

A total of 7,588 individuals who sought substance abuse treatment services at Kentucky Opiate Treatment Programs (OTP) between SFY 2008 and SFY 2011 reported having an injection drug use history compared to 3,957 individuals in the general substance abuse treatment centers between FY09-FY11 who had a history of injection drug use.

Overall, there were a total of 16,385 individuals over the course of about four years who sought addiction treatment in Kentucky and had a history of injection drug use. Only one-fourth of those individuals were in OTPs during that time period and the numbers across years did not change significantly among the OTP client sample. The increase in individuals reporting a history of injection drug use among the CMHC substance abuse treatment sample is statistically significant.

**Strengths:**

1. Kentucky has eleven (11) licensed OTPs, two (2) publically funded and nine (9) independently owned. Kentucky regulates and monitors its OTPs more stringently than many states, and as a result, the programs provide good quality care, both medical and psychosocial.
2. Kentucky has relatively low rates of HIV AIDS.

**Unmet Needs:**

1. Though the public is aware of the serious opiate addiction problem in the state, many Kentucky communities and CMHCs have been resistant to medication-assisted treatment (MAT). Although no data has been collected on this, CMHC site reviews have revealed that: 1) most CMHCs do not screen for IV drug use on first contact as required for the Block Grant; 2) MAT is seldom presented as a treatment option to patients; and 3) the majority of CHMC programs are abstinence-based and do not accept patients on MAT. Over the past 1-2 years, there has been some loosening of treatment program policies barring any psychotropic medication, so that most programs do now allow prescribed antidepressants, and some allow prescribed anti-anxiety medications.
2. There are very few medically-supported detoxification services in the state, and virtually none available to individuals without insurance. Individuals in the CMHC using IV drugs normally are detoxed in a social setting, without any pharmacological assistance.
3. Most substance abuse clients currently served through Block Grant funds are indigent, which puts the private OTPs out of reach. The two publically funded programs are in the main urban areas, and have such an extensive waiting list that there is normally over a year wait. Because the state is poor, rural, and mountainous, accessibility needs to be a part of any solution.
4. Although Kentucky has a serious Hepatitis C problem substance abuse Prevention efforts do not currently include any education about the dangers of IV drug use and needle sharing because such education is seen as a "harm reduction strategy." This is true of Prevention services provided to selective and indicated populations as well as universal. Treatment programs also do not offer education on the dangers of IV drug use and needle sharing.

### **Priorities for SFY 2014/2015**

1. All CMHCs should screen for IV drug use on initial contact in order to be in full compliance with Block Grant requirements. DBHDID needs to educate the CMHCs and hold them accountable through the onsite review process.
2. KY needs to follow national standards such as the *NQF Standard of Care regarding Withdrawal Management*. “Supportive pharmacotherapy should be available and provided to manage the symptoms and adverse consequences of withdrawal, based on a systematic assessment of the symptoms and risk of serious adverse consequences of the withdrawal process.” This could be accomplished by increasing the number of detox services so that there is a minimum of one medically supported detox center in each of the 14 CMHC regions, and more where population or geography requires.
3. KY should follow national standards such as the NQF Standard of Care regarding Pharmacotherapy: “Pharmacotherapy should be recommended and available to adult patients diagnosed with opioid dependence and without medical contraindications.” CMHCs should be required to recommend MAT when appropriate, and affordable MAT options need to be increased (see #4).
4. There needs to be a minimum of one publically-funded OTP program in each of the 14 CMHC regions. With the health care changes coming in 2014, some Block Grant funds should be used to provide MAT to indigent urban and rural residents.
5. KY SA Prevention and Treatment education needs to include information on the danger of IV drug use and needle sharing.
6. More data needs to be gathered about prevalence of IV drug use and treatment outcomes, and data needs to be shared between DBHDID and other agencies such as the Recovery Kentucky centers, Department for Public Health, Department of Juvenile Justice, Department of Corrections, and Administrative Offices of the Courts.

### **Data Sources**

- Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (July 19, 2007). The National Survey on Drug Use and Health (NSDUH) Report: Demographic and Geographic Variations in Injection Drug Use. Rockville, MD.
- Center on Drug and Alcohol Research (CDAR) University of KY.

### **Individuals with Tuberculosis**

The Kentucky Tuberculosis (TB) Control Program is operated through the Cabinet for Health and Family Services (CHFS), Department for Public Health (DPH), and is authorized by state law to coordinate TB control activities in Kentucky. The program’s overarching objective is to eliminate TB as a public health problem. The program works to achieve that objective by

focusing its efforts on rendering and maintaining all individuals who have TB disease as non-infectious, ensuring non-infected persons do not become infected, and ensuring that individuals who are infected but who do not have TB disease remain non-infectious.

State employees, local health department employees and private health care providers carry out TB control activities. Funds are allocated to designated local health departments which serve as local lead agencies for the TB Control Program. State level public health personnel provide program planning, implementation and evaluation, program performance standards, technical assistance and consultation including X-ray, nursing, medical, clerical, statistical, financial, and managerial support, and training and disease surveillance.

The Division of Behavioral Health continues to assess for compliance with both contractual and regulatory mandates through the comprehensive, onsite reviews that are conducted biennially at the CMHCs and annually at the licensed Opioid Treatment Programs. Review teams, which include a peer reviewer from the field, examine client service records for documentation of a referral for TB screening and evidence that the client was provided with information and the option to be tested for HIV. Review team members also interview clients and program staff and review personnel records and agency policies to ensure requirements are met and the appropriate services are provided. The DBHDID continues to ensure appropriate training is available to substance abuse staff and that continuing education is provided that offers the most current information on infectious diseases.

Kentucky continues to show a declining rate of TB, as reported by the DPH. A total of 71 cases of TB were reported for 2011, which is a rate of 1.6 per 100,000. This is lower than the 2008 rate of 2.4 per 100,000 and Kentucky has seen a nearly continual decline since 2000, when the rate was 3.7 per 100,000.

The Division of Behavioral Health continues to work with the DPH to obtain the most current data on Kentucky's rates of newly diagnosed cases of TB, so the most appropriate services may be coordinated.

**Data Sources:**

- Department for Public Health

***Persons with or at risk for HIV/AIDS and who are in treatment for substance abuse***

The Kentucky HIV/AIDS Program is operated by the Cabinet for Health and Family Services (CHFS), Department for Public Health (DPH), and is mandated by state law to document and maintain the HIV/AIDS case reports data. The HIV/AIDS Program's primary goal is to promote the prevention of HIV transmission and associated morbidity and mortality. The program works to accomplish this goal by ensuring that HIV/AIDS surveillance is a quality, secure system, ensuring that all people at risk for HIV infection know their sero-status, ensuring that those who are not infected with HIV remain uninfected, ensuring that those infected with HIV do not transmit HIV to others, ensuring that those infected with HIV have access to the most effective therapies possible, and ensuring a quality professional education program that includes the most current HIV/AIDS information.

According to the DPH reports, the number of new AIDS cases diagnosed in 2009 in Kentucky for persons ages 13 and older was 239. This translates to a rate of 7.9 per 100,000. This is comparatively lower than the US estimated rate of 12.2 per 100,000 for 2008. The reports for 2011 identify 150 cases that have been diagnosed for persons age 13 and older. Only 35

pediatric cases of AIDS have been diagnosed in Kentucky since 1989, with only 3 of those being diagnosed since 2004. The case of pediatric AIDS was diagnosed in 2005.

States that have a prevalence rate of 10 per 100,000 or higher must comply with 45 CFR Part 96.128 Requirements regarding Human Immunodeficiency Virus. Kentucky is exempt from the HIV early intervention set aside requirement due to the AIDS cases being less than 10 per 100,000 for the last several years.

The Division of Behavioral Health continues to assess for compliance with both contractual and regulatory mandates through the comprehensive, onsite reviews that are conducted biennially at the CMHCs and annually at the licensed Opioid Treatment Programs. Review teams, which include a peer reviewer from the field, examine client service records for documentation of a referral for TB screening and evidence that the client was provided with information and the option to be tested for HIV. Review team members also interview clients and program staff and review personnel records and agency policies to ensure requirements are met and the appropriate services are provided. The DBHDID continues to ensure appropriate training is available to substance abuse staff and that continuing education is provided that offers the most current information on infectious diseases.

The Division of Behavioral Health continues to work with the DPH to obtain the most current data on Kentucky's rates of newly diagnosed cases of HIV/AIDS so the most appropriate services may be coordinated. Although Kentucky has been a lower risk state for HIV/AIDS for several years, DBHDID staff has recognized that there is a need to address Hepatitis C more intensively in substance abuse services as well as increasing education about Hepatitis A and B. Currently there are no free testing services for Hepatitis C in Kentucky and there are very few affordable treatment services. Due to these needs, Kentucky is also beginning to coordinate more with the DPH Viral Hepatitis Prevention Coordinator.

**Data Sources:**

- Department for Public Health

***Adolescents with substance abuse and/or mental health problems***

In Kentucky some of the main barriers to improving adolescent substance abuse services are a lack of state funds, a lack of service options, and a lack of community awareness about the problem.

Currently, youth are being assessed for mental health and substance abuse issues by the Administrative Office of the Courts (AOC) as well as the Department for Juvenile Justice (DJJ). There have been clinical staff trained in assessment methods/tools in most every CMHC and there are state and national trainers within Kentucky to continue to provide training and coaching on the use of the Global Assessment of Individual Needs (GAIN) family of screening and assessment tools. Due to turnover and difficulty with adoption of the GAIN within some treatment provider agencies, the momentum of the assessment has waned. There is a need to encourage the use of the assessment tool as it is not being utilized by the CMHSs consistently.

The need to enhance treatment options for adolescents with juvenile justice involvement is especially pronounced. While some adolescents will engage in troubling behavior, appropriate and consistently-applied discipline can ensure youth have opportunities to learn from mistakes and become successful contributing adults. Unfortunately, Kentucky, like many states has responded to such troubling behavior by detaining youth, including those who commit status

offenses, an approach shown to be ineffective and highly expensive (Nelson, 2008). In fact, Kentucky detains youth charged with status offenses at the second highest rate in the nation, even though the most populous county in the state does not use this practice (KYA, 2011). With national estimates of approximately 70% of youth with juvenile justice involvement meet criteria for a diagnosable mental health disorder and about 61% have a co-occurring substance use disorder (National Center for Mental Health and Juvenile Justice, 2006), adolescents with juvenile justice involvement present a unique challenge to the system of care. Not only is the intensity of their needs likely to be greater, but proper response to their multiple needs requires increased collaboration, continuity of care, and the ability to recruit and retain providers who are equipped to treat multiple needs. Unfortunately, many of the youth do not receive much needed behavioral health treatment that could prevent initial involvement with the juvenile justice system or reduce the likelihood of recidivism. The Kentucky Department of Juvenile Justice (DJJ), one of five departments under the Kentucky Justice and Public Safety Cabinet within the Executive Branch, is responsible for statewide detention services, residential placement/treatment services, probation, community aftercare/reintegration programs and youth awaiting adult placement or court. Of Kentucky youth coming into contact with the juvenile justice system, 32% are committed to the DJJ, 28% are informally adjusted (diverted), and 40% of cases are probated (Kentucky Department for Juvenile Justice, 2006). Thus, the need for accessible and effective treatment is paramount throughout the system.

A fairly comprehensive array of services for youth with emotional disorders is available to varying degrees across Kentucky. This is less the case for youth identified with substance abuse treatment needs. While Kentucky has over twenty (20) years of experience in providing behavioral health services to children, youth and their families through a system of care interagency infrastructure called Kentucky IMPACT and utilization of the State Interagency Council (SIAC). SIAC meets monthly to oversee coordinated policy development, comprehensive planning and collaborative budgeting for Kentucky's system of care for children. In addition to representatives from sister agencies from within the Cabinet, there are representatives from AOC, DJJ, Department of Education and parents and youth. SIAC has developed formal recommendations for state and local community changes to support youth with substance use and co-occurring disorders and within the realm of case management services. The SIAC has established a workgroup to focus on adolescent substance abuse and juvenile justice. The purpose of this workgroup is to promote comprehensive, integrated services for youth with substance use or co-occurring substance use and mental disorders.

There are two (2) nationally recognized Reclaiming Futures sites and two (2) sites that are working as state Reclaiming Future sites. Reclaiming Futures is a proven national model working toward systems change to address youth with substance abuse and juvenile justice issues. Working with the National Reclaiming Futures Office and Kentucky Youth Advocates a "Kentuckyized" version of the model and implementation guide has been completed to address youth with complex issues, who may be status offenders that are being detained and the disproportionate minority contact of youth within our juvenile justice system. A third Reclaiming Futures site established through a SAMHSA/MacArthur Policy Academy/Action Network grant has been established using the KY version of the Reclaiming Futures implementation guide. This third site has focused on working with youth in a pre-diversion status that has focused efforts on screening, assessing, and treating youth on "the front end" of the juvenile justice system as a means of avoiding net widening into the juvenile justice system.

A significant service gap is the limited array of available services for adolescent substance use treatment, both community-based and residential. In fact, in some regions of the state, there is an absence of treatment options, requiring youth to be served outside their home communities,



and the use of evidence-based screening, assessment, and intervention options are likewise limited. Finally, and perhaps, most difficult to address, is a pervasive cultural lack of understanding of the potential benefits of community-based treatment options grounded in a belief that substance use challenges require residential treatment. A survey of residential treatment facilities was initially conducted between December 4, 2009 and December 7, 2009, by the University of Kentucky Center on Drug and Alcohol Research. The information on residential treatment and recovery beds was then updated to include all facilities in operation by August 2010. Data showed 223 inpatient psychiatric beds available for adolescent substance abuse treatment and are included in this report since they constitute the majority of publicly funded inpatient care for adolescents. There are 231 non-medical residential beds for adolescent substance abuse in the state. The male/female distribution is flexible depending on admission needs. The state does not operate any inpatient facilities for children and youth under eighteen (18) years of age. There are no Recovery Center beds for adolescents. (2010 Report from Center for Drug and Alcohol Research at University of Kentucky, *Residential Treatment Bed Capacity for Kentucky: Adult Substance Abuse Residential Treatment*).

Services for adolescents are provided by CMHCs, private providers, and Psychiatric Residential Treatment Facilities. The juvenile justice system also frequently serves as a de facto treatment provider in response to identified gaps in the service array.

Kentucky has made strides in promoting evidence based practices and has implemented an evidence based practice, Seven Challenges, across the state in various treatment milieus with both public and private providers. This was done with the assistance of Kentucky Youth First (SAC grant) for infrastructure building and Reclaiming Futures. Additionally, statewide trainings to treatment providers and other youth-serving staff in the use of motivational interviewing skills with adolescents were offered through Kentucky Youth First. Training for trainers as well as developing coaches for MI for adolescents have subsequently continued and sustained among a variety of child- and family-serving agencies across the state. However this limited use of evidence based treatment needs to be enhanced so that there is more options for evidence-based interventions for youth with substance use or co-occurring mental health and substance use needs and their families. Kentucky recently was awarded a SAMHSA State Adolescent Treatment Enhancement and Dissemination Grant (SAT-ED). Through this cooperative agreement, a learning laboratory with two sites working toward certification of the Adolescent Community Reinforcement Approach (ACRA) evidence based treatment model will provide a feedback loop that will allow for identification of barriers and testing of solutions regarding implementation policy and program information/recommendation and expansion of evidence based treatment models.

**Unmet Needs/Prevalence Data/Data Sources** for this population include:

- Based on the National Survey on Drug Use and Health, 2008 (<https://www.oas.samhsa.gov/nsduh.htm>) , Ages 12-25 49,000 youth needed but did not receive treatment for illicit drug use and ages 12-25 64,000 youth needed but did not receive treatment for alcohol use.
- On March 31, 2009, only 1,386 youth under the age of 18 were in treatment for substance abuse or mix of mental health and substance abuse services.
- The definition of a person needing but not receiving treatment for an illicit drug problem is that the person meets the criteria for abuse of or dependence on illicit drugs according to the DSM-IV, but has not received specialty treatment for an illicit drug problem in the

past year. Specialty treatment is treatment received at a drug and alcohol rehabilitation facility (inpatient or outpatient), hospital (inpatient only), or mental health center

**Table B.1 Illicit Drug Use in Past Month, by Age Group and State: Percentages, Annual Averages Based on 2004 and 2005 National Survey on Drug Use and Health (NSDUH)**  
<https://www.oas.samhsa.gov/nsduh.htm>.

State	Total		AGE GROUP (Years)					
			12-17		18-25		26 or Older	
	Estimate	95% Prediction Interval	Estimate	95% Prediction Interval	Estimate	95% Prediction Interval	Estimate	95% Prediction Interval
Kentucky	8.39	(7.09 - 9.90)	11.30	(9.40 - 13.54)	18.21	(15.27 - 21.57)	6.35	(4.91 - 8.17)

- In terms of adolescent services, the Division of Behavioral Health conducted a survey in February, 2002, of licensed Alcohol and Drug Entities (AODEs) in the state and found that, of the 300+ licensed programs in Kentucky, only 55-or less than 20%- had ongoing structured programming for adolescents. This hasn't changed in any great leaps for better or for worse. A structured program was defined as, at minimum, a weekly therapy group. Other examples included intensive outpatient programs, residential and inpatient treatment. In short, structured programs for adults were found to be more consistently available in the state than programs for adolescents.
- Kentucky detains youth charged with status offenses at the second highest rate in the nation,
- Some 1,746 youth charged with status offenses were locked up in secure detention facilities in 2009, accounting for nearly 20% of all youth incarcerated in Kentucky. ([http://kyyouth.org/issue\\_areas/Juvenile\\_Justice/](http://kyyouth.org/issue_areas/Juvenile_Justice/))
- Secure detention is the most expensive option available. Counties pay \$94 per day for each youth detained for a status offense and added to that is the cost for the Sheriff to transport the youth to the regional facilities. ([https://kyyouth.org/issue\\_areas/Juvenile\\_Justice/](https://kyyouth.org/issue_areas/Juvenile_Justice/))
- While the access to community based services for adolescents with substance use disorders has improved slightly, the recognition and concern for parity with child and adolescent Medicaid reimbursed mental health services is recognized and a focus for change.

Along with the social determinants of health often driven by poverty, Kentuckians face many health-related problems associated with lifestyle choices, community culture, and industries driving Kentucky's economy. Two industries, in particular alcohol and tobacco, have heavily influenced agriculture, economics, politics, and public health in the Commonwealth for many years. Kentucky has the largest number of distilleries in the nation, accounting for over \$1 billion in annual revenues, and industry-wide revenues related to tobacco production and consumption account for approximately \$500 million. While causal statements cannot be made, data on tobacco and alcohol use indicate rates exceeding national averages:

- Approximately 26% of Kentucky high school students are current smokers compared to 18.2% nationally (YRBS, 2009).

- Significantly more Kentucky residents (40%) report having a family member who smokes tobacco compared to 26% nationally (NSCH, 2007).
- Among youth, 21% of Kentucky 10th graders report being drunk in the past month compared to 14.7% nationally (KIP, 2010; MTF, 2010).
- Among those 18 and older, Kentucky had the highest frequency of past-month binge drinking in the nation, with an average of 5.9 episodes compared to 4.4 episodes nationally (BRFSS, 2010).

Additionally, increased abuse of prescription drugs is taking a toll on Kentucky's families and communities. Myriad factors have been attributed to the emergence of this problem, including a population of laborers (e.g., coal miners) who seek relief from pain, a culture in which the sharing of prescription medications is acceptable, an interstate highway system that promotes the transport of medicines across state lines, and persistent poverty that leads to the generation of income through illegal means (Kentucky State Epidemiological Outcomes Workgroup, 2012). The following data depict the extent of prescription drug abuse in Kentucky:

- Past-year nonmedical use of opioids was highest among transition-age youth (18-25 year olds), with approximately 15.4% reporting use compared to 11.9% nationally (NSDUH, 2008-2009).

#### **Goals for SFY 2014/2015:**

- Support the statewide use (especially the CMHCs) of a common tool for their initial screening/assessment process i.e., the GAIN Family of instruments—since this is already being used in some form by other child serving agencies. With all CMCHs using and conducting standard screening and assessment for trauma and substance use/abuse on all youth whom enter their doors
- Continue to work with the Reclaiming Futures National Program Office and AOC, DJJ and communities across the state to move towards Kentucky becoming a “Reclaiming Futures State” with implementing the “Kentucky-ized “version with having a statewide judicial training on Reclaiming Futures and the judges role in becoming a collaborator in system change and engaging mental health and substance abuse treatment and the community to work together to help adolescents and their families who may have substance use disorders and co-occurring substance use and mental health disorders.
- Kentucky has provided access to training/coaching in the GAIN, Cannabis Youth Treatment (CYT), and Seven Challenges. Kentucky has provided training to partner agencies in adolescent development, stages of change, and trends in adolescent substance abuse through Motivational Interviewing basics. We would like to enhance/strengthen the infrastructure to use evidence based treatment and assessment by developing a training plan that will look at expansion of additional ACRA sites and clinicians and address any need to train/coach/support already in place evidence based models
- Continue to provide specific training and coaching on the identification, diagnosis and treatment planning for adolescents with substance use and co-occurring disorders to

CMHCs as a cross training for child/adolescent mental health staff as well as for substance abuse clinicians who treat adolescents, then increase the amount of programming in the state for adolescents with co-occurring so that each CMHC will feel competent to develop at least one IOP and feel competent to treat adolescent substance abuse and co-occurring issues. We would like to continue to provide support and coaching as well as begin to move the adolescent programs more toward a co-occurring model by use of the Dual Diagnosis Capability family of instruments, including the DDCYT. The DDCYT assesses an agency's ability to provide high quality co-occurring disorder (COD) services through an objective evaluation of strengths and weaknesses in the areas of Program Environment, Clinical Processes, Continuity of Care, Program Structure, Staffing, and Training. We would like to pilot the use of the DDCYT assessment and assess at least 6 sites and train DDCYT assessors within the CMHC system. Through the assessment process, specific avenues for change are identified to expand an organization's capability to effectively treat adolescents with co-occurring disorders by providing a baseline

- Conduct a new survey in an effort to ascertain views on the strengths, as well as the needs and barriers to more effective adolescent services in local communities and in the state and to look at tying in prevention efforts with Adolescent treatment needs.
- Strengthen training and consultation resources so that there is a greater clinical presence regarding adolescent treatment in state-funded programs. In addition, gather and use intake and follow-up data to help clinicians and policy makers better understand the characteristics of clients entering treatment and their needs.
- Need to more clearly identify adolescents as a priority treatment population in the state and clearly target expectations for adolescent treatment providers by mandating the use of best practices
- Continue to provide clinicians with adolescent specific client-level data on characteristics of adolescents entering treatment as well as follow-up outcomes on clients who have received treatment to strengthen the use of data in guiding treatment efforts and to compare outcomes for adolescents with those of adults.
- Continue to assist with the ongoing work of the Kentucky Adolescent Substance Abuse Consortium (KASAC). KASAC currently has a Board of Directors, bylaws and regional contacts in each of the 14 Regional Mental Health/Mental Retardation regions of the state. In the past, Consortium meetings have been held bi-monthly at varying locations around the state so that providers could more easily attend a meeting. KASAC's annual meeting is held in conjunction with the Kentucky School of Alcohol and Other Drug Studies. Now the Consortium provides an Annual Adolescent Specific Two day Conference supporting evidence based adolescent specific practices and DBHDID could provide a "boost" to the Consortium by providing technical assistance, some limited financial support and by introducing new opportunities to carry out their mission.
- One of the most significant service gaps pertains to the lack of a specific funding stream for adolescent substance use services in the state. Current efforts are underway to explore the use of EPSDT, Medicaid Waivers, and Medicaid SPAs as a means of increasing funding for substance use treatment. Through the requirements of the SAT-ED cooperative agreement, Kentucky is planning to develop a cross-agency State/

financial map of Federal and State/ financial resources which include but are not limited to Medicaid/CHIP, SAPT Block Grant, and other funding streams available to deliver evidence-informed substance use and co-occurring substance use and mental disorders treatment and recovery support services to adolescents and their families, with the intention of providing information to those agencies on options for redeployment of financial resources and ways to expand the continuum of treatment/recovery services and supports

- Look at performing workforce mapping of the available clinicians that provide services to adolescents with substance use and co-occurring substance use and mental health disorders and continue to work on KASACs previous work on development of State standards for endorsement of adolescent and family substance use and co-occurring mental disorders treatment counselors.

**Data Sources:**

Substance Abuse and Mental Health Services Administration. (2010), Description of a Modern Addictions and Mental Health Delivery system, Office of Policy, Planning and Innovation, Rockville, MD <http://www.samhsa.gov/healthreform/docs/AddictionMHSsystemBrief.pdf>

Substance Abuse and Mental Health Services Administration, *Results from the 2011 National Survey on Drug Use and Health: Summary of National Findings*, NSDUH Series H-44, HHS Publication No. (SMA) 12-4713. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012.

## II: Planning Steps

Table 1 Step 3,4: -Priority Area and Annual Performance Indicators

Priority #: 1  
Priority Area: Pregnant Women  
Priority Type: SAT  
Population(s): PWWDC

Goal of the priority area:

Educate and offer treatment services for pregnant women with substance use disorder.

Strategies to attain the goal:

It has been found that the CMHCs are not asking about pregnancy upon first contact. Additional education and close monitoring of the CMHCs will be performed to address this deficiency.

More than 25% of pregnant women in Kentucky smoke. Other than a national cessation hotline, there are no smoking cessation services in the state. The Division will work closely with the Department for Public Health to develop local programs and a statewide hotline.

A new statewide prevalence study for substance use during pregnancy is needed. Kentucky will let a Request for Proposal to update this study. The most recent was completed in 1990.

Residential services for pregnant women in Kentucky are scarce. The Commonwealth will continue to fund "Independence House," a residential program for pregnant women.

Annual Performance Indicators to measure goal success

Indicator #: 1  
Indicator: Assure all Community Mental Health Centers are asking about pregnancy at first contact.  
Baseline Measurement: 16%  
First-year target/outcome measurement: 25%  
Second-year target/outcome measurement: 30%

Data Source:

National prevalence estimates and an outdated state survey.

Description of Data:

1990 State Survey

Data issues/caveats that affect outcome measures::

The state survey used is from 1990; Kentucky must obtain more up-to-date information to more accurately determine client numbers.

Priority #: 2  
Priority Area: Reduce consequences of underage drinking  
Priority Type: SAP  
Population(s): Other (Youth Aged 12 -20)

Goal of the priority area:

Reduce state 10th grade,  
30 day binge drinking rate by at least 1% .

Strategies to attain the goal:

KY Incentives for Prevention (KIP) 2012 survey will be used as a baseline. KIP 2014 data will be used to measure outcomes. Utilization of the Changing Social Norms and Policy protocol aimed at changing norms around acceptability of usage and limit availability of access in the following ways:

- Limiting social and retail access of alcohol to underage youth through establishment of Social Host Ordinances, or strengthening enforcement of these ordinances in counties where they already exist.
- Retail access strategies such as shoulder taps and compliance checks.
- Expanding and intensifying the "I Won't Be the One" campaign – a large scale informational efforts at older adults about the legal and health consequences of providing alcohol to underage youth.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Implement local policies that target social access of alcohol to youth (social host & unruly gathering ordinances) in areas of identified need-as evidenced by high alcohol use by minors as reported on KIP survey

Baseline Measurement: 0

First-year target/outcome measurement: 3

Second-year target/outcome measurement: 4

Data Source:

Regional Prevention Centers will report to the Division of Behavioral Health as local ordinances are created and KIP survey results will be evaluated.

Description of Data:

Regional Prevention Center reports as processed through the State Prevention System. Each Regional Prevention Center is required to enter data monthly E.g.number of evidence-based programs implemented, number of people reached, number of ordinances passed, number of people served through universal direct, indirect etc. Reports are generated from the system by the Prevention Branch Data Manager. The Prevention Branch is in the process of changing some of its program codes and revamping its data system. As soon as the revisions are made we will submit baseline data.

Data issues/caveats that affect outcome measures::

Variables in the Commonwealth beyond control, including no ordinances/data in these locales.

Priority #: 3

Priority Area: Women with Dependent Children

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Escalate parents (women) with dependent children to priority population status.

Strategies to attain the goal:

Continued collaboration with the Kentucky Department for Community-Based Services (child protective services) in the sobriety treatment and recovery teams (START). Currently, there are six of fourteen regions throughout the state that provide family mentors (people in recovery) to team with child protective service workers to engage clients in services and keep children at home. These regions provide quick access to assessment and referral to the appropriate level of care. Kentucky would like to expand these services to at least one other region within FFY2014.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Expand the number of START programs in Kentucky

Baseline Measurement: 6

First-year target/outcome measurement: 6

Second-year target/outcome measurement: 7

Data Source:

Kentucky Department for Community Based Services

Description of Data:

Because of a decrease in funding from child protective services, one of the currently implemented START programs is in danger of folding. For federal fiscal year 2014, it is the intent of the DBH to first stabilize the current programs, and attempt to implement one additional program in another region within Kentucky.

Data issues/caveats that affect outcome measures::

Reductions in funding.

Priority #: 4

Priority Area: Individuals with Substance Use Disorders and TB

Priority Type: SAT

Population(s): TB

Goal of the priority area:

Identify clients seeking treatment for substance use disorder who may currently have, or have in the past, had a tuberculosis diagnosis.

Strategies to attain the goal:

The Kentucky Department for Public Health (DPH) administers the tuberculosis control program in Kentucky. The Division of Behavioral Health will work in collaboration with DPH to share client diagnoses as they pertain to substance use disorder, or tuberculosis infection.

#### Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increased knowledge of clients with Substance Use Disorder with Tuberculosis

Baseline Measurement: 1.8 per 100,000

First-year target/outcome measurement: 1.8 per 100,000

Second-year target/outcome measurement: 1.5 per 100,000

Data Source:

Cross-referenced with client data from the Kentucky Department for Public Health

Description of Data:

Client data pulled from substance abuse clients with a secondary TB diagnosis.

Data issues/caveats that affect outcome measures::

The Kentucky Division of Behavioral Health (DBH) seeks to share client data with the Kentucky Department for Public Health (DPH) in order to more accurately determine the number of clients in treatment for substance use disorder who have been, or currently are, being treated for Tuberculosis.

Priority #: 5

Priority Area: Individuals with Substance Use Disorders and HIV

Priority Type: SAT

Population(s): HIV EIS

Goal of the priority area:



For federal fiscal year 2014, as in years' past, the Commonwealth of Kentucky is not an HIV designated state. This performance indicator and priority area are not applicable.

Strategies to attain the goal:

Not applicable.

Annual Performance Indicators to measure goal success

Priority #: 6  
Priority Area: Suicide Prevention  
Priority Type: MHP  
Population(s): SMI, SED

Goal of the priority area:

All 14 Regional Boards will submit a Suicide Care in Systems Framework organizational readiness baseline assessment and a plan for systemic improvement of their suicide care.

Strategies to attain the goal:

Through contract and training/technical assistance offered to each Board, they will successfully meet the goal of improving their readiness and clinical protocols to improve the state's overall suicide rate among adults with SMI and children with SED.

Annual Performance Indicators to measure goal success

Indicator #: 1  
Indicator: Readiness Assessments and Care Plans Conducted & Created by the 14 Regional Boards  
Baseline Measurement: 0  
First-year target/outcome measurement: 14 Readiness Assessments submitted and approved  
Second-year target/outcome measurement: 14 Suicide Prevention Care Plans submitted and approved

Data Source:

Regional Boards will submit documentation to the Division of Behavioral Health and Division staff will review and approve (or work with the Board to adequately complete)

Description of Data:

Data will be submitted through contract required protocol

Data issues/caveats that affect outcome measures::

N/A

Priority #: 7  
Priority Area: Adults with SMI who reside in Personal Care Homes  
Priority Type: MHS  
Population(s): SMI

Goal of the priority area:

Assist adults with SMI to move from living in a Personal Care Home (PCH) to an integrated community setting

Strategies to attain the goal:

Further develop services and supports to allow adults with SMI to move from PCHs to community housing of their choice.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of Adults with SMI who move from a PCH to an integrated community residence

Baseline Measurement: Estimated 2,000 persons with SMI currently residing in PCHs

First-year target/outcome measurement: 200 Adults with SMI will move from a PCH to an integrated community residence

Second-year target/outcome measurement: 200 (additional) Adults with SMI will move from a PCH to an integrated community residence

Data Source:

The Division of Behavioral Health will strictly monitor this along with an independent monitor

Description of Data:

There are identified individuals that will be priority -provided by P&A

Data issues/caveats that affect outcome measures::

N/A

Priority #: 8

Priority Area: Youth with co-occurring SED and Substance Use Disorders (SUDs)

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Increase the number of youth with co-occurring mental health and substance use disorders that receive services from the Regional Boards.

Strategies to attain the goal:

Utilize newly developed funding streams to enhance provider competence to screen, assess and treat youth with co-occurring MH and SU disorders. Utilize E BPs for youth with SUDs- 7 Challenges, Cannabis Youth Treatment (CYT), Motivational Interviewing, MET-CBT, Adolescent Community Reinforcement Approach (ACRA)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of youth with identified SED and Substance Use Disorders

Baseline Measurement: Baseline Year - No date

First-year target/outcome measurement: 150

Second-year target/outcome measurement: 250 (Additional)

Data Source:

MHSIP data set used by the Department and the 14 Regional Boards

Description of Data:

Data will show how many individuals served by diagnostic category and services type.

Data issues/caveats that affect outcome measures::

data currently available provides some detail to estimate current service numbers but diagnostic and services category type and actual numbers of youth with SED and youth with SUDs is available separately, but not a reliable count of youth with co-occurring.

Priority #: 9  
Priority Area: Prescription Drug Use among Adults and Youth  
Priority Type: SAP  
Population(s): Other (Youth ages 12- 18 Adults 20-24)

Goal of the priority area:

Reduce the misuse of prescription drugs by adults and youth

Strategies to attain the goal:

Utilizing the Changing Social Norms and Policy protocol, focus on environmental strategies that aim to change norms around acceptability of usage and limit availability of access. Regions that are concentrating on prescription drugs will concentrate their efforts primarily on:

- Correcting three (3) youth misperceptions about prescription drugs - that they are: 1.) safer than street drugs, 2.) less addictive than street drugs, 3.) OK to share among friends and family
- Safe storage and disposal of prescription drugs
- Support for new Kentucky legislation which licenses pain clinics and mandates the use of the Kentucky All Scheduled Prescription Electronic Drug Reporting (KASPER) system for all doctors in the state
- Conducting large scale informational efforts directed at parents, caregivers and prescribers of prescription drugs

Annual Performance Indicators to measure goal success

Indicator #: 1  
Indicator: Reduce misuse of prescription drugs  
Baseline Measurement: Incidence of misuse as reported on NSDUH survey and the KIP survey for youth  
First-year target/outcome measurement: 5% decrease in misuse  
Second-year target/outcome measurement: 8% decrease in misuse

Data Source:

NSDUH survey and the KIP survey for youth

Description of Data:

The National Survey on Drug Use and Health (NSDUH) is an annual nationwide survey involving interviews with approximately 70,000 randomly selected individuals aged 12 and older. Every even-numbered year, the Kentucky Division of Behavioral Health, with the support of the Governor's Office of Drug Control Policy and the Federal Center for Substance Abuse Prevention, jointly sponsor the KIP survey to assess the extent of alcohol, drug, and tobacco use among 11 to 18-year-olds throughout Kentucky, and to evaluate the impact of prevention efforts aimed at reducing substance use.

Data issues/caveats that affect outcome measures::

There are no data issues. Data may show as skewed as the NSDUH is a smaller sample.

Priority #: 10  
Priority Area: IVDUs - Intravenous drug users  
Priority Type: SAT  
Population(s): IVDUs

Goal of the priority area:

All 14 Community Mental Health Centers to screen for IV drug use upon initial contact.

Strategies to attain the goal:

Continued education and monitoring of client intake data. In addition, Kentucky shall work with the CMHCs to encourage them to follow the NQF

Standard of Care regarding Withdrawal Management; specifically, "Supportive pharmacotherapy should be available and provided to manage the symptoms and adverse consequences of withdrawal, based on a systematic assessment of the symptoms and risk of serious adverse consequences of the withdrawal process." Kentucky will accomplish this by increasing detox services so that there is a minimum of one medically supported detox center in each of the 14 regions; more where population or geography requires.

Kentucky will continue to strive to follow the NQF Standard of Care regarding pharmacotherapy: "Pharmacotherapy should be recommended and available to adult patients diagnosed with opioid dependency and without medical contraindications." CMHCs should be required to recommend MAT when appropriate, and affordable MAT options need to be increased to provide services to indigent residents.

Annual Performance Indicators to measure goal success

Indicator #: 1  
Indicator: Increased number of clients screened for IV drug use at initial contact.  
Baseline Measurement: 50%  
First-year target/outcome measurement: 70%  
Second-year target/outcome measurement: 80%

Data Source:

Kentucky Opioid Replacement Therapy Outcome Study (KORTOS)

Description of Data:

Client data collected through KORTOS

Data issues/caveats that affect outcome measures::

Kentucky's addicted follow what seems to be the national norm in that the Opioid prescription drug users, when faced with no available source, turn to IV heroin use, which then shows a disproportionate number of users.

footnote:

### III: Use of Block Grant Dollars for Block Grant Activities

Table 2 State Agency Planned Expenditures [SA]

Planning Period Start Date: 7/1/2013      Planning Period End Date: 6/30/2015

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	\$32,343,147		\$0	\$116,450	\$26,765,106	\$0	\$0
a. Pregnant Women and Women with Dependent Children*	\$6,600,000		\$0	\$0	\$1,794,800	\$0	\$0
b. All Other	\$25,743,147		\$0	\$116,450	\$24,970,306	\$0	\$0
2. Substance Abuse Primary Prevention	\$8,613,495		\$0	\$661,536	\$1,325,376	\$0	\$0
3. Tuberculosis Services	\$0		\$0	\$0	\$0	\$0	\$0
4. HIV Early Intervention Services	\$0		\$0	\$0	\$0	\$0	\$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention							
9. Mental Health Evidenced-based Prevention and Treatment (5% of total award)							
10. Administration (Excluding Program and Provider Level)	\$60,000		\$0	\$0	\$2,245,206	\$0	\$0
11. Total	\$41,016,642	\$0	\$0	\$777,986	\$30,335,688	\$0	\$0

\* Prevention other than primary prevention

**Footnotes:**

Zeros may represent data is not available

### III: Use of Block Grant Dollars for Block Grant Activities

Table 2 State Agency Planned Expenditures [MH]

Planning Period Start Date: 1/1/2014 Planning Period End Date: 1/1/2015

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			\$0	\$0	\$0	\$0	\$0
6. Other 24 Hour Care		\$16,696	\$0	\$0	\$0	\$0	\$0
7. Ambulatory/Community Non-24 Hour Care		\$8,273,360	\$0	\$21,093,750	\$44,502,200	\$0	\$0
8. Mental Health Primary Prevention		\$8,000	\$0	\$0	\$0	\$0	\$0
9. Mental Health Evidenced-based Prevention and Treatment (5% of total award)		\$323,455	\$0	\$0	\$0	\$0	\$0
10. Administration (Excluding Program and Provider Level)		\$554,448	\$0	\$10,546,875	\$5,858,800	\$0	\$0
11. Total	\$0	\$9,175,959	\$0	\$31,640,625	\$50,361,000	\$0	\$0

\* Prevention other than primary prevention

**Footnotes:**

Some data not available where zeros are entered.

### III: Use of Block Grant Dollars for Block Grant Activities

Table 3 State Agency Planned Block Grant Expenditures by Service

Expenditure Period Start Date: 7/1/2013      Expenditure Period End Date: 6/30/2015

Service	Unduplicated Individuals	Units	SABG Expenditures	MHBG Expenditures
Healthcare Home/Physical Health			\$43,675	\$333,050
Specialized Outpatient Medical Services	40	86.00	\$475	\$7,200
Acute Primary Care	120	385.00	\$1,200	\$1,850
General Health Screens, Tests and Immunizations	75	2000.00	\$14,000	\$12,000
Comprehensive Care Management	45	1080.00	\$24,000	\$300,000
Care coordination and Health Promotion	0	0.00	\$	\$
Comprehensive Transitional Care	0	0.00	\$	\$
Individual and Family Support	120	2000.00	\$4,000	\$12,000
Referral to Community Services Dissemination	0	0.00	\$	\$
Prevention (Including Promotion)			\$7,800	\$1,200
Screening, Brief Intervention and Referral to Treatment	0	0.00	\$	\$

Brief Motivational Interviews	150	300.00	\$7,800	\$1,200
Screening and Brief Intervention for Tobacco Cessation	0	0.00	\$	\$
Parent Training	0	0.00	\$	\$
Facilitated Referrals	0	0.00	\$	\$
Relapse Prevention/Wellness Recovery Support	0	0.00	\$	\$
Warm Line	0	0.00	\$	\$
Substance Abuse (Primary Prevention)			\$300,000	\$8,000
Classroom and/or small group sessions (Education)	45000	85.00	\$300,000	\$8,000
Media campaigns (Information Dissemination)	0	0.00	\$	\$
Systematic Planning/Coalition and Community Team Building(Community Based Process)	0	0.00	\$	\$
Parenting and family management (Education)	0	0.00	\$	\$
Education programs for youth groups (Education)	0	0.00	\$	\$
Community Service Activities (Alternatives)	0	0.00	\$	\$
Student Assistance Programs (Problem Identification and Referral)	0	0.00	\$	\$
Employee Assistance programs (Problem Identification and Referral)	0	0.00	\$	\$



Community Team Building (Community Based Process)	0	0.00	\$	\$
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental)	0	0.00	\$	\$
Engagement Services			\$10,940,000	\$10,760,000
Assessment	160000	1750000.00	\$800,000	\$600,000
Specialized Evaluations (Psychological and Neurological)	20000	32000.00	\$500,000	\$500,000
Service Planning (including crisis planning)	200000	200000.00	\$600,000	\$600,000
Consumer/Family Education	20000	80000.00	\$40,000	\$60,000
Outreach	250000	250000.00	\$9,000,000	\$9,000,000
Outpatient Services			\$15,339,000	\$15,957,000
Evidenced-based Therapies	8000	2000000.00	\$14,289,000	\$15,837,000
Group Therapy	4500	200000.00	\$1,050,000	\$120,000
Family Therapy	0	0.00	\$	\$
Multi-family Therapy	0	0.00	\$	\$
Consultation to Caregivers	0	0.00	\$	\$
Medication Services			\$105,000	\$275,000

Medication Management	900000	200000.00	\$105,000	\$275,000
Pharmacotherapy (including MAT)	0	0.00	\$	\$
Laboratory services	0	0.00	\$	\$
Community Support (Rehabilitative)			\$186,000	\$815,000
Parent/Caregiver Support	0	0.00	\$10,000	\$165,000
Skill Building (social, daily living, cognitive)	0	0.00	\$	\$
Case Management	1500	18000.00	\$14,000	\$50,000
Behavior Management	0	0.00	\$	\$
Supported Employment	3725	0.00	\$12,000	\$400,000
Permanent Supported Housing	12000	0.00	\$150,000	\$200,000
Recovery Housing	0	0.00	\$	\$
Therapeutic Mentoring	0	0.00	\$	\$
Traditional Healing Services	0	0.00	\$	\$
Recovery Supports			\$2,000	\$34,000
Peer Support	500	1500.00	\$2,000	\$34,000
Recovery Support Coaching	0	0.00	\$	\$

Recovery Support Center Services	0	0.00	\$	\$
Supports for Self-directed Care	0	0.00	\$	\$
Other Supports (Habilitative)			\$	\$61,000
Personal Care	0	0.00	\$	\$
Homemaker	0	0.00	\$	\$
Respite	0	0.00	\$	\$
Supported Education	0	0.00	\$	\$
Transportation	0	0.00	\$	\$
Assisted Living Services	0	0.00	\$	\$
Recreational Services	0	0.00	\$	\$
Trained Behavioral Health Interpreters	134	400.00	\$	\$61,000
Interactive Communication Technology Devices	0	0.00	\$	\$
Intensive Support Services			\$20,000	\$1,200
Substance Abuse Intensive Outpatient (IOP)	75	200.00	\$20,000	\$
Partial Hospital	0	0.00	\$	\$

Assertive Community Treatment	10	80.00	\$	\$1,200
Intensive Home-based Services	0	0.00	\$	\$
Multi-systemic Therapy	0	0.00	\$	\$
Intensive Case Management	0	0.00	\$	\$
Out-of-Home Residential Services			\$	\$
Children's Mental Health Residential Services				
Crisis Residential/Stabilization				
Clinically Managed 24 Hour Care (SA)				
Clinically Managed Medium Intensity Care (SA)				
Adult Mental Health Residential				
Youth Substance Abuse Residential Services				
Therapeutic Foster Care				
Acute Intensive Services			\$	\$
Mobile Crisis				
Peer-based Crisis Services				

Urgent Care				
23-hour Observation Bed				
Medically Monitored Intensive Inpatient (SA)				
24/7 Crisis Hotline Services				
Other (please list)			\$	\$

footnote:

Zeros in some places may equate to unknown data

### III: Use of Block Grant Dollars for Block Grant Activities

Table 4 SABG Planned Expenditures

Expenditure Period Start Date: 10/1/2013      Expenditure Period End Date: 9/30/2015

Expenditure Category	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	\$15,939,971	
2 . Substance Abuse Primary Prevention	\$4,249,170	
3 . Tuberculosis Services		
4 . HIV Early Intervention Services**		
5 . Administration (SSA Level Only)	\$45,000	
6. Total	\$20,234,141	

\* Prevention other than primary prevention

\*\* HIV Early Intervention Services

footnote:

### III: Use of Block Grant Dollars for Block Grant Activities

Table 5a SABG Primary Prevention Planned Expenditures

Expenditure Period Start Date: 10/1/2013 Expenditure Period End Date: 9/30/2015

Strategy	IOM Target	FY 2014	FY 2015
		SA Block Grant Award	SA Block Grant Award
Information Dissemination	Universal	\$607,903	
	Selective	\$12,575	
	Indicated	\$1,231	
	Unspecified		
	Total	\$621,709	
Education	Universal	\$449,752	
	Selective	\$7,547	
	Indicated	\$1,733	
	Unspecified		
	Total	\$459,032	
Alternatives	Universal	\$273,168	
	Selective	\$1,158	
	Indicated		
	Unspecified		
	Total	\$274,326	
Problem Identification and Referral	Universal	\$219,981	
	Selective	\$3,029	
	Indicated	\$521	
	Unspecified		
	Total		

	Total	\$223,531	
Community-Based Process	Universal	\$1,247,473	
	Selective	\$12,269	
	Indicated	\$295	
	Unspecified		
	Total	\$1,260,037	
Environmental	Universal	\$372,496	
	Selective	\$1,948	
	Indicated		
	Unspecified		
	Total	\$374,444	
Section 1926 Tobacco	Universal		
	Selective		
	Indicated		
	Unspecified	\$100,000	
	Total	\$100,000	
Other	Universal		
	Selective		
	Indicated		
	Unspecified	\$936,091	
	Total	\$936,091	
Total Prevention Expenditures		\$4,249,170	
Total SABG Award*		\$20,234,141	
Planned Primary Prevention Percentage		21.00 %	



\*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

footnote:

### III: Use of Block Grant Dollars for Block Grant Activities

Table 5b SABG Primary Prevention Planned Expenditures

Expenditure Period Start Date: 10/1/2013      Expenditure Period End Date: 9/30/2015

Activity	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
Universal Direct	\$2,070,393	
Universal Indirect	\$1,916,490	
Selective	\$35,497	
Indicated	\$226,790	
Column Total	\$4,249,170	
Total SABG Award*	\$20,234,141	
Planned Primary Prevention Percentage	21.00 %	

\*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

footnote:

### III: Use of Block Grant Dollars for Block Grant Activities

Table 5c SABG Planned Primary Prevention Targeted Priorities

Expenditure Period Start Date:  Expenditure Period End Date:

Targeted Substances	
Alcohol	☐
Tobacco	☐
Marijuana	☐
Prescription Drugs	☐
Cocaine	☐
Heroin	☐
Inhalants	☐
Methamphetamine	☐
Synthetic Drugs (i.e. Bath salts, Spice, K2)	☐
Targeted Populations	
Students in College	☐
Military Families	☐
LGBTQ	☐
American Indians/Alaska Natives	☐
African American	☐
Hispanic	☐
Homeless	☐
Native Hawaiian/Other Pacific Islanders	☐
Asian	☐
Rural	☐
Underserved Racial and Ethnic Minorities	☐

footnote:

### III: Use of Block Grant Dollars for Block Grant Activities

Table 6a SABG Resource Development Activities Planned Expenditures

Expenditure Period Start Date: 10/1/2013 Expenditure Period End Date: 9/30/2015

Activity	FY 2014 SA Block Grant Award				FY 2015 SA Block Grant Award			
	Prevention	Treatment	Combined	Total	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	\$	\$	\$					
2. Quality Assurance		\$45,000		\$45,000				
3. Training (Post-Employment)	\$20,000	\$85,000		\$105,000				
4. Education (Pre-Employment)								
5. Program Development	\$148,121	\$145,636		\$293,757				
6. Research and Evaluation	\$222,200	\$46,000		\$268,200				
7. Information Systems		\$9,000		\$9,000				
8. Enrollment and Provider Business Practices (3 percent of BG award)								
9. Total	\$390,321	\$330,636		\$720,957				

footnote:  
No revision necessary.

### III: Use of Block Grant Dollars for Block Grant Activities

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period - From 07/01/2013 to 06/30/2014

Service	Block Grant
MHA Technical Assistance Activities	\$250,000
MHA Planning Council Activities	\$30,000
MHA Administration	\$32,789
MHA Data Collection/Reporting	\$200,000
Enrollment and Provider Business Practices (3 percent of total award)	\$365,500
MHA Activities Other Than Those Above	
Total Non-Direct Services	\$878,289
Comments on Data: <input type="text"/>	

footnote:

## IV: Narrative Plan

### C. Coverage M/SUD Services

#### Narrative Question:

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Beginning in 2014, Block Grant dollars should be used to pay for (1) people who are uninsured and (2) services that are not covered by insurance and Medicaid. Presumably, there will be similar concerns at the state-level that state dollars are being used for people and/or services not otherwise covered. States (or the Federal Marketplace) are currently making plans to implement the benchmark plan chosen for QHPs and their expanded Medicaid programs (if they choose to do so). States should begin to develop strategies that will monitor the implementation of the Affordable Care Act in their states. States should begin to identify whether people have better access to mental and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering mental health and substance abuse services and whether services are offered consistent with the provisions of MHPAEA.

Please answer the following questions:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?
2. Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations of MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?

#### Footnotes:

This section was left blank intentionally.



## IV: Narrative Plan

### D. Health Insurance Marketplaces

#### Narrative Question:

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Health Insurance Marketplaces (Marketplaces) will be responsible for performing a variety of critical functions to ensure access to desperately needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. SMHAs and SSAs should understand their state's new eligibility determination and enrollment system, as well as how insurers (commercial, Medicaid, and Medicare plans) will be making decisions regarding their provider networks. States should consider developing benchmarks regarding the expected number of individuals in their publicly-funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set similar benchmarks for the number of providers who will be participating in insurers' networks that are currently not billing third party insurance.

QHPs must maintain a network of providers that is sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay. Mental health and substance abuse providers were specifically highlighted in the rule to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities.

Please answer the following questions:

1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?
2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?
3. How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing Medicaid, CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?
4. How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?
5. Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.
6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.
7. For the providers identified in Table 8 -Statewide Entity Inventory of the FY 2013 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.
8. Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.

Footnotes:

## IV. Narrative Plan

### D. Affordable Insurance Exchange *(requested, not required)*

*Affordable Insurance Exchanges (Exchanges) will be responsible for performing a variety of critical functions to ensure access to desperately needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. SMHAs and SSAs should understand their state's new eligibility determination and enrollment system, as well as how insurers (commercial, Medicaid, and Medicare plans) will be making decisions regarding their provider networks. States should consider developing benchmarks regarding the expected number of individuals in their publicly-funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set similar benchmarks for the number of providers who will be participating in insurers' networks that are currently not billing third party insurance.*

*QHPs must maintain a network of providers that is sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay. Mental health and substance abuse providers were specifically highlighted in the rule to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities.*

*Please answer the following questions:*

- 1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?*
- 2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?*
- 3. How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing third party Medicaid, the CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?*
- 4. How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?*
- 5. Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.*
- 6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.*
- 7. For the providers identified in Table 8 -Statewide Entity Inventory of the FY 2012 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.*
- 8. Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.*

On July 17, 2012, an initial Executive Order (EO) was issued by the Governor, creating the Office of the Kentucky Health Benefit Exchange (KHBE) within the Cabinet for Health and Family Services. The Office of the KHBE operates under the leadership of an Executive Director and is composed of four divisions, including the Divisions of:

- Health Care Policy Administration;
- Information Systems;
- Financial and Operations Administration; and
- Communication and Outreach.

An estimated 640,000 Kentuckians are uninsured as of 2013, or 14.9 percent of the state's population. The KHBE will operate as an online marketplace where individual

Kentuckians and employees of small businesses can comparison shop for health insurance based on cost, benefits and quality. It will also allow individuals and businesses to apply for premium subsidies and tax credits. Through the Exchange, an individual can also apply and have eligibility determined for Medicaid and the Kentucky Children's Health Insurance Program (KCHIP).

On December 14, 2012, the U.S. Department of Health and Human Services' Centers for Medicare & Medicaid Services (CMS) announced that Kentucky has made significant progress in setting up a state-based Health Benefit Exchange and is on track to begin open enrollment by October 1, 2013. In the announcement, Health and Human Services Secretary Kathleen Sebelius said "I applaud Kentucky's commitment in achieving this milestone and moving forward to build a marketplace." CMS approval is conditional until all federal requirements are satisfied. This announcement recognizes that Kentucky is on target to meet those requirements.

On October 1, 2012, Kentucky recommended that the Anthem Preferred Provider Organization (PPO) plan serve as the "benchmark" plan for the Kentucky Health Benefit Exchange, as well as for plans offered outside the exchange. The Anthem PPO is the largest small group plan currently offered in Kentucky and includes coverage for all state mandates and the 10 essential health benefits, or categories of care, specified by the federal government under the Affordable Care Act. The benchmark plan sets the minimum level of benefits offered in the individual and small group markets beginning Jan. 1, 2014.

The Anthem PPO plan is the most cost effective of the 10 plans reviewed, will not create additional costs for the state and should not increase the price for those who have coverage currently. Since the Anthem PPO plan does not offer the minimum requirements for pediatric vision and dental services, Kentucky has recommended that the benefits in the Kentucky Children's Health Insurance Program (KCHIP) be substituted in the benchmark plan. Exchanges must be certified by Jan. 1, 2013, fully operational by Jan. 1, 2014 and self-sustaining after Jan. 1, 2015.

On August 15, 2012, the Office of KHBE submitted a *Level One Establishment* grant for additional funding to develop a Navigator program and conduct a comprehensive study of our current health care workforce and the future needs to maintain an adequate workforce. Kentucky is currently developing a Navigator program in accordance with federal requirements. Navigators will play a large role with outreach efforts in all 120 counties of the Commonwealth. During the development phase, the KHBE is requesting input from the public and interested groups to begin the process of identifying qualified individuals and entities that can perform Navigator duties. A Navigator Fact Sheet has been developed to assist with educating all interested parties. See:

[http://healthbenefitexchange.ky.gov/Documents/Public%20Forum%20Navigator%20Factsheet%20\(3\)%20\(2\).pdf](http://healthbenefitexchange.ky.gov/Documents/Public%20Forum%20Navigator%20Factsheet%20(3)%20(2).pdf) and <http://kynect.ky.gov/>

### **Kentucky Health Benefit Exchange has an established Advisory Board**

Advisory Board members have relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, and other health policy issues related to the small group and individual markets and the uninsured.

#### Board Members

- Sharon Clark is Commissioner of the Department of Insurance. **Commissioner Clark serves as Chair of the Board.**
- Gabriela Alcalde, of Louisville, is a health policy officer at Foundation for a Healthy Kentucky. Ms. Alcalde represents individual purchasers of health benefit plans in Kentucky.
- David Allgood, of Louisville, is director of advocacy at the Center for Accessible Living and a member of the board of directors of Kentucky Voices for Health. He represents consumer advocates or consumer representatives.
- Andrea Bennett, of Louisville, is deputy director of Kentucky Youth Advocates. Ms. Bennett represents consumer advocates or consumer representatives.
- Jeff Bringardner, of Louisville, is president of Humana Inc., Kentucky. He represents insurers.
- Ruth Brinkley, of Louisville, is president of KentuckyOne Health. Ms. Brinkley represents facility-based health care providers.
- Joe Ellis, O.D., of Benton, is an optometrist at EyeCare Associates of Kentucky. Dr. Ellis represents small employers doing business in Kentucky.
- Ed Erway, of Lexington, is chief revenue officer at University of Kentucky Healthcare. Mr. Erway represents facility-based health care providers.
- Carl Felix, of Frankfort, is chief operating officer at Bluegrass Family Health. Mr. Felix represents insurers.
- Donna Ghobadi, of Lexington, is vice president of revenue cycle at Central Baptist Hospital. Ms. Ghobadi represents facility-based health care providers.
- Betsy Dunnigan is the Commissioner of the Department for Behavioral Health and Developmental and Intellectual Disabilities. Commissioner Dunnigan serves as an ex-officio member.
- Connie Hauser, of Barbourville, is a physical therapist at P.T. Pros, Inc. Ms. Hauser represents non facility-based providers.
- Michael Huang, M.D, of Lexington, is a general internal medicine physician at Kentucky Clinic South. Dr. Huang represents non facility-based providers.
- Lawrence Kissner is the Commissioner of the Department for Medicaid Services. Commissioner Kissner serves as an ex-officio member.
- Deborah Moessner, of Louisville, is president and general manager at Anthem Blue Cross and BlueShield. Ms. Moessner represents insurers.
- Julie Paxton, of Prestonsburg, is an attorney for Mountain Comprehensive Care Center. Ms. Paxton represents facility-based health care providers.
- Tihisha Rawlins, of Louisville, is associate state director of AARP. Ms. Rawlins represents consumer advocates or consumer representatives.
- John Thompson, D.M.D., of Lexington, is a dentist at Thompson, Lee and Lee P.S.C. Dr. Thompson represents non facility-based providers.
- Marcus Woodward, of Ashland, is a health insurance broker at Woodward and Associates. Mr. Woodward represents insurance agents.

## Subcommittees

### Behavioral Health

Mental health and substance abuse services, including behavioral health treatment, are one of the essential health benefits required to be provided by Qualified Health Plans. The Behavioral Health Subcommittee reviews and makes recommendations on policy issues related to the provision of mental health and substance abuse services under the Kentucky Health Benefit Exchange.

### Dental/Vision

Beginning in 2014, pediatric dental and vision services are one of the essential health benefits required to be provided by Qualified Health Plans. The Dental and Vision Subcommittee reviews and makes recommendations on policy issues related to the provision of dental and vision services under the Kentucky Health Benefit Exchange.

### Education/Outreach

The Kentucky Health Benefit Exchange is required to provide culturally and linguistically appropriate outreach and educational materials to the public regarding eligibility and enrollment options, program information, benefits, and services available through the Exchange, the Insurance Affordability Programs, and the SHOP (Blueprint Section 2.3.pdf). The Education and Outreach Subcommittee reviews and makes policy recommendations related to education and outreach programs and activities by the Exchange.

### Navigator/Agent

Under the ACA, states are required to establish and operate a Navigator program to provide educational materials and assistance to individuals and small businesses accessing the new online health insurance marketplace. (Click here to learn more about Navigator requirements and duties.) The Navigator/Agent Subcommittee reviews and develops policy recommendations relating to specific aspects of the Navigator program, including performance standards, conflicts of interest standards, financial compensation and sustainability, training and certification, as well as delineating roles for Navigators and agents.

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#### Qualified Health Plans

Only “qualified health plans” that meet both federal and state requirements will be offered by the Kentucky Health Benefit Exchange. (Click here to learn more about the ACA definition of a qualified health plan (QHP)) The Qualified Health Plan Subcommittee will review and make policy recommendations relating to certification and other plan management issues for Qualified Health Plans.

#### Small Employer Health Options Program

Under ACA requirements, the Kentucky Health Benefit Exchange must establish a Small Employer Health Options Program (SHOP). The SHOP is designed to assist qualified employers and facilitate the enrollment of qualified employees into qualified health plans that are both of high quality and affordable. The Small Employer Health Options Program Subcommittee reviews and makes policy recommendations on specific aspects of the SHOP, including enrollment and eligibility, employer choice requirements, and group participation rules.

See <http://healthbenefitexchange.ky.gov/Pages/home.aspx> for further information about Kentucky’s office of KHBE.

## IV: Narrative Plan

### E. Program Integrity

#### Narrative Question:

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The Affordable Care Act directs the Secretary of HHS to define EHBs. Non-grandfathered plans in the individual and small group markets both inside and outside of the Marketplaces, Medicaid benchmark and benchmark-equivalent plans, and basic health programs must cover these EHBs beginning in 2014. On December 16, 2011, HHS released a bulletin indicating the Secretary's intent to propose that EHBs be defined by benchmarks selected by each state. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in that state as required by the Affordable Care Act.

SMHAs and SSAs should now be focused on two main areas related to EHBs: monitoring what is covered and aligning Block Grant and state funds to compensate for what is not covered. There are various activities that will ensure that mental and substance use disorder services are covered. These include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including EHBs as per the state benchmark; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring utilization of behavioral health benefits in light of utilization review, medical necessity, etc.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. SAMHSA expects states to implement policies and procedures that are designed to ensure that Block Grant funds are used in accordance with the four priority categories identified above. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment. States should describe their efforts to ensure that Block Grant funds are expended efficiently and effectively in accordance with program goals. In particular, states should address how they will accomplish the following:

1. Does the state have a program integrity plan regarding the SABG and MHBG?
2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?
3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:
  - a. Budget review;
  - b. Claims/payment adjudication;
  - c. Expenditure report analysis;
  - d. Compliance reviews;
  - e. Encounter/utilization/performance analysis; and
  - f. Audits.
4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?
5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?

SAMHSA will review this information to assess the progress that states have made in addressing program integrity issues and determine if additional guidance and/or technical assistance is appropriate.

#### Footnotes:

## **E. Program Integrity**

The Department of Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) relies on the Division of Administration and Financial Management (A&FM) and the Division of Behavioral Health (DBH) to provide fiscal and programmatic oversight of MHBG and SAPT block grant funds.

The role of A&FM is primarily to assure that fiscal requirements (e.g. maintenance of effort calculations, expenditure reports, etc.) are met. DBH is primarily responsible for assuring that programmatic requirements are met, that funds are spent to serve adults with SMI, that funds are spent on targeted services, etc. While the state does not have a formal program integrity plan in place regarding the SABG and MHBG, specific staff within A&FM and DBH are responsible for key oversight functions. These functions include:

A&FM – helps to ensure that the programs and services of the department are managed in accordance with appropriate statutes and regulations through the provision of centralized administrative, financial and grant management support, as well as budget preparation, execution and analysis.

This division's staff oversees preparation and management of approximately 197 contracts; works with the Cabinet for Health and Family Services staff in all purchasing, payment, contract monitoring, budgeting and accounting arenas; and provides support and technical assistance to all Department staff.

AFM consists of:

### **Contracts and Procurement Branch:**

The Contracts and Procurement staff assists with various areas. The group is responsible for all purchasing-related activities within the department. This includes:

- Procuring both goods and services (professional and non-professional).
- Coordinating the contracting process (PSC, MOA, MOU, and RFP development and evaluation).
- Coordinating and monitoring contract compliance.
- Monitoring contractor payments.
- Coordinating the development and modification of administrative regulations.
- Coordinating inventory-related activities.
- Coordinating records retention and disposal.
- Coordinating comprehensive, vehicle and medical liability insurance programs.
- Monitoring purchasing card ("Pro-card") activities.
- Overseeing responses to open records requests for the department.
- Overseeing building maintenance and security.

### **Financial Management Branch**

The Financial Management Branch staff members are liaisons to each of the program areas in the department. They are responsible for preparing biennial budget requests, creating annual budgets, monitoring expenditures and revenues monthly, and audit oversight. They make payments to major contractors and work closely with their respective programs to provide technical assistance and advice when needed.

### **Information Systems Branch**

The Information Systems (IS) Branch staff supports DBHDID technology needs in Central Office and all state hospital sites. IS oversees the department's support for infrastructure, local area networks, devices and security issues, as well as providing support for the Facility Information System.

IS staff members also act as liaisons to program areas to provide assistance in planning and implementing strategies for data collection, storage and retrieval. IS Branch also works with other departments and cabinets to coordinate efforts and streamline solutions across agencies.

DBH –

Beginning in SFY 2011, the Regional Boards were required, on their *Financial Spending Plans*, to allocate at least 50% of their mental health block grant funds to support the implementation of evidence-based or promising practices. This requirement continued for SFY 12 and 13. Efforts to capture data regarding training for staff and the number of clients receiving evidence-based practices continue. The Department has begun the process of realigning the allocated amount of funding to more equitably correspond with the number of individuals each Region serves. In this years' (SFY14) Plan and Budget requirements, all Mental Health adult block grant funds have been further targeted to Assertive Community Treatment, Supported Housing, Supported Employment, and Peer Support. DBH is exploring adding a similar requirement to the allocation and expenditure of SAPT funding in future years.

Mental health block grant funds are drawn down by Kentucky through the submission and acceptance of the federally required planning document (application) to CMHS. These funds have historically been used for programs that are not reimbursable through Medicaid, especially programs that advance development of a system of care. These funds are limited to programs for adults with SMI and children with SED.

Additionally, in SFY2013, DBH added a clause to each CMHC contract ensuring “that Federal Community Mental Health Block Grant (MHBG) and Substance Abuse Prevention and Treatment Block Grant (SAPT) funding is used to provide priority treatment and support services for individuals without insurance (Medicaid, Medicare or private insurance) or [for individuals] who cycle in and out of health insurance coverage”. DBH is exploring adding a clause in the SFY2014 contracts requiring the CMHCs to provide a certification of this through their annual audit process.

Specific program activities and DBHDID’s activities include:



**Budget Review** – This has become a proactive process involving staff within all the respective Branches during the annual Plan & Budget process. In accordance with KRS 210.430, plan and budget applications are submitted as part of the Regional Boards’ annual “Plan and Budget” application process. Information from Regional plans for SFY 12 and beyond has been incorporated into the planning documents for adults with SMI and children with SED, included in Section III of the application.

Each CMHC receives a funding allocation; they then submit a spending plan for the subsequent fiscal year which is either approved or denied by staff. Final approval of each CMHC spending plan is assured by the Division’s respective Financial Analyst.

**Claims/Payment Adjudication** – Federal block grant funds are not accounted for on an individual billing or claims basis between CMHCs and DBHDID. Some projects, however, are set up as expense reimbursed projects and require reconciliation (whether MHBG or SAPT).

**Expenditure Report Analysis** – A monthly standing meeting is held to review all DBHDID and DBH expenses. This meeting includes a review of block grant expenditures. This is a joint meeting between A&FM and DBH staff liaisons.

**Compliance Reviews** – For SAPT block grant funds, specific programs are monitored by DBH staff on-site annually at each of the 14 CMHCs. For MHBG funds, desk monitoring of semi-annual spending reports and performance indicator reports is conducted.

**Encounter/Utilization/Performance Analysis** – DBH staff review client (demographic) and event (services) for the number of individuals served who meet the priority population definition for SMI and SED along with a review of specific evidence-based or targeted services (e.g. targeted case management , peer support) that are only to be delivered to individuals with SMI or SED.

**Audits** – Each CMHC is required to submit annual audit reports which are reviewed by A&FM staff. This is a contract requirement, along with the requirement not to expend federal block grant funds for SAMHSA stipulated purposes (e.g. inpatient treatment). Once the CMHC’s allocation is determined, and its spending plan approved, funding is disbursed in 1/12<sup>th</sup> payment each month. Some projects are expense-reimbursed and are reconciled at the end of the state fiscal year. All block grant funds are accounted for with required semi-annual expenditure reports.

DBH, in an effort to create an organized system of care, is moving toward requiring the delivery of specific evidence-based practices (e.g. ACT, peer support). These practices have specific fidelity tools that assist in improving service quality when they are seen as performance improvement tools. Specific Federal requirements (such as the prohibition of using block grant funds for inpatient services) are passed on to providers through the contracting process and monitored through the audit process.

In State Fiscal Year 2013, DBH inserted a clause in the CMHC contracts that requires Block Grant funding must be used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid. As part of an overall Departmental assessment of the use of Federal and state funds for “safety net” populations and services, a workgroup has been formed to make recommendations to the DBHDID Commissioner concerning the further targeting of funding to the “indigent” population.

## IV: Narrative Plan

### F. Use of Evidence in Purchasing Decisions

Narrative Question:

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SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers decisions regarding mental health and substance abuse services. SAMHSA is requesting that states respond to the following questions:

- 1) Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?
- 2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?
  - a) What information did you use?
  - b) What information was most useful?
- 3) How have you used information regarding evidence-based practices?
  - a) Educating State Medicaid agencies and other purchasers regarding this information?
  - b) Making decisions about what you buy with funds that are under your control?

Footnotes:

## **F. Use of Evidence in Purchasing Decisions**

DBHDID does have specific staff that are responsible for promoting the use of evidence-based behavioral health practices. They are each focused on specific populations groups: adults with serious mental illness, children with serious emotional disturbances and individuals with substance use disorders. This said, these individuals do not spend 100% of their time tracking and disseminating information regarding evidence-based or promising practices. A plan to establish a Center of Excellence around specific evidence-based practices has been floated for several years, however, limited funding has prevented its implementation. In the meantime, staff continues work to align existing funding streams and policy opportunities to promote EBPs as part of purchasing decisions.

Currently, DBH staff are promoting a “rebalancing” initiative using state general funds (from the facility budget) coupled with MHBG funding to create a system of Assertive Community Treatment teams in the 14 CMHCs. Some MHBG funds are being used to hire a consultant to provide initial and ongoing training for CMHCs who are motivated to establish teams in the next fiscal year. Likewise, children’s mental health staff have been promoting the wraparound model for a number of years and have aligned technical assistance opportunities with outcome requirements in the CMHC contract.

In making purchasing decisions regarding evidence-based or promising practices, DBH staff have relied on SAMHSA Toolkits as well as independent consultants to assist in arming providers with the latest evidence and implementation science needed to replicate models under local conditions. DBH has learned a great deal while being a partner state in the Johnson & Johnson / Dartmouth Supported Employment program using the IPS model. After three years in the initiative, the state now has 7 of 14 CMHCs implementing the IPS model with three new sites to be selected for SFY14 under a Request for Applications (RFA) . The most aspects of this grant include the fidelity scale itself, the elements of practice and funding to hire a full-time trainer at the state level. DBH now builds fidelity requirements into its purchasing practices.

In the process of implementing EBPs, DBH is always attempting to secure permanent funding streams to allow programs to become sustainable. In the process Medicaid staff are educated about these new practices. Currently we are pursuing two new 1915(i) State Plan Amendments : one to increase services for individuals with substance use disorders (SUDs) and one to increase specialty services for adults with SMI. We have definitely needed to educate Medicaid staff about Recovery Oriented Systems of Care, Assertive Community Treatment, Supported Employment and Peer Support.

## IV: Narrative Plan

### G. Quality

#### Narrative Question:

Up to 25 data elements, including those listed in the table below, will be available through the Behavioral Health Barometer which SAMHSA will prepare annually to share with states for purposes of informing the planning process. The intention of the Barometer is to provide information to states to improve their planning process, not for evaluative purposes. Using this information, states will select specific priority areas and develop milestones and plans for addressing each of their priority areas. States will receive feedback on an annual basis in terms of national, regional, and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the Block Grant-funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in providing technical assistance to improve behavioral health and related outcomes.

	Prevention	Substance Abuse Treatment	Mental Health Services
Health	Youth and Adult Heavy Alcohol Use - Past 30 Day	Reduction/No Change in substance use past 30 days	Level of Functioning
Home	Parental Disapproval Of Drug Use	Stability in Housing	Stability in Housing
Community	Environmental Risks/Exposure to prevention Messages and/or Friends Disapproval	Involvement in Self-Help	Improvement/Increase in quality/number of supportive relationships among SMI population
Purpose	Pro-Social Connections Community Connections	Percent in TX employed, in school, etc - TEDS	Clients w/ SMI or SED who are employed, or in school

- 1) What additional measures will your state focus on in developing your State BG Plan (up to three)?
- 2) Please provide information on any additional measures identified outside of the core measures and state barometer.
- 3) What are your states specific priority areas to address the issues identified by the data?
- 4) What are the milestones and plans for addressing each of your priority areas?

#### Footnotes:

This section was left blank intentionally.

## IV: Narrative Plan

### H. Trauma

#### Narrative Question:

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In order to better meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed care approach consistent with SAMHSA's trauma-informed care definition and principles. This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate so that these services and programs can be more supportive and avoid being traumatized again.

Please answer the following questions:

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?
2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?
3. Does your state have any policies that promote the provision of trauma-informed care?
4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?
5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

Footnotes:

## H. Trauma

Page 72 of the Application Guidance

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4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?
5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

The Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) understands the pervasiveness of trauma and the necessity of infusing trauma-informed principles into the existing behavioral health services delivery system. Kentucky has made an effort to provide awareness training and educate providers in such practices as Seeking Safety; however, there was not a widespread knowledge or acceptance of the principles until SAMHSA made available funding through the Transformation Transfer Initiative (TTI) grant.

In 2012, Kentucky was one of eleven (11) states to receive funds to carry out planned activities. Funds were used to support the implementation of a statewide Interagency Trauma-Informed Steering Committee as well as to support eight (8) Regional Interagency Trauma-Informed Care Community Forums and subsequent follow up support to each. The Division of Behavioral Health contracted with a national consultant, through Community Connections in Washington, D.C., to facilitate the forums. These forums provided an opportunity to share information with local communities about trauma and trauma-informed care and to guide a discussion around "Creating Cultures of Trauma-Informed Care". Participants were provided with tools to guide them in developing strategic plans around trauma-informed care implementation. There were over 400 participants and 57 different agencies and groups in attendance over the eight forums. Four of the CMHC regions that participated in the forums have submitted Trauma-Informed Care Work Plans for the future.

The Division of Behavioral Health provides the following:

- Interagency Steering Committee on Trauma-Informed Care – the committee voted to continue after the TTI grant ended and includes state level personnel from over 15 different agencies and groups;
- Trauma-Informed Care Training for Trainers – an overview of trauma-informed care is presented in training for trainers format and provided to trainers within a variety of agencies. It is held on a quarterly basis and is free to participants;
- Seeking Safety – a present focused therapy to help people attain safety from trauma/PTSD and substance abuse. DBH staff offer a three hour overview of Seeking Safety to agencies

interested in providing this evidence based model of treatment. These overviews are held on an as needed basis;

- Trauma-Focused Cognitive Behavioral Therapy Learning Collaborative – a ten month training and coaching program (November 2012 – August 2013) for 28 clinicians across the state;
- Ending Domestic Violence and Sexual Assault Conference (December 2012) – Scholarships were provided for the preconference institutes as well as the main conference. A trauma track was included in the workshop schedule;
- Community Connections Webinars – DBH is collaborating with Community Connections to provide five Trauma-Informed Care-related webinars to any interested Kentucky provider;
- Louisville Childhood Trauma Symposium (May 17, 2013) – DBH provided support to the Symposium by sponsoring plenary speakers, Dr. Monique Marrow (National Child Traumatic Stress Network) and Dr. Christopher Mallett (Cleveland State University);
- Social Marketing Efforts – A Kentucky Trauma-Informed care logo was developed to support the branding in Kentucky. Posters were printed that highlight the principles of Trauma-Informed care. DBH collaborated with Kentucky Partnership for Families and Children to produce a youth-oriented music video related to trauma care. DBH is finalizing a brochure that will provide additional detail and show how an agency can become more trauma-informed;
- Trauma Recovery and Empowerment Model (TREM) training at Kentucky School for Alcohol and Other Drug Studies – Lori Beyer from Community Connections provided a two day Trauma Recovery and Empowerment Model (TREM) workshop at Kentucky School on July 22 & 23, 2013. TREM is an evidence-based, fully manualized, group based, intervention designed to facilitate trauma recovery among women with histories of exposure to sexual and physical abuse;
- Trauma-Informed Care Overview Trainings – various DBH staff are providing Overview Trainings on an as needed/as requested basis.

Kentucky does not currently have a contractual requirement for providers to screen for personal histories of trauma, nor to provide trauma-focused therapies to individuals with trauma histories. However, many providers screen for trauma histories as part of the biopsychosocial assessment process, as well as utilizing *Seeking Safety* as a treatment protocol. DBHDID's contracts with the fourteen CMHCs encourage the use of *Seeking Safety* and the use of fidelity instruments regarding *Seeking Safety*. Technical assistance is available upon request.

The Division of Behavioral Health is currently in the process of finalizing a Trauma-Informed Care policy statement and standards of care.



## IV: Narrative Plan

### I. Justice

#### Narrative Question:

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The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance abuse disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.<sup>42,43</sup> Rottman described the therapeutic value of problem-solving courts: Specialized courts provide a forum in which the adversarial process can be relaxed and problem solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs. Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient utilization of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; and therefore, risk factors remain unaddressed.<sup>44</sup>

A true diversion program takes youth who would ordinarily be processed within the juvenile justice system and places them instead into an alternative program. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention

Please answer the following questions:

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?
2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities, and the reentry process for those individuals?
4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?
5. What cross-trainings do you provide for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

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42 The American Prospect: In the history of American mental hospitals and prisons, The Rehabilitation of the Asylum. David Rottman, 2000.

43 A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs U.S. Department of Justice, Renee L. Bender, 2001.

44 Journal of Research in Crime and Delinquency: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide.

#### Footnotes:

This section was left blank intentionally.

## IV: Narrative Plan

### J. Parity Education

Narrative Question:

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SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action states can develop communication plans to provide and address key issues. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position.

Please answer the following questions:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?
2. How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.?)
3. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?

**Footnotes:**

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## IV: Narrative Plan

### K. Primary and Behavioral Health Care Integration Activities

#### Narrative Question:

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Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be rewarded to coordinate care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please answer the following questions:

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?
2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?
3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?
4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.
5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.
6. Describe how your behavioral health providers are screening and referring for:
  - a. heart disease,
  - b. hypertension,
  - c. high cholesterol, and/or
  - d. diabetes.

Footnotes:

## Narrative K. Primary and Behavioral Health Care Integration Activities

### Medicaid Health Homes

During SFY 2013, DBHDID formed a group to study Medicaid Health Homes. This initial group included representatives from the DBHDID, the Department for Medicaid Services, Kentucky Association of Regional Programs, Kentucky Primary Care Association, CMHCs, and two (one urban and one rural) Federally Qualified Health Centers. This group went to Missouri to study a successful Medicaid health homes initiative. In December 2012, DBHDID, with the support of this group, responded to a Request for Applications (RFA) regarding State Integration and Medicaid Health Homes, a National Council Learning Community, from the National Council for Behavioral Health. The application was awarded in January 2013. The Learning Community brings state leaders together in a group learning model that accelerates change and helps participants tackle confounding problems of integration and Medicaid Health Homes for persons with disabilities. The six (6) month Learning Community covers policy development, clinical models, and implementation strategies. At the end of the Learning Community, group members will have developed a strategic plan for implementing health integration/Medicaid Health Homes for special populations in Kentucky.

## IV: Narrative Plan

### L. Health Disparities

#### Narrative Question:

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In the Block Grant application, states are routinely asked to define the population they intend to serve (e.g., adults with SMI at risk for chronic health conditions, young adults engaged in underage drinking, populations living with or at risk for contracting HIV/AIDS). Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services, American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community, and African American women may be at greater risk for contracting HIV/AIDS due to lack of access to education on risky sexual behaviors in urban low-income communities.

While these factors might not be pervasive among the general population served by the Block Grant, they may be predominant among subpopulations or groups vulnerable to disparities. To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. In order for states to address the potentially disparate impact of their Block Grant funded efforts, they will be asked to address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

In the space below please answer the following questions:

1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?
2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?
3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity-vulnerable subpopulations?
4. How will you use Block Grant funds to measure, track and respond to these disparities?

#### Footnotes:

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## IV: Narrative Plan

### M. Recovery

#### Narrative Question:

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SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

### Indicators/Measures

Please answer yes or no to the following questions:

1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?
2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?
3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?
4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).
5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?
7. Does the state have an accreditation program, certification program, or standards for peer-run services?
8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

### Involvement of Individuals and Families

Recovery is based on the involvement of consumers/peers and their family members. States must work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system. In completing this response, state should consider the following questions:

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?
2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?
4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

### Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?
2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a

supportive community?

Footnotes:

## IV. Narratives

### M. Recovery

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*SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.*

#### Indicators/Measures

*Please answer yes or no to the following questions:*

- 1. Has the state developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery? **YES***
- 2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system? **YES***
- 3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care? **YES***
- 4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in *The Good and Modern Continuum of Care Service Definitions*, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care). **YES***
- 5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others? **NO***
- 6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? **YES***
- 7. Does the state have an accreditation program, certification program, or standards for peer-run services? **YES***
- 8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system. **See Narrative Below***

#### Involvement of Individuals and Families



Recovery is based on the involvement of consumers/peers and their family members. States must work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system. In completing this response, state should consider the following questions:

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services? **See Narrative Below**
2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns? **See Narrative Below**
3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support? **See Narrative Below**
4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services? **See Narrative Below**

#### Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary? **See Block Grant Application Criterion 1**
2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a supportive community? **See Block Grant Application Criterion 1**

Since the mid-1980s, the DBHDID has been committed to consumer and family involvement in program development and service delivery as a strategy for strengthening informal community supports. This focus has empowered consumers and family members to become more active in assisting Department staff in developing policies, monitoring and providing technical assistance to local programs, and evaluating requests for funding. The Division of Behavioral Health was directed by leadership to convene a workgroup in SFY 2009 with the goal of redesigning the consumer affairs function within the Division. A workgroup was convened that consisted of several adult mental health program staff members, including the consumer liaison, a representative from the substance use treatment branch, and an adult consumer. A framework for a redesign of the consumer affairs office was developed. Statewide consumer input was gathered at several points along the way, including informal meetings with the Division Director and during two (2) Olmstead/Consumer Advisory Committee meetings.

During SFY 2010, the Division of Behavioral Health began working to implement these recommendations. Department leadership agreed to hire a full time "Recovery Services Coordinator", who is a self-identified consumer of behavioral health services and who is a part of the management team. Department staff as well as consumers gave input on the job

description for this individual. In February of 2011, a Recovery Services Coordinator was hired and the same individual remains in place.

KDBHDID has adopted SAMHSA's working definition of recovery from mental disorders and or substance use disorders. "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." As well as the four (4) dimensions that support a life in recovery: Health, Home, Purpose and Community. In addition, Kentucky recognizes the ten (10) guiding principles of recovery as defined by SAMHSA: Hope, Person-Driven, Many Pathways, Holistic, Peer Support, Relational, Culture, Addresses Trauma, Strengths/Responsibility, and Respect.

The Department currently provides funds for a variety of statewide and local consumer and family support initiatives. These initiatives are focused on goals related to advocacy, discrimination reduction, wellness and recovery programs, peer support, education and training, and operating support. During SFY 2010, Division staff used consumer recommendations to rewrite contracts to be awarded to statewide consumer and family groups. These two contracts were renamed, appropriately, as 1) Recovery Oriented Family Support Services contract and 2) Recovery Oriented Training and Technical Assistance contract. These two (2) contracts were awarded initially in SFY 2011, and renewable annually thereafter. A Department liaison is designated to monitor these contracts.

The Recovery Oriented Family Support Services contract was awarded to NAMI Kentucky and included requirements for organizing and providing a series of recovery oriented trainings and support activities for family members, utilizing established training modalities and implementation of other support groups that are established as best or promising practices. In addition, NAMI Kentucky must provide at least one "train the trainer" session per year for individuals who will provide the family support group training. This contract also required the provision of leadership in advocacy activities including collaboration with other organizations in supporting improved and evidence based practices such as supported employment, stigma reduction and mental health recovery. New to this contract was the requirement to develop a comprehensive needs assessment and the provision of seven (7) regional symposiums. These educational symposiums' content was individualized to address local needs and requests. NAMI must assure at least monthly contact with training/support staff across the state in an effort to enhance community integration and inclusion and ensure coordination of family support services and other outreach. A statewide "train the trainer" training for Family to Family Teachers and Family Support Group Facilitators is held annually. NAMI provided 18 Family to Family 12 week classes with 225 individuals graduating. They also provided monthly family and consumer support groups and conducted monthly conference calls with Family to Family teachers and support group facilitators to enhance community integration, inclusion and outreach. NAMI Kentucky partnered with DBHDID to host five (5) "Community Conversations" across the state to educate and gather input on the 1915 (i) state plan amendment. NAMI Kentucky, as the family advocacy team leader, partnered with DBHDID to assist with an "Individual Placement and Supports" (IPS) Supported Employment pilot project in four (4) regions in the state. In addition, they created a listserv to promote mental health and community integration with statewide providers, consumers and family members.

Goals for NAMI Kentucky for SFY 2014/2015 include:

- Growing and strengthening NAMI affiliates by making personal visits to their community and having community meetings to enhance community integration, inclusion, outreach and increased efforts in stigma reduction;

- Educating local education authorities and the business community on mental health disorders and available resources; and
- Increasing the number of trainers for NAMI signature programs.

The Recovery Oriented Training and Technical Assistance contract required the development of a Technical Assistance Center and the provision of recovery oriented trainings across the state. Contractors gathered stakeholders from across the state, including consumers, family members and providers, and developed consensus for the formation of Kentucky System Transformation, Advocacy, Recovery and Support (KY STARS), a training and technical assistance center focusing on recovery oriented mental health services. During SFY 2012, KY STARS provided education to consumers and staff at state psychiatric hospitals, consumers and staff of CMHCs, and to Kentucky Peer Specialists and Leadership Academy graduates. KY STARS also provided technical assistance to consumers of peer run programs, staff of local CMHCs, and staff of state psychiatric hospitals. In addition, KY STARS worked to expand the number of peer to peer support groups available across the state and worked to train peers as facilitators of activities that are considered best practice.

KY STARS developed, conducted and analyzed a Comprehensive Needs Assessment of all mental health services in Kentucky during SFY 2012. The Assessment polled over 300 providers, consumers, and family members from across the state and looked at major issues in the mental health system, including service gaps, consumer inclusion and cultural competence. The data was broken down by geographical region and has guided KY STARS activities toward the mission of infusing recovery oriented care into all aspects of the state's mental health system.

The KY STARS Training and Technical Assistance Center is located at Participation Station, Inc. This is one of Kentucky's first Peer Operated Centers. KY STARS has provided Participation Station with significant assistance in SFY 2012/2013 with adopting and implementing the SAMHSA Toolkit for Consumer Operated Services. Participation Station is using the Fidelity Assessment Common Ingredients Tool (FACIT) to guide programming and evaluation and has selected the Peer Outcomes Protocol (POP) to measure individual outcomes for the participants of the program.

KY STARS has partnered with DBH to develop and facilitate support groups for individuals with co-occurring substance use and mental disorders. Double Trouble in Recovery (DTR) groups, are traditional twelve (12) step programs geared toward the special needs of individuals who are also dealing with a psychiatric diagnosis. To date there are twenty-one (21) DTR support groups across the state including nine (9) CMHC regions and two (2) state psychiatric hospitals.

The Recovery Oriented Training and Technical Assistance contract requires the provision of Leadership Academy across the state. The **Leadership Academy** is a three (3) day educational program for persons with a mental health disorder who have interest in developing and improving their leadership and advocacy skills. Lessons are geared to address local and state concerns and provide students with practical and useful communication skills. The Leadership Academy consists of two training levels. Level I Training is the general skills training. Level II training is a Train-the-Trainers format, where graduates are able to return to their regions and serve as group instructors. Graduates of the Leadership Academy are able to:

- Identify and assess community issues and needs,
- Create, develop and participate in group action plans,

- Organize local advocacy groups into a respected and effective voice on mental health issues, and
- Participate on boards, councils and commissions.

Since April of 2007, Leadership Academy graduates have attended and participated on Eastern State Hospital's Recovery Mall Leadership Council, by attending monthly meetings. These graduates assist the attendees at the Council meetings in learning recovery skills and in learning how to conduct effective meetings. These meetings benefit both the residents at Eastern State Hospital who are working on their own recovery, as well as the Leadership graduates who are utilizing their newly learned skills.

During SFY 2013, one (1) Leadership Academy training was held, in Bardstown, Kentucky. Instructors for these trainings are Kentucky Peer Specialists. As a result of the Leadership Academy Training in Bardstown, Kentucky, the group of consumers trained became so inspired that they negotiated with their local NAMI affiliate and CMHC, and with technical assistance from KY STARS, opened a peer operated center in their area. The goal for SFY 2014/2015 is to provide at least two (2) Leadership Academy trainings per year.

During SFY 2012, KY STARS provided training and technical assistance to staff at Western State Hospital to assist with the successful implementation of a Recovery Mall as part of the services offered to inpatient mental health consumers. This program was modeled after the Recovery Mall at Eastern State Hospital and Appalachian Regional Hospital psychiatric facilities. The treatment mall model has now been adopted by three (3) of Kentucky's four (4) state psychiatric hospitals. Feedback from consumers has been very encouraging and many comment that they became more engaged in their recovery.

KY STARS presented a state-wide conference for consumers of mental health services during SFY 2012. This conference was attended by almost four hundred (400) consumers from across the state. Peter Ashenden, from Optum Health was the keynote speaker. He is a national leader in mental health peer support and proved to be an inspiration toward expansion of peer support services in Kentucky.

In regards to peer support services in the state, KY STARS also held a preconference plenary for a selected group of Kentucky Peer Specialists from various geographical areas of the state. Cherene Allen-Caraco, a Certified Peer Specialist from Charlotte, NC presented a full day workshop entitled "Organizational Recovery" in which she taught Kentucky Peer Specialists how to interface with the public mental health system, Community Mental Health Centers, and other provider entities to fully integrate peer support into existing systems.

During SFY 2013, KY STARS presented a state-wide conference for consumers of mental health services as well. Approximately two hundred, fifty (250) attended. Steve Harrington from the International Association of Peer Support was the keynote speaker as well as the speaker for the preconference the day before.

In order to further the cause of expanded peer support services in Kentucky, KY STARS developed a functional website to share programs, recruit new Kentucky Peer Specialists and educate the public.

**Kentucky Peer Specialist Training** is a five day intensive training program for persons with a mental illness who have a desire to learn more about the recovery process and learn how to

help others move forward in their own recovery process. The training program was modeled after the Georgia and South Carolina models of Peer Support.

While Kentucky Peer Specialist services are still not a billable service under Medicaid, DBHDID continues to train consumers for this service. During SFY 2012 three (3) peer support trainings were conducted. During SFY 2013 four (4) trainings were held. The manner in which we present these classes has been improved in the following ways:

- Upgrading the curriculum by adopting the second edition of the Georgia training model from the Appalachian Consulting Group which was copyrighted in 2011;
- Improving our delivery model to accomplish greater efficiency and economy. Previously we brought trainers and students from across the state to a single training location and paid everyone's travel, food and lodging for up to six days. It was expensive. We now depend upon community mental health centers to team with us by providing the location so that we can train our students regionally. Students are able to travel back and forth from their homes to the training. Thus we are expanding our reach and we are responsible only for the meals and lodging for the trainers; and
- Expanding our training corps so that we have competent trainers in several regions of the state to facilitate additional trainings, and deliver coaching and continuing education programs.

During SFY 2013, DBHDID began to work toward establishing a Kentucky Peer Support Organization. DBHDID is exploring joining the International Association of Peer Specialists.

During SFY 2013, DBHDID developed a new curriculum for peer support persons who are interested in serving people experiencing substance use disorders. This is an urgent need since 60% of those with mental health problems also experience substance use disorders and 80% of those with substance use disorders also experience mental health problems.

Three (3) **Peer Operated Programs** are working on the process of establishing fidelity to the SAMHSA Consumer Operated System of Care Model. Participation Station in Lexington, Kentucky, (Bluegrass region), the Personal Involvement Empowering Recovery (PIER) program in Northern Kentucky (NorthKey Community Care region), and a new Participation Station in Bardstown, Kentucky. (Communicare, Inc. region) The program in Bardstown began in March 2013. All three (3) of these programs are completely operated by consumers.

The goals for SFY 2014/2015 are to continue to provide credentialing for peers in Kentucky, both for Kentucky Peer Specialists and persons experiencing substance use disorders. Also, DBHDID hopes to offer peer support as a Medicaid billable service. In addition, DBHDID hopes to foster Consumer Operated programs in additional regions through issuing an RFA (Request for Applications) to develop four (4) new programs using Mental Health Block Grant funding. During SFY 2013 an RFA was issued and awarded to four (4) CMHCs, Four Rivers Behavioral Health, Lifeskills, Inc., Communicare, Inc., and Mountain Comprehensive Care Center. Those regions are currently working on establishing their programs with fidelity to the Consumer Operated Programs model.

KDBHDID and the Regional Boards use a number of strategies to support consumer and family involvement. Block Grant funding supports various consumer involvement activities, including:

- Encouraging increased collaboration between Regional Boards and advocacy organizations;
- Sponsoring or co-sponsoring recovery oriented events in the regions;

- Recovery oriented training and technical assistance from consumers and family members to state psychiatric hospitals and providers;
- Consumer support groups on a regional basis;
- Wellness Action and Recovery Plan (WRAP) trainings for consumers; and
- Reimbursement for consumer and family members to attend state and regional meetings, conferences, and other gatherings.

The DBHDID and the Regional Boards encourage consumer and family member participation in planning, monitoring, and service delivery. To improve on existing weaknesses and build on existing strengths, plans are to:

- Continue to involve consumers and family members in the Behavioral Health Block Grant planning process;
- Design programs, trainings, and outcome measures that incorporate recovery principles;
- Implement Supported Employment training to encourage hiring of consumers;
- Encourage the growth of consumer run services by encouraging processes that establish fidelity to the SAMHSA model of Consumer Operated Programs;
- Continue to encourage statewide consumer participation at all planning events; and
- Make Recovery Model training available in all regions.

While the DBHDID and the Regional Boards have come a long way in fostering consumer and family member participation in planning, monitoring, and service delivery, many challenges remain, including:

- Lack of additional dedicated funding for consumer run services;
- Few programs that fully incorporate recovery principles;
- Limited number of consumer run services that can serve as “mentor” programs; and
- Persistent transportation barriers for individuals to attend meetings and other events.

## IV: Narrative Plan

### N.1. Evidence Based Prevention and Treatment Approaches for the SABG

#### Narrative Question:

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As specified in 45 C.F.R. §96.125(b), states shall use a variety of evidence-based programs, policies, and practices to develop prevention, including primary prevention strategies (45 CFR §96.125). Strategies should be consistent with the IOM Report on Preventing Mental Emotional and Behavioral Disorders, the Surgeon General's Call to Action to Prevent and Reduce Underage Drinking, the NREPP or other materials documenting their effectiveness. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance abuse prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SABG statute directs states to implement strategies including : (1) information dissemination: providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities; (2) education aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities; (3) alternative programs that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use; (4) problem identification and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use; (5) community-based processes that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and (6) environmental strategies that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

States should provide responses to the following questions:

1. How did the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?
2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. What outcome data does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
5. How is the state's budget supportive of implementing the Strategic Prevention Framework?
6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)
7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program.

#### Footnotes:

**Narratives**

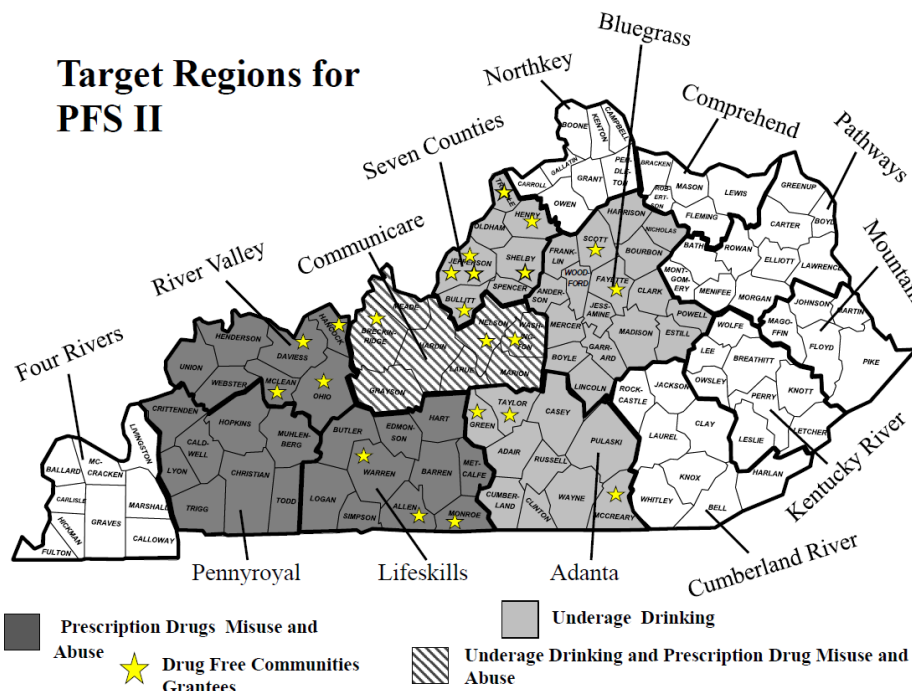
**N1. Evidence Based Prevention and Treatment Approached for the SABG**

Many of the gaps identified in the last Prevention Block Grant Plan were either partially or wholly realized through our State Prevention Enhancement (SPE) Grant and the State Epidemiological Outcomes Workgroup (SEOW) grant. The SPE grant, aimed at strengthening state prevention capacity, ended in June 2012. The SEOW grant, scheduled to last until September 2013 was relinquished as a prerequisite to qualifying for SAMHSA’s Partnership for Success (PFS) funding.\*

In October of 2012 the Substance Abuse Prevention Branch of the Division of Behavioral Health was one of 15 States/Territories to be awarded a SAMSHA’s Partnership for Success (PFS) II grant. All PFS recipients are required by SAMSHA to utilize the Strategic Prevention Framework to plan and implement strategies aimed at reducing the consequences associated with underage drinking (UAD) and prescription drug (Rx) abuse. Since the focus of the PFS is very similar to pre-existing underage drinking and prescription drug components of our prevention block grant plan covered under our Changing Social Norms and Policy (CSNaP) initiative, there is much overlap between the two. The additional financial and technical assistance resources that the PFS affords will allow Kentucky to pursue these existing block grant goals more thoroughly and more systematically. If you will, the PFS is like a new motor in an old vehicle whose destination has already been set.

The PFS is a three year grant, scheduled to run until September 30, 2015, thus covering the time frame for this Block Grant planning period. Globally, the goal of the PFS and of our Rx and UAD block grant goals are to achieve a statewide reduction of past 30 day consumption of both of these substances. The information below provides more detail on the needs assessment activities, capacity building goals and types of activities and strategies that will be implemented.

As a requirement of the PFS application the SEOW was required to conduct a needs assessment to determine communities of high priority. Unlike past SAMSHA grants, where community was defined by the county boundaries, the PFS defines community on the much larger regional scale. The SEOW identified seven regions of need for UAD and Rx. These target regions are identified on the map below.





The SEOW utilized a number of data sources to determine regions of high need. The two principle sources that informed the SEOW findings were Kentucky Incentives for Prevention (KIP) Survey 2010 data and the 2011 Youth Risk Behavior Survey (YRBS) (included below).

**Table 2: Weighted prevalence of alcohol and prescription drug abuse among Kentucky high school students, YRBS 2011**

Characteristics	Any Alcohol	Binge	Prescription Drugs <sup>1</sup>
	%	%	%
<b>Total</b>	34.6	23.2	19.0
<b>Gender</b>			
Male	35.6	24.8	20.6
Female	33.4	21.2	17.0
<b>Grade</b>			
9 <sup>th</sup>	23.3	13.5	15.1
10 <sup>th</sup>	31.8	21.8	16.3
11 <sup>th</sup>	41.0	26.7	24.4
12 <sup>th</sup>	44.1	32.0	20.9
<b>Race/Ethnicity</b>			
White	35.2	24.2	20.4
Black	23.7	10.3	11.8
Hispanic	50.6	37.2	21.6
Other	34.9	21.3	24.2

The distribution of prevalence rates for alcohol intoxication and associated risk and protective factors from the 2010 KIP Survey are summarized in Table 3 by region. Table 4 provides similar data for prescription drug abuse.

**Table 3: Prevalence of alcohol-related indicators among Kentucky adolescents by Regional Prevention Center district, KIP 2010**

RPC Region	Type of Alcohol Abuse			Risk & Protective Factors		
	Intox	Binge <sup>1</sup>	Any	Early Abuse <sup>2</sup>	Access <sup>3</sup>	Disapproval <sup>4</sup>
	%	%	%	%	%	%
Kentucky	11.2	9.5	17.4	3.1	23.4	6.7
Adanta	11.4	9.5	17.5	3.4	24.7	7.6
Cumberland River	8.7	7.4	13.7	2.8	21.8	5.9
Bluegrass	12.0	9.8	18.0	2.6	23.3	7.8
Comprehend	10.6	9.9	17.0	4.1	24.4	6.4
Northkey	11.3	9.6	17.8	3.4	23.5	6.0
Communicare	13.0	11.1	20.8	3.4	26.0	7.5
River Valley	12.0	10.2	17.9	3.0	22.8	7.0
Four Rivers	10.5	9.0	17.3	3.5	23.6	6.4
Pennyroyal	11.0	9.1	17.3	3.2	25.1	6.7
KY River	9.9	8.9	14.4	3.1	20.3	6.5
Mountain	10.2	9.5	14.5	2.5	22.1	6.0
Pathways	10.8	9.4	16.5	3.0	22.9	6.7
Seven Counties	13.2	11.0	21.0	2.7	24.1	7.2
Lifeskills	10.6	9.3	13.7	3.3	22.1	7.8

<sup>1</sup>Binge drinking during the past 2 weeks

<sup>2</sup>Began drinking regularly, at least one or twice a month, at age 12 or younger

<sup>3</sup>Reported very easy access to getting some beer, wine, or hard liquor

<sup>4</sup>Reported not wrong at all for someone their age to regularly drink beer, wine, or hard liquor

**Table 4: Prevalence of prescription drug-related indicators among Kentucky adolescents by Regional Prevention Center district, KIP 2010**

	Prescription Drug Type <sup>1</sup>				Risk & Protective Factors	
	Oxy	Tranq	Speed	Any	Access <sup>2</sup>	Disapproval <sup>3</sup>
<b>RPC Region</b>	%	%	%	%	%	%
Kentucky	1.0	1.5	0.9	2.8	5.6	1.7
Adanta	0.9	1.6	0.8	2.8	5.3	1.5
Cumberland River	1.0	1.4	0.7	2.6	5.8	1.4
Bluegrass	0.9	1.4	0.7	2.7	5.9	1.8
Comprehend	1.3	0.9	0.5	2.5	5.1	1.7
Northkey	1.3	1.6	1.0	2.7	6.0	1.8
Communicare	1.3	2.0	0.9	2.9	4.6	1.8
River Valley	0.9	1.7	1.2	3.5	5.3	1.9
Four Rivers	1.0	2.0	1.3	2.9	6.1	1.9
Pennyroyal	0.9	1.5	1.1	3.3	6.8	1.9
KY River	0.5	0.8	0.6	2.3	5.7	1.6
Mountain	0.5	0.8	0.4	1.7	6.0	1.4
Pathways	0.8	1.0	0.7	2.0	5.8	1.8
Seven Counties	1.1	1.8	1.1	3.2	4.1	1.6
Lifeskills	1.4	2.1	0.8	3.6	5.6	1.9

<sup>1</sup>Reported use on one or more occasions in the past month

<sup>2</sup>Reported very easy access to getting cocaine, LSD, or amphetamines

<sup>3</sup>Reported not wrong at all for someone their age to use LSD, cocaine, or other illegal drugs

Changing Social Norms and Policy, as the title suggests, focuses on environmental strategies that aim to change norms around acceptability of usage and limit availability of access. Regions that are concentrating on prescription drugs will concentrate their efforts primarily on:

- Correcting three (3) youth misperceptions about prescription drugs - that they are: 1.) safer than street drugs, 2.) less addictive than street drugs, 3.) OK to share among friends and family
- Safe storage and disposal of prescription drugs
- Support for new Kentucky legislation which licenses pain clinics and mandates the use of the Kentucky All Scheduled Prescription Electronic Drug Reporting (KASPER) system for all doctors in the state
- Conducting large scale informational efforts directed at parents, caregivers and prescribers of prescription drugs

Regions that are concentrating on Underage Drinking (UAD) binge drinking will focus primarily on:

- Limiting social and retail access of alcohol to underage youth through establishment of Social Host Ordinances, or strengthening enforcement of these ordinances in counties where they already exist.
- Retail access strategies such as shoulder taps and compliance checks.
- Expanding and intensifying the “I Won’t Be the One” campaign – a large scale informational efforts at older adults about the legal and health consequences of providing alcohol to underage youth.

Additionally, the PFS will seek to strengthen prevention capacity/infrastructure at the State and community levels for addressing underage drinking, prescription drug misuse and abuse and for promoting mental health.

Kentucky's PFS proposal also embraces three (3) of the four (4) prevention goals of SAMSHA's Strategic Initiative # 1 which are already long term goals of our Block Grant plan. Briefly, those goals are:

- With primary prevention as the focus, build emotional health, prevent or delay onset of, and mitigate the symptoms and complications from substance abuse and mental illness
- Prevent or reduce the consequences of underage drinking
- Prevent or reduce the consequence of prescription drug misuse and abuse

\*As per the criteria of the PFS Request for Proposals (RFP), states awarded PFS funding must give up the remainder of the SEOW funding. SAMHSA's expectation is that PFS funding can be used to support the SEOW throughout the PFS grant cycle.

Many of the gaps that were identified in our prevention infrastructure will require long term effort to fill. Below is a list of the gaps that were included in last year's report and a bolded update on what has been done to address them.

Need to focus more efforts on diverted prescription drugs and underage drinking, both of which emerged as priorities in the most recent SEOW needs assessment;

**Status: As described above, a large part of our UAD and Rx efforts have been rolled into our PFS grant. Carry over block grant funding has also been provided to the Regional Prevention Centers (RPC's) not covered in the PFS so that all counties of the state are served.**

The capacity for engaging with behavioral health issues (e.g. indicators of social, emotional, and behavioral well-being) is minimal and has not received emphasis heretofore;

**Status: In 2012 the state offered three (3) Statewide trainings that addressed the integration of mental health and substance abuse. The Integration of Mental Health and Substance Abuse Prevention, facilitated by Michael Compton, drew 117 participants from Regional Prevention Centers, Community Mental Health Centers and private treatment providers. Seventeen (17) state staff from the Division of Behavioral Health also attended.**

There is a need for a more systematic and comprehensive system for disseminating information about Evidence Based Practices (EBP) and Programs and for providing related training and technical support to the field. Kentucky proposes to form an Evidence-based workgroup to help translate the findings of the SEOW with meaningful and appropriate preventive interventions at community level;

**Status: An Evidence-Based Practices Workgroup was formed last year and has met several times. The workgroup created two (2) very useful training tools related to community capacity building: 1) Understanding the Strategic Prevention Framework - an instructional poster explaining of the five (5) steps of the SPF in everyday language that volunteer community members are more likely to understand. 2) "The Process" a training DVD which elaborates and dramatizes the utility of community-level strategic planning with a particular focus on the SPF.**

There is a need for renewed effort toward integrating and focusing limited resources in high-need communities. This will require broad systemic effort at the state level, but also focused

coordination and planning at the community (regional) level with the full engagement of stakeholders;

**Status:** The SEOW identified seven (7) regions (55 counties) of high need in its PFS application. Resources have been directed to these regions to conduct additional needs assessments and to begin strategic planning. State prevention staff are looking at ways that block grant allocations to RPCs might be reformulated based on need and performance. Revision of the RPC work plans, which was just completed, is the first step in this process. We are also working with a team of out-of-state experts to see how other states have tackled this problem.

There remain some major gaps in terms of problems and populations, including the state's growing Hispanic population, adult substance abuse (especially older adults), emerging adults in the 18-24 age range, data on substance abuse and mental health difficulties in the workplace, LGBTQ youth and military families and children (Kentucky hosts two (2) of the nation's largest military posts: Fort Knox and Fort Campbell). There is a need for data development in these areas;

**Status:** In July of 2012 The Division of Behavioral Health hosted an LGBTQ2S Training which drew seventy-one (71) participants – ten (10) state staff from the Division of Behavioral Health, as well as a number of Regional Prevention Center staff and community coalition members. State staff participated in a LGBTQ2S work group which conducted a needs and resource assessment for this population and drafted a work plan. Plans are currently underway to expand the workgroup to include branches of the entire Department.

The Faith Hope Future Conference which targeted risk factors for substance abuse and behavioral health among the military and their families drew seventy-seven (77) participants. The conference focused on such issues as mental and spiritual health injuries; Post Traumatic Stress Disorder; Post Traumatic Spiritual Disorder; Traumatic Brain Injuries; Military Sexual Trauma; spousal and child abuse; depression, substance abuse, and adjustment disorders. Eleven (11) RPC Staff and two (2) DBH staff attended.

There remain significant issues with respect to Appalachian life and culture that must be considered when targeting those geographic areas;

**Status:** This issue has been discussed at Regional Prevention Center Directors meetings and at Evidence-based Work group meetings, but as of yet there are no milestones or outcomes to report.

Need to update and expand the functionality of Kentucky's Data Warehouse (e.g., mapping and charting capacities), improve its attractiveness and usability (e.g., data visualization, infographics), and provide much more extensive training and support in its use within active planning processes;

**Status:** This gap has been fully addressed. The data warehouse has been expanded to include mental health indicators, mapping and graphing features have been enhanced and three (3) training videos have been added "Public Health: Telling the Story Using Data", "Translating Data into Public Health Priorities", and "Introduction to Epidemiology".

Several areas that need strengthening through workforce development and training include: (1) basic knowledge about the SPF framework; (2) knowledge and skills in planning processes, including data integration and goal formulation; (3) more knowledge about EBPs in prevention and the capacity to thoughtfully select strategies; (4) skill in data distillation and synthesis for the purposes of planning and evaluation; (5) skill in program management and implementation; (6) general knowledge and skills related to program evaluation, including instrument design, data analysis, and portrayal; (7) skills related to coalition-building; and, (8) skill in utilizing the enhanced data warehouse.

**Status: Gaps 4, 5, and 8 have been partially filled by the data warehouse training modules mentioned above. The PFS Project Director and Coordinator have scheduled training with the developers of the data warehouse to familiarize themselves with the new features. We are looking at the possibility of conducting a webinar for RPC staff and local coalitions on how to use the new data warehouse.**

## Prevention Goals for SFY 2014/2015

Priority	Goal	Strategy	Performance Indicator	Target Population	Status
With primary prevention as the focus build emotional health, prevent or delay onset of, and mitigate symptoms and complications from substance abuse and mental illness.	Integrate the prevention of mental illness into state and local substance abuse prevention efforts as appropriate.	Provide training to Prevention staff state and regional regarding strategies/ resources to address the prevention of mental illness, including cultural training on high risk population, LGBTQ & military & Native American  Include relevant mental health data as indicated in the KY SEOW Epi-profile to the data warehouse	Number of trainings provided, number of state and RPC staff trained. Increased knowledge of mental illness prevention as measured by training evaluations.  The number of mental health promotion activities performed by the RPCs as measured by the prevention data set.	RPC Staff and Prevention Professionals	Ongoing In 2012 the state offered three (3) Statewide trainings that addressed the integration of mental Health and Substance Abuse. One hundred seventeen (117) RPC and CMHC staff attended. (SFY 2012)
Prevent or reduce consequences of underage drinking	Reduce state 10 <sup>th</sup> grade, 30 day binge drinking rate by at least 1% . KIP 2012 survey will be used as a baseline. KIP 2014 data will be used to measure outcomes.	Supporting/strengthening the enforcement of existing laws regarding adults providing alcohol to minors.  Implement local policies that target social access of alcohol to youth (social host & unruly gathering ordinances)	Increase in enforcement of UAD laws as measured by local law enforcement data and reports to coalitions  An increase in RPC time spent on UAD environmental strategies as measured by the prevention data set.  Number of polices developed	9 <sup>th</sup> -10 <sup>th</sup> grade youth in targeted counties  Parents & community at large.	Ongoing until September 30 <sup>th</sup> 2015. Applied for and was granted CSAP's PFS – a grant that specifically focuses on UAD and Rx. The PFS grant will be used to fund this goal. A needs assessment has been conducted which identified seven (7) regions of high need. Target regions are currently in the planning process. (SFY 2012)
Prevent	Integrate the		Number of trainings provided, number of	RPC Staff and Prevention	Ongoing RPC staff have received

Priority	Goal	Strategy	Performance Indicator	Target Population	Status
suicides and attempted suicides among populations at high risk.	prevention of suicide among high risk populations into state and local substance abuse prevention efforts as appropriate.	Provide training to state and regional level prevention staff on the need for, and strategies and resources to address, suicide prevention, including cultural training on high risk population (LGBTQ, Native American and military families).	state and RPC staff trained.  Increased knowledge of suicide prevention strategies and of the high risk populations as measured by training evaluations  Number of suicide awareness activities conducted by the RPCs as measured by the Prevention Data Set	Professionals	QPR Suicide Prevention Training. Some RPCs have hosted this training for local coalitions. (SFY 2012)
Reduce prescription drug misuse and abuse	Increase in parental awareness of youth Rx drug abuse  Reduce state 10 <sup>th</sup> grade 30 day Rx drug abuse. KIP 2012 survey will be used as a baseline. KIP 2014 will be used to measure outcomes.	Parental Rx education & awareness programs that stress proper storage, monitoring and disposal of Rx drugs.  Determine three (3) main misperceptions of students garnered from RPC Conducted focus group information around Rx drug misuse. Enlist the partnership of local high schools to participate in a youth contest that develops media messages that address of the three (3) identified misperceptions.	Number of flyers delivered, number of distribution points as measured in the prevention data set. Increase in RPC time of spent on environmental strategies relating to Rx drugs in selected counties, as measured by the Prevention Data Set.  Number of contest winners  Number of youth who see the media messages	Adults in the community  9 <sup>th</sup> Graders in targeted counties	Ongoing until September 30th 2015. Applied for and was granted CSAP's PFS – a grant that specifically focuses on UAD and Rx. The PFS grant will be used to fund this goal. A needs assessment has been conducted which identified 7 regions of high need. Target regions are currently in the planning process. (SFY 2012)

Priority	Goal	Strategy	Performance Indicator	Target Population	Status
Reduce prescription drug misuse and abuse	Expand indicators related to prescription drug abuse	Revise KIP Survey to include questions on perceived availability peer usage, perception of risk of Rx drugs and favorable attitudes toward Rx drugs.	# of new questions added to KIP concerning prescription drug abuse and misuse	6 <sup>th</sup> , 8 <sup>th</sup> , 10 <sup>th</sup> and 12 <sup>th</sup> graders	<b>Completed (SFY 2012)</b>
Reduce access of tobacco products to underage youth	A decrease of two (2) percentage points in perceived availability of tobacco products to underage youth in 6 <sup>th</sup> , 8 <sup>th</sup> , 10 <sup>th</sup> 12 <sup>th</sup> Increased knowledge of Synar program, methodology goals and outcomes and KY youth tobacco use trends.	Develop a tobacco vendor education program consistent with new FDA guidelines.  Begin phase I of tobacco retail licensing initiative  Issue report on Reward and Remind outcomes and lessons learned to RPC Staff and partner agencies  Organize an annual Synar conference ,  Regular e-mail updates to field	Number of students who respond “very hard” or “sort of hard “ to the question “ If you wanted to get some cigarettes how easy would it be for you to get some “ or (KIP Survey 2012)  Distribution of report  Evaluation results from conference  # of participants at conference	Tobacco Retailers  Tobacco Retailers  State and RPC staff, and agency stakeholders  RPC staff and Prevention Professionals	KIP 2012 survey results are not yet available. Once they are made available we will compare tobacco availability data for 2010 and 2012. Tobacco Vendor Training was developed in SFY 2011 and launched in SFY 2012  <b>Completed (SFY 2012)</b>
Smokeless tobacco	Increase state-level smokeless tobacco prevention efforts	Update RPC’s and prevention professionals on current smokeless data trends, and related information.	Number of email updates  Number of smokeless tobacco presentations, made at RPC meetings, and other prevention venues	RPC Staff and Prevention Professionals  RPC Staff and	Ongoing (3 presentations given)  Tobacco Prevention



Priority	Goal	Strategy	Performance Indicator	Target Population	Status
		<p>Increase resources to address Smokeless tobacco.</p> <p>Work with ABC to increase number of smokeless tobacco compliance checks</p>	<p>Number of Smokeless related e-mails sent to RPC staff and other prevention professionals.</p> <p>Number of new resources created or existing resources made available to RPC's and Prevention Professionals.</p> <p>Number of smokeless tobacco checks performed by ABC during FFY 2012</p>	<p>Prevention Professionals</p> <p>RPC Staff and Prevention Professionals</p> <p>Tobacco Vendors</p>	<p>Enhancement Site created "Smart Mouth," A prevention curriculum that targets youth smokeless tobacco use. (SFY 2012-13)</p>
Make the data warehouse a more useful prevention planning tool	Update and expand the functionality of the KY data Warehouse				<b>Completed (SFY2012)</b>

**Prevention Block Grant Goals for 2014-2015**

Priority	Goal	Strategy	Performance Indicator	Target Population	Status
Smokeless Tobacco Use	Increase the number of Synar inspections for smokeless tobacco.	Revise Synar inspection protocol smokeless tobacco and submit to CSAP for approval.	Number of Synar smokeless checks in 2012 compared to 2013	Tobacco vendors	

Smokeless Tobacco	Track # of smokeless checks done through ABC tobacco inspections and monitor retail violation rate	Modify ABC tobacco inspection form to distinguish smokeless inspections from cigarettes (Currently there is no information on the ABC inspection sheet to differentiate smokeless from cigarettes. .So we do not know how many violations are for smokeless)	Establishment of a baseline for number of smokeless checks performed  Establishment of a baseline retail violation rate for annual ABC smokeless checks.	Tobacco vendors	
Cigarettes and smokeless tobacco		Develop Marketing campaign to advertise TRUST.	Increase in number of tobacco retailers trained in 2013 compared to 2012.	Tobacco vendors	
	Increase the number of Kentucky Tobacco retail clerks who have received TRUST training	Identify stakeholders,  Compile the latest research on best practices for implementing smoking cessation in mental health and substance abuse treatment settings	Formation of a mental health and substance abuse treatment smoking cessation workgroup.  Compilation of research	Persons suffering from mental health and substance abuse	

<p>Tobacco</p>	<p>Support Departmental efforts to implement smoking cessation in substance abuse and mental health treatment facilities</p>	<p>Collaborate with other departmental contacts to form a work group to synthesize research, and draft a work plan.</p> <p>Conduct workshops for all RPC's on the SPF process. Focus of the workshop will be how to overcome real life challenges that occur as communities implement the SPF.</p>	<p>Formation of mental health substance abuse treatment smoking cessation workgroup</p> <p>Drafting of workgroup recommendations for addressing tobacco addiction among those with mental health and substance abuse problems.</p> <p>Number of RPC Staff and coalition members trained on the SPF.</p> <p>Number of RPC Staff who report they are comfortable using the SPF process. Number of counties that RPC staff report are using the SPF process effectively as compared to a 2012 baseline survey</p>	<p>RPC Directors and Staff</p>	
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Strengthen state prevention infrastructure	Increase capacity of RPC staff to train communities on the Strategic Prevention Framework	<ol style="list-style-type: none"> <li>1. Convene a statewide work group of RPC representatives focused on Prevention Data, reviewing modules or themes of information collected in the Prevention Data System, making recommendations for improvements (Nov 2012 to Dec 2013)</li> <li>2. Address the number of elements used for capturing data into the prevention data system, ensuring a connection between elements and reporting purposes (Jan to Apr 2013)</li> <li>3. Review data (modules of services/activities,</li> </ol>	<ol style="list-style-type: none"> <li>1. Data elements include ways to gather effective or short-term outcomes</li> <li>2. Process outcomes are more reliable and verifiable</li> <li>3. Data Manual is updated to reflect improvements</li> <li>4. RPC staff self-report improved</li> <li>5. Data review of modules or themes indicate improved use of the Prevention Data System by RPC staff through connecting data</li> </ol>		
Data Reporting	Improve quality of data reported into the Prevention Data System by RPC staff	<p>programs, participants) for clear understanding of barriers to reliable data, providing information and training sessions for branch staff and RPC staff (Nov 2012 to Dec 2013)</p> <p>Develop a series of reports that are performance and process oriented for</p>	<p>pieces, which indicate improved reliability of data</p> <p>Reports produced provide performance measures to RPC staff.</p>		

	across the state	RPC staff to use in their strategic planning and work (July to December 2013)			
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**Data sources:**

- The (KIP) Kentucky Incentives for Prevention Survey (modeled after the Monitoring the Future Survey and conducted in grades 6,8,10,12). KIP is implemented every two years on even numbered years. Approximately 150 out of 170 school districts across the state participate in the KIP survey;
- Behavioral Risk Factor Surveillance System (BRFSS);
- CDC Wide-ranging Online Data for Epidemiologic Research;
- National Survey on Drugs and Health (NSDUH) is an annual survey that collects comprehensive information on substance abuse and mental health. Two-year prevalence rates from the NSDUH are used based on small area estimation procedures that combine state-level data with a national model. Like the KIP and MTF, the NSDUH asks respondents about past-month alcohol and tobacco use. For nonmedical use of pain relievers, illicit drug abuse/dependence, and alcohol abuse/dependence, prevalence rates are based on the past year;
- Kentucky All Scheduled Prescription Electronic Reporting System (KASPER) tracks controlled substances dispensed in Kentucky. Data are primarily intended for physicians, pharmacists and law enforcement officials;
- Kentucky Cancer Registry (KCR) is the centralized population-based cancer registry for the Commonwealth of Kentucky. Mandatory reporting to KCR began in 1991;
- Dartmouth Atlas of Healthcare (DAHC) documents variations in how medical resources are distributed and utilized;
- The Gallup-Healthways Well-Being Index Survey (WBI) surveys roughly 1,000 Americans a day, 350 days a year about health and well-being. Based on their responses individuals and communities receive an overall well-being composite score and a score for each of six sub-indices including life evaluation, emotional health, physical health, healthy behavior, work environment, and basic access; and
- The United States Census Bureau.

1. How did the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?

Response: This process was launched at the state level through the work of the SEOW and was then enhanced by local data collection efforts (community norms surveys, focus groups, key leader interviews.) The SEOW conducted a statewide needs assessment as part of the PFS II application in 2012. Once alcohol and prescription drugs were identified as statewide priorities along with the regions of greatest need, the Prevention Branch manager requested more detailed regional reports on consumption patterns and risk and protective factors in each county of those target regions. Using KIP data, the counties were given rankings which identified "hotspots" within each of the regions. These regional reports were followed by a state report on Prescription Drug Abuse and Alcohol Abuse. The SEOW then drafted a dissemination plan outlining the types of strategies that could be useful in targeting prescription drugs. (based on evaluation data obtained from other states) Actual strategy selection was based upon local data collection efforts as integrated into each region's logic model contained within their strategic plan. The prevention specialists' knowledge of evidence based strategies and programs and how they matched up with the identified intervening variables contained within those logic models helped guide that process.

2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?

Response: The state does not fund prevention programs practices and strategies with its SABG set aside dollars. SABG Set aside is used to pay the salaries and overhead of the Regional Prevention Centers who train communities on best practices and appropriate evidence-based program selection criteria. In the past, the State has funded some prevention programs and strategies with carry over funds - (Reward and Remind and Changing Social Norms and Policy).

3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?

Response: With continued budget cuts, building capacity of the prevention system and its workforce has become increasingly difficult. However the three main components of the Kentucky prevention workforce remain solid. These are:

1. Prevention Academy
2. Kentucky Prevention Network
3. Kentucky School of Alcohol and Other Drug Studies
4. The annual RPC Directors' Summit

Since DBH took over the organization and coordination of Kentucky school the Prevention Branch has had more influence in selecting effective prevention tracks and creating venues for shared learning among prevention coalitions throughout the state. These components will ensure that those new to the prevention workforce will receive a through grounding in effective prevention practices and the Strategic Prevention Framework and that Certified Prevention Professionals will remain abreast of new developments in the prevention field and earn enough credit hours to meet their recertification needs.

4. What outcome data does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?

Response: The primary source of youth data is the KIP survey which is administered every 2 years in even numbered years. KIP 2012 will serve as our baseline. We will

measure this against the 2014 results. For adult data we will use BRFSS.

5. How is the state's budget supportive of implementing the Strategic Prevention Framework?

Response: The Kentucky Prevention Branch has expended considerable resources to integrate the SPF into our state prevention system. Here are some ways in which that process has been carried out:

- Prevention Academy our two week prevention training for new RPC staff and interested coalition members was completely restructured around the 5 steps of the SPF. In essence it is a SPF 101.
- The Regional Prevention Center work plans have been redesigned to fit the five steps of the SPF.
- The Prevention Data Set which captures RPC activities and outcomes has been redesigned with SPF codes to track the work completed under each of the five steps. These reports can then be compared to the work plans to compare percentage of planned activities that were actually completed.
- In 2012 the Prevention Branch revised the regulatory statutes governing the Regional Prevention Centers KRS 222.211, 222.231 to include the following language:  
Section 6. Department Responsibilities. The department shall:
  - (1) Conduct on-site visits to:
    - (a) Review program progress and compliance; and
    - (b) Conduct random record checks for accuracy and validity.
  - (2) Review and approve budgets and quarterly reports to ensure accuracy and efficiency in spending;
  - (3) Review training plans for RPC staff; and
  - (4) Ensure adherence to the Strategic Prevention Framework to include:
    - (a) Assessment;
    - (b) Building capacity;
    - (c) Planning;
    - (d) Implementation;
    - (e) Evaluation;
    - (f) Sustainability; and
    - (g) Cultural competence.
- Early on during the SPF Grant Kentucky developed a Cadre of SPF Master Trainers to assist communities to develop local plans that were consistent with the SPF. These trainers are still active within our system and include some prevention coalition members as well as RPC Staff. During the summer of 2012 the Prevention Branch contracted with JBS to provide two two-day trainings on the SPF Process. Approximately 70 people attended both trainings. The training received very positive reviews. The same trainers will provide SPF training at our 2014 Kentucky School Conference.

6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)

Response: We do not direct fund coalitions with Block Grant dollars. We fund the RPCs to build local capacity to implement the SPF. RPCs may choose to pass some of this funding on to communities, but as stated above in question 2, the bulk of Block Grant dollars pays RPC salaries and overhead. In 2013 \$3,143,492 or 75% of the prevention set side was allocated to our 14 RPCs. The remaining 25% (\$1,017,717) goes to contracts, travel expenses supplies and salaries for state staff.

7. How much of the prevention set-aside goes to evidence-based practices and

environmental strategies? List each program.

Response: As stated earlier Kentucky does not use its Block Grant dollars to fund strategies. The direct funding of evidence-based practices and environmental strategies only occurs when the Prevention Branch receives Block Grant carry over funding. Block Grant carry over dollars were used to fund the Changing Social Norms and Policy Campaign in 2011 and 2012 and Reward and Remind in 2011 & 2013. Since this is not a stable funding source it is not possible to establish a fixed amount.



1. How did the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?

Response:

This process was launched at the state level through the work of the SEOW and was then enhanced by local data collection efforts (community norms surveys, focus groups, key leader interviews.) The SEOW conducted a statewide needs assessment as part of the PFS II application in 2012. Once alcohol and prescription drugs were identified as statewide priorities along with the regions of greatest need, the Prevention Branch manager requested more detailed regional reports on consumption patterns and risk and protective factors in each county of those target regions. Using KIP data, the counties were given rankings which identified "hotspots" within each of the regions. These regional reports were followed by a state report on Prescription Drug Abuse and Alcohol Abuse. The SEOW then drafted a dissemination plan outlining the types of strategies that could be useful in targeting prescription drugs. (based on evaluation data obtained from other states) Actual strategy selection was based upon local data collection efforts as integrated into each region's logic model contained within their strategic plan. The prevention specialists' knowledge of evidence based strategies and programs and how they matched up with the identified intervening variables contained within those logic models helped guide that process.

2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?

Response:

The state does not fund prevention programs practices and strategies with its SABG set aside dollars. SABG Set aside is used to pay the salaries and overhead of the Regional Prevention Centers who train communities on best practices and appropriate evidence-based program selection criteria.

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Response:

With continued budget cuts, building capacity of the prevention system and its workforce has become increasingly difficult. However the three main components of the Kentucky prevention workforce remain solid. These are:

1. Prevention Academy
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4. What outcome data does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?

Response:

The primary source of youth data is the KIP survey which is administered every 2

years in even numbered years. KIP 2012 will serve as our baseline. We will measure this against the 2014 results. For adult data we will use NSDUH. The SEOW will review these data and compare them to: 1) trend data going back to 2004 and 2) the 2012 KIP data which is the baseline for our PFS efforts. We will also compare the actual results to the projections that SEOW has made, using linear regression, based on annual decreases since 2004. The SEOW will compare these expected values with the observed values obtained in 2014 and 2016, to determine if our prevention strategies have been successful. If the projected decreases are realized we will continue implementation of our current strategies. If the survey results fall short of the projected outcomes we will have to look at what strategies need to be modified or replaced. This process will be guided by SEOW findings and then shared with the Regional Prevention center Directors who guide planning efforts on the local level.

5. How is the state's budget supportive of implementing the Strategic Prevention Framework?

Response:

The Kentucky Prevention Branch has expended considerable resources to integrate the SPF into our state prevention system. Here are some ways in which that process has been carried out:

- Prevention Academy our two week prevention training for new RPC staff and interested coalition members was completely restructured around the 5 steps of the SPF. In essence it is a SPF 101.
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- Early on during the SPF Grant Kentucky developed a Cadre of SPF Master Trainers to assist communities to develop local plans that were consistent with the SPF. These trainers are still active within our system and include some prevention coalition members as well as RPC Staff. During the summer of 2012 the Prevention Branch contracted with JBS to provide two two-day trainings on the SPF Process. Approximately 70 people attended both trainings. The training received very positive reviews. The same trainers will provide SPF training at our 2014 Kentucky School Conference.

6. How much of the SABG prevention set-aside goes to the state, versus community

organizations? (A community is a group of individuals who share common characteristics and/or interests.)

Response:

We do not direct fund coalitions with Block Grant dollars. We fund the RPCs to build local capacity to implement the SPF. RPCs may choose to pass some of this funding on to communities, but as stated above in question 2, the bulk of Block Grant dollars pays RPC salaries and overhead. In 2013 \$3,143,492 or 75% of the prevention set aside was allocated to our 14 RPCs. The remaining 25% (\$1,017,717) goes to contracts, travel expenses supplies and salaries for state staff.

7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program.

Response:

As stated earlier, Kentucky funds the Regional Prevention centers to guide the implementation of evidence-based practices and environmental strategies on the local level. The state does not normally direct fund evidence-based programs, though this has happened on two occasions with our statewide Reward and Remind Program.

In 2013 the Regional Prevention Centers allocated roughly 10.5% of their total funding to environmental strategies. This figure is based upon data from our Prevention Data Set. The types of evidence-based practices and environmental strategies include:

- o Reward and Remind
- o Drop boxes for unused prescription medication.
- o Individual lock boxes to store and monitor prescription medication
- o Social Norms Campaigns focusing on alcohol and prescription drugs
- o Media efforts directed at increasing the perception of risk around prescription medication
- o Media efforts directed at increasing the perception of risk around underage alcohol use
- o Alcohol vendor education
- o Sobriety checkpoints
- o WISE program
- o Lifeskills,
- o Smartmouth ( a curriculum that addresses smokeless tobacco)
- o MEDS (Monitor Educate Dispose Secure: an information dissemination/education campaign that teaches individuals how to properly store, monitor and dispose of unused prescription medication
  
- o Social Host Ordinances
- o Unruly gathering ordinances
- o Party Patrols
- o Keg Registration
- o Responsible Beverage Server training
- o Smoke free indoor air ordinances

## IV: Narrative Plan

### N.2. Evidence Based Prevention and Treatment Approaches for the MHBG (5 percent)

Narrative Question:

States are required to use their 5 percent set-aside of their Mental Health Block Grant (MHBG) allocation to support "evidenced-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders."

Please note that this set aside funding is dedicated to provide supports and services for those "with early serious mental illness" and not for primary prevention or preventive intervention for those at risk of serious mental illness. States are encouraged to fund programs to meet the needs of persons with early psychotic disorders, specifically first episode psychosis. States may address these needs either through enhancing existing program activities or development of new activities.

Describe the states assessed need for the target population and proposed evidence-based programs, an explanation for why this population was chosen, a description of planned activities and a budget showing how the 5% will be spent.

Footnotes:

KY is not a state that receives 2% of the total FFY 2014 allotment

## **Request for Revision of the 2014-15 MHBG Plan 5% Set-Aside**

*States will be required to revise their two-year plan to propose what early serious mental illness(es) they propose to address and how they will utilize the 5 percent set-aside funding to support appropriate evidence-based programs.*

Kentucky proposes to utilize the five percent (5%) MHBG set-aside funds to address the needs of youth and young adults between 15-30 years old with early serious mental illness (SMI) including schizophrenia, schizoaffective disorder, schizophreniform disorder, brief psychotic disorder, or psychotic disorder NOS. The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (KDBHDID) will focus on developing the capacity to implement and sustain *Coordinated Specialty Care (CSC)* for this population. The OnTrackNY model, with some modifications to include Oregon's Early Assessment and Support Alliance (EASA) model will be utilized in Kentucky. This will allow for the flexibility needed to implement the program in both urban and rural pilot sites by the end of FFY 2015, with the goal of statewide implementation within six years.

### **Infrastructure to support sustainability:**

Kentucky has infrastructure in place to support the implementation and sustainability of CSC for the targeted population. There are a variety of services and supports already in place that are focused on transition age youth. There is a strong collaborative focus to connect the child and adult services arenas and provide cross training to service providers. There is heightened interest in the age group and in prevention at all levels. Within the Department, there is a strong body of knowledge about implementing and evaluating new programs, about fidelity monitoring, addressing the needs of the transition age youth population, and about Prevention strategies. KDBHDID continues to invest resources into creating and maintaining a recovery-oriented system of care for adults with SMI that includes person centered planning, use of evidence based practices with fidelity, and various "Continuity of Care" processes.

There is also a rich history of children's behavioral health services and supports that utilize System of Care principles. Wraparound has been utilized in evolving formats over the last 25 years within the children's targeted case management program, KY IMPACT, for youth up to 21 years old. This program is operated through the community mental health centers across the state. The KDBHDID requires the use of one of the wraparound fidelity tools by all eighteen (18) KY IMPACT Programs statewide. Kentucky's Medicaid State Plan has recently been amended to include coverage for an expanded population and to cover or expand many services not previously offered. Peer Support, Assertive Community Treatment, Comprehensive Community Support and services for individuals with substance use disorders are among those services that are now available and Medicaid reimbursable.

Even before Medicaid reimbursement was available, KDBHDID paved the way for peer support services among adult and child populations by supporting legislation to provide for Adult, Youth and Family Peer Support services. Over the past several years, the

KDBHDID has advocated strongly for these services to be Medicaid billable and in so doing has educated providers, consumers and payers about the value of these services across the service delivery system.

KDBHDID and the Kentucky Partnership for Families and Children (KPFC), Kentucky's statewide family organization, collaborate very closely on many initiatives. KPFC provides strong support to youth and young adult leaders and empowers them to be respected leaders in their community. Their statewide youth council, which has been in operation for over 10 years and has up to eighteen members, became an official Youth M.O.V.E. affiliate in 2012. KPFC has also been instrumental in providing support and leadership in the development of Regional Youth Councils across the state for youth with behavioral health issues who are between 14 – 25 years old. There are currently fourteen (14) active Regional Youth Councils. These Councils are supported by the local KY IMPACT Program and provide youth and young adults who have behavioral health issues with hands-on supports related to education, employment, and other transition needs. Several of these youth have become statewide youth leaders and several have received national recognition for their advocacy efforts. The Councils will serve as a very beneficial community connection as KDBHDID moves to increase access to specialty care for youth and young adults with intensive treatment needs.

Kentucky has a long history of providing Supported Employment (SE) services. Kentucky developed supported employment in 1985 through a Title III Systems Change grant. The Office of Vocational Rehabilitation (OVR) established a Supported Employment Branch in 1990 and continues to be committed to the development of Supported Employment. Kentucky has a network of more than 75 supported employment providers. The KY Behavioral Health Planning and Advisory Council has identified transition age youth as a priority population and also are very strong advocates of Supported Employment and Supportive Housing. These two services are not Medicaid reimbursable in KY and thus a priority for mental health block grant funds. The Council recently formed a new ad-hoc committee on Advocacy and Public Policy. One of the priorities of the committee members is to specifically address housing and employment issues for individuals with serious mental illness, particularly as it relates to transition age youth.

KDBHDID became a recipient of a \$280,000, four year grant from the Johnson & Johnson - Dartmouth Community Mental Health Program (Dartmouth Grant) in 2009. The purpose of this grant was to implement evidence-based Supported Employment services for adults ages 18 and older who also have serious behavioral health issues using the Individual Placement and Support (IPS) model of Supported Employment. As of SFY 2013, seven (7) of fourteen (14) Community Mental Health Centers were offering Supported Employment with "good fidelity" to the Dartmouth model. Because Supported Employment is not reimbursed by KY Medicaid, there is limited funding for the long term employment supports needed by adults with SMI. All fourteen (14) Community Mental Health Centers are now required to provide the IPS Model to individuals within their communities with at least two full-time employment specialists operating in each region by June 30, 2014. As part of the Dartmouth initiative, NAMI

Kentucky has also been a strong partner in ensuring that NAMI Family Advocates are part of the local supported employment team.

Cross-agency collaboration is integral if youth and young adults with early serious mental health issues are going to gain access to a seamless array of supportive services. The Kentucky Partners for Youth Transition, an interagency group focusing on youth and young adults between 14-25 years old who have behavioral health issues, began meeting in 2008 out of a need to address the gaps in services for these individuals. Over fifteen (15) different child and adult serving agencies as well as a youth and family member continue to meet regularly. In 2009, this committee was formally recognized by the State Interagency Council for Services to Children with an Emotional Disability (SIAC) as a standing committee and advisory group to SIAC. SIAC is a legislated committee with required members who are state leaders in child serving agencies as well as a youth and family member. Their purpose is to reduce the gaps to services for children and youth with behavioral health issues and their families. The KY Partners for Youth Transition's focus areas include employment and career, education, living situation and skills management. The goal is that youth and young adults with serious behavioral health issues will have earlier, faster and easier access to the developmentally appropriate care that they need. The KY Partners for Youth Transition will be a strong resource to provide ongoing support and accountability as Kentucky moves to implement CSC across the state.

Kentucky recently became a recipient of a BRSS TACS Policy Academy process focusing on Employment Supports for Young Adults. Through this Policy Academy, the aim is to increase access to the Individual Placement and Support model of Supported Employment for young adults between 18 – 25 years old. Coordination with this committee will be necessary to implement supports for youth with serious mental illness.

*The revision must include information on assessed need for such services within the proposed target population and provide an explanation for why this population was chosen, planned activities, and budget. In states without CSC programs, FY 2014 set-aside funds should be used to develop initial capacity for FEP specialty care. Any state implementing a CSC program for the first time is encouraged to focus on starting a single program that adheres closely to the CSC principles.*

**Assessed need for services and why population was chosen:**

Although the strengths in Kentucky are great, it is very evident that there are significant gaps in services and supports for youth and young adults who have early serious mental illness. The chasm between the inpatient services that youth and young adults receive and the community-based support services that need to be provided to these individuals before or after an inpatient stay is unmistakable in the data collected below regarding young adults between the ages of 18 – 24 years old.

KDBHDID operates four state psychiatric hospitals for adults 18 years of age and older. An October 2013 data report indicated that there has been a steadily increase in the

number of young adults (18 – 24 years old) admitted to one of the four hospitals with schizophrenia or a related disorder. In 2009, there were 516 and in 2013, 770 young adults were admitted with schizophrenia or a related disorder.

The data regarding continuity of care for young adults who enter Kentucky's state hospitals also shows a huge gap in services. Only half of all of the young adults (18 – 24 years old) who were admitted to one of Kentucky's state hospitals and whose discharge living arrangement was "home" received at least one service at the community mental health center within one year after their hospital stay. One third of these young adults had received a service at the community mental health center within one year prior to their hospital stay. It is very clear that a more coordinated approach to care is desperately needed in Kentucky.

Utilizing coordinated specialty care, and particularly, the OnTrack NY and EASA models, will provide the needed coordination of services and supports to fill the gap for these youth and young adults who are in urgent need of intensive community-based treatment.

### **Planned activities**

Kentucky plans to utilize the funds to develop an initial capacity to provide targeted CSC to youth and young adults between 15 – 30 years old with early serious mental illness. Kentucky will focus primarily on data collection and planning during the first year and will create a detailed implementation plan using Fixsen's model of Implementation Science. This thoughtful process will provide support to sustainability of the OnTrackNY and EASA models in Kentucky. It is expected that a coordinated training and coaching model will be developed to support new and existing staff who will utilize the OnTrackNY and EASA models of care. This may include face to face and online modules and will include state level staff dedicated to the sustainability of this program. Funds will also be used to provide awareness training to families and community providers in order to increase understanding of mental illness and decrease stigma.

As training and coaching are developed, a pilot CSC – "OnTrack Kentucky" program will be chosen by the end of the first year. It will be expected that this program will have experience offering team-based treatment, will be youth oriented and understand the unique needs of youth and young adults, and the program will have the ability to provide case management, individual or group therapy, supported employment and education, pharmacotherapy and primary care coordination. Key roles/services in this program will be team leadership, case management, supported employment/education, group and individual therapy (mental health and substance abuse if needed), family education and support, pharmacotherapy, primary care coordination and peer support services. Set-aside funds will be utilized to support a Team Leader as well as a Supported Employment/Education Specialist as the other positions will be potentially offset by Medicaid reimbursement. Information about this program development area has been shared with several community mental health centers and at least two have voiced interest in becoming pilot sites in the first phase of implementation. Providers will also participate fully in planning activities.



**Budget**

Kentucky’s estimated 5% Set Aside for to support evidence based programs that address the needs of individuals with early serious mental illness is \$323,455 for FFY 2014. It is anticipated that the majority of funds will be utilized for service delivery and the remainder will be utilized to support planning activities in the first year and training/technical assistance for providers and project data collection/evaluation in both years.

5% Set Aside Budget

FFY 2014	\$323,455	<p>\$150,000. contracted to providers to develop services  <i>Plan to request proposals from each of the 14 CMHCs and fund up to three at \$50,000 each.</i>            \$100,000.contracted to develop training modules and provide training and technical assistance to providers            \$35,000. Creation of data collection and evaluation system for the project (likely to be an add on to an existing system).</p> <p>\$36,455. Will be used to support planning group time and travel            \$ 2,000. Purchase of program related materials and supplies</p>
FFY 2015	\$323,455 (estimated)	<p>\$200,000 + \$90,000 contracted to providers to develop services  <i>Plan to request proposals from each of the remaining CMHCs and fund up to 4 new ones while continuing to fund the three established ones at \$30,000 for one additional year.</i>            \$20,000. Maintain data collection and evaluation system            \$11,455. Training and Technical Assistance supports            \$ 2,000. Purchase of program related materials and supplies</p>

## IV: Narrative Plan

### O. Children and Adolescents Behavioral Health Services

#### Narrative Question:

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Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with over 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

SAMHSA expects that states will build on this well-documented, effective system of care approach to serving children and youth with behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please answer the following questions:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?
3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

#### Footnotes:

This section was left blank intentionally.

## IV: Narrative Plan

### P. Consultation with Tribes

Narrative Question:

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SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinions between parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues.

For the context of the Block Grants awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees. SAMHSA is requesting that states provide a description of how they consulted with tribes in their state, which should indicate how concerns of the tribes were addressed in the State Block Grant plan(s). States shall not require any tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for tribal members on tribal lands. If a state does not have any federally-recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect. For states that are currently working with tribes, a description of these activities must be provided in the area below. States seeking technical assistance for conducting tribal consultation may contact the SAMHSA project officer prior to or during the Block Grant planning cycle.

Footnotes:

P. Consultation with Tribes

No federally-recognized Tribes or Tribal Lands exist within the Commonwealth of Kentucky. However, the Division of Behavioral Health continues its dialog with the Kentucky Council on Native American Heritage. Staff within the division continues to work with the Kentucky Incentives for Prevention Survey Statistician to obtain cross tabulation on Native American's past 30 days' consumption of all substances included on the survey.

## IV: Narrative Plan

### Q. Data and Information Technology

Narrative Question:

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In the FY 2012/2013 Block Grant application, SAMHSA asked each state to:

- Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data;
- List and briefly describe all unique information technology systems maintained and/or utilized by the state agency;
- Provide information regarding its current efforts to assist providers with developing and using EHRs;
- Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and
- Identify the specific technical assistance needs the state may have regarding data and information technology.

Please provide an update of your progress since that time.

**Footnotes:**

This section was left blank intentionally.

## IV: Narrative Plan

### R. Quality Improvement Plan

#### Narrative Question:

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In the FY 2012/2013 Block Grant application, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, that will describe the health of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, continue reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints and grievances. In an attachment, states must submit a CQI plan for FY 2014/2015.

#### Footnotes:

This section was left blank intentionally.

## IV: Narrative Plan

### S. Suicide Prevention

Narrative Question:

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In the FY 2012/2013 Block Grant application, SAMHSA asked states to:

- Provide the most recent copy of your state's suicide prevention plan; or
- Describe when your state will create or update your plan.

States shall include a new plan as an attachment to the Block Grant Application(s) to provide a progress update since that time. Please follow the format outlined in the new SAMHSA document [Guidance for State Suicide Prevention Leadership and Plans](#) available on the SAMHSA website at [here](#).

**Footnotes:**

This section was left blank intentionally.

## IV: Narrative Plan

### T. Use of Technology

Narrative Question:

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In the FY 2012/2013 Block Grant application, SAMHSA asked states to describe:

- What strategies the state has deployed to support recovery in ways that leverage ICT;
- What specific application of ICTs the State BG Plans to promote over the next two years;
- What incentives the state is planning to put in place to encourage their use;
- What support system the State BG Plans to provide to encourage their use;
- Whether there are barriers to implementing these strategies and how the State BG Plans to address them;
- How the State BG Plans to work with organizations such as FQHCs, hospitals, community-based organizations, and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine;
- How the state will use ICTs for collecting data for program evaluation at both the client and provider levels; and
- What measures and data collection the state will promote to evaluate use and effectiveness of such ICTs.

States must provide an update of any progress since that time.

**Footnotes:**

This section was left blank intentionally.



## IV: Narrative Plan

### U. Technical Assistance Needs

#### Narrative Question:

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States shall describe the data and technical assistance needs identified during the process of developing this plan that will facilitate the implementation of the proposed plan. The technical assistance needs identified may include the needs of the state, providers, other systems, persons receiving services, persons in recovery, or their families. Technical assistance includes, but is not limited to, assistance with assessing needs; capacity building at the state, community and provider level; planning; implementation of programs, policies, practices, services, and/or activities; evaluation of programs, policies, practices, services, and/or activities; cultural competence and sensitivity including how to consult with tribes; and sustainability, especially in the area of sustaining positive outcomes. The state should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

1. What areas of technical assistance is the state currently receiving?
2. What are the sources of technical assistance?
3. What technical assistance is most needed by state staff?
4. What technical assistance is most needed by behavioral health providers?

#### Footnotes:

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## IV: Narrative Plan

### V. Support of State Partners

#### Narrative Question:

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The success of a state's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. States should identify these partners in the space below and describe how the partners will support them in implementing the priorities identified in the planning process. In addition, the state should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the state education authority(ies), the State Medicaid Agency, entity(ies) responsible for health insurance and health information marketplaces (if applicable), adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan.<sup>45</sup> This could include, but is not limited to:

- The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
- The state justice system authorities that will work with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system. Specific service issues, such as the appropriate use of psychotropic medication, can also be addressed for children and youth involved in child welfare.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities.

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<sup>45</sup> SAMHSA will inform the federal agencies that are responsible for other health, social services, and education

#### Footnotes:

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## IV: Narrative Plan

### W. State Behavioral Health Advisory Council

#### Narrative Question:

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Each state is required to establish and maintain a state Behavioral Health Advisory Council (Council) for services for individuals with a mental disorder. While many states have established a similar Council for individuals with a substance use disorders, that is not required. SAMHSA encourages states to expand their required Council's comprehensive approach by designing and use the same Council to review issues and services for persons with, or at risk of, substance abuse and substance use disorders. In addition to the duties specified under the MHBG statute, a primary duty of this newly formed Council will be to advise, consult with, and make recommendations to SMHAs and SSAs regarding their activities. The Council must participate in the development of the MHBG state plan and is encouraged to participate in monitoring, reviewing, and evaluating the adequacy of services for individuals with substance abuse and mental disorders within the state. SAMHSA's expectation is that the State will provide adequate guidance to the Council to perform their review consistent with the expertise of the members on the Council. States are strongly encouraged to include American Indians and/or Alaska Natives in the Council; however, their inclusion does not suffice as tribal consultation. In the space below describe how the state's Council was actively involved in the plan. Provide supporting documentation regarding this involvement (e.g., meeting minutes, letters of support, etc.)

Additionally, please complete the following forms regarding the membership of your state's Council. The first form is a list of the Council members for the state and second form is a description of each member of the Council.

There are strict state Council membership guidelines. States must demonstrate (1) that the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council and (2) that no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services. States must consider the following questions:

- What planning mechanism does the state use to plan and implement substance abuse services?
- How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?
- Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved.
- Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?
- Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
- Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders.

#### Footnotes:

# Kentucky Behavioral Health Planning & Advisory Council

## W. State Behavioral Health Advisory Council

Page 85 of the Application Guidance

*Each state is required to establish and maintain a state Behavioral Health Advisory Council (Council) for services for individuals with a mental disorder. SAMHSA encourages states to expand and use the same Council to review issues and services for persons with, or at risk of, substance abuse and substance use disorders. In addition to the duties specified under the MHBG statute, a primary duty of this newly formed Council will be to advise, consult with, and make recommendations to SMHAs and SSAs regarding their activities. The Council must participate in the development of the MHBG state plan and is encouraged to participate in monitoring, reviewing, and evaluating the adequacy of services for individuals with substance abuse and mental disorders within the state. States are strongly encouraged to include American Indians and/or Alaska Natives in the Council; however, their inclusion does not suffice as tribal consultation. In the space below describe how the state's Council was actively involved in the plan. Provide supporting documentation regarding this involvement (e.g., meeting minutes, letters of support, etc.). Additionally, please complete the following forms regarding the membership of your state's Council. The first form is a list of the Council members for the state and second form is a description of each member of the Council. There are strict state Council membership guidelines. States must demonstrate (1) that the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council and (2) that no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services. States must consider the following questions:*

- What planning mechanism does the state use to plan and implement substance abuse services?*
- How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?*
- Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved.*
- Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?*
- Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?*
- Please describe the duties and responsibilities of the Council.*

### **What planning mechanism does the state use to plan and implement substance abuse services?**

The Department holds annual Public Forums to provide information about the SAPT block grant and to solicit feedback from citizens. Department staff also solicits input from the regional substance abuse treatment directors and regional substance abuse prevention directors at quarterly peer group meetings. In August 2009, the Mental Health Block Grant was included on the agenda of the annual Block Grant Public Forum. The forums have been combined since that time.

### **How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?**

The Division of Mental Health and the Division of Substance Abuse combined in 2005 to become the Division of Mental Health and Substance Abuse. The name of the Division was more recently changed to the Division of Behavioral Health. Efforts remain ongoing to integrate at the local, regional and state level. It is an ongoing process and efforts have incrementally moved toward integration. DBHDID seeks technical assistance and grant opportunities when available.

The Kentucky Mental Health Planning and Advisory Council began actively integrating substance abuse prevention and treatment into its work in January 2011 when SAMHSA released its guidance for the FFY 2012-2013 Unified Block Grant Application to the states. The Kentucky Mental Health Planning and Advisory Council officially became a Behavioral Health Council in November 2012.

In February 2013, Kentucky submitted an application for the State Planning Council Intensive Technical Assistance Grant and was awarded targeted technical assistance to integrate substance abuse prevention and treatment onto the Council. The following were the three technical assistance goals:

1. Create a membership body that is integrated, balanced, meets federal guidelines, and stays within our logistical restrictions.
2. Review committee structure and determine how it can be restructured to support Council duties.
3. Communicate the transition of the mission of the Council and improve outreach to substance abuse prevention and treatment stakeholders.

Fredrick Sandoval was selected as the consultant to Kentucky. Mr. Sandoval spent two and a half days working with the Council and staff in July. As a result of that work, the Council recommended the following two new Committees to support Council duties:

- Policy and Advocacy Committee – Cathy Epperson, Chair
- Services Committee - Sherry Sexton, Chair

The recommendation was reviewed and approved by the full Council at its August 22, 2013 quarterly meeting.

With Mr. Sandoval's assistance, the Council also created the following two lists in July:

- Prospective new members to represent substance abuse prevention and treatment.
- Communication outlets to improve outreach to prevention and treatment stakeholders.

Kentucky's integration efforts are ongoing and will be for a number of years. Department staff and Council members appreciate the opportunity for technical assistance and to be a part of the National Learning Community and hope the opportunity becomes available again.

#### **Describe how the Council was actively involved in developing the State BG Plan.**

The process for developing the Plan and the Implementation Report is the same except that a Public Forum is only held for the Plan. Department staff drafts the State Block Grant Plan and Council members and the public are notified and provided with opportunities to provide written and/or verbal feedback. The draft of the Plan and Implementation Report is placed as a "Hot Topic" on the Department website. The public is invited to provide comments on the draft. For the Plan, a Public Forum is held in Frankfort at the Department for Behavioral Health, Developmental and Intellectual Disorders. Council members are notified of the date of the Public Forum (March 20<sup>th</sup> this year) and invited to attend; however, travel reimbursement and stipends are not offered for the event. Staff provides the same presentation to the Council (March 21<sup>st</sup> this year) as was provided at the Public Forum. To give members time to review the documents, staff provides the Plan and the Implementation Report to the Council at least 10 days prior to the quarterly meeting. Time is given on the agenda for comment on the Plan and Implementation Report. The Council creates a letter confirming their participation and opportunity to review and provide feedback on them. At the Public Forum and Council meeting, staff encourages the public and members to continue to submit feedback and provides information about how to submit comments via mail, fax, email, and telephone. Comments are encouraged up to the submission date. Comments are included in the final document. An [archive](#) of past Block Grant reports is available for members to review at the Planning Council website.

The State Plan and the Public Forum were also advertised by two newspapers this year, one in the eastern half of the state and one in the western half. The newspapers were the following:

- Lexington Herald Leader – paper and online
- Messenger Inquirer (Owensboro) – paper

Per KRS 45.351, the Department provides a draft of the Plan to the Legislative Research Commission (LRC) for their review. The Interim Joint Committee on Health and Welfare of the Kentucky General Assembly holds a public hearing prior to the federal due date. The public is made aware of these hearings by the LRC's [Daily Calendar](#) and email notification by the Department and statewide advocacy organizations. Video streaming of Interim Joint Committee meetings is occasionally available through Kentucky Educational Television ([KET](#)).

**Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?**

The Kentucky Behavioral Health Planning and Advisory Council is actively transitioning toward becoming an integrated council. The following is a timeline of integration initiatives:

- **August 2009** – The Division of Mental Health and Substance Abuse holds a joint Public Forum for public comment on the SAPT and MH block grants.
- **January 2011** – The Membership Committee was provided with an update on changes proposed by SAMHSA and discussed the potential impact on membership and Council proceedings.
- **February 2011** – The Council was provided with an update on changes proposed by SAMHSA to combine the MHBG and SAPT block grants, revise report submission dates, Eight Strategic Initiatives to incorporate into the application, and planning and outreach to additional vulnerable populations.
- **July 2011** – Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities decided to prepare and submit a Unified Block Grant Application on September 1. Staff were educated on new reporting requirements.
- **September 2011** - KDBHDID submitted a Unified Block Grant application for FY 2012.
- **October 2011** – The Council Membership application was revised to parallel membership categories referenced in the FY 2013 Block Grant Application guidance:

Former Membership Category	Current Membership Category
Adult Consumer of Mental Health Services	Individual in Recovery from a Mental Health and/or Substance Use Disorder
Family Member of An Adult with SMI	Family Member of an Individual in Recovery from a Mental Health and/or Substance Use Disorder
Parent of a Child with SED	Parent of a Child with Behavioral Health Challenges
Young Adult Consumer	Young Adult in Recovery from a Mental Health and/or Substance Use Disorder

- **November 2011** – Member categories were revised on selected print and electronic materials, such as name tents, membership roster, and website. Also, the Council asked that the Membership Application be revised to include the following statement: “Recovery is an on-going, non-linear process that may include relapse.”
- **January 2012** – Membership Committee made a recommendation to the Bylaws Committee to add a statewide advocacy organization for individuals in recovery from a substance use disorder to the Council membership.
- **February 2012** – Staff reviewed the Consensus Statement on State MHAs and SSAs. The Council recommended forming an ad hoc committee to plan changes for Council transformation. To date, this committee has not convened due to competing priorities (e.g., implementation of Medicaid managed care on November 1, 2011 and January 1, 2013).

- **May 2012** – The Council received a prevention overview – prevention goals, prevention strategies, and Kentucky data.
- **May 2012** – The Council received a substance abuse treatment overview – services, priority populations, importance of integrated treatment and trauma-informed care, and data.
- **November 2012** – The Council adopted the name Kentucky Behavioral Health Planning and Advisory Council.
- **November 2012** – The Council added a membership seat for a statewide advocacy organization for individuals in recovery from substance use disorders.
- **January 2013** – The Executive Committee discussed the State Planning Council Application for Intensive Technical Assistance opportunity and made a recommendation to prepare and submit an application.
- **February 2013** – The Council submitted a State Planning Council Application for Intensive Technical Assistance to the Advocates for Human Potential, Inc.
- **March 2013** – The Council is awarded targeted technical assistance to integrate substance abuse prevention and treatment onto the Council.
- **July 2013** – The Council holds a special meeting with TA Consultant Fredrick Sandoval. It develops a list of prospective members, communication outlets, and two new committees.

**Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?**

Diversity is important to the Kentucky Behavioral Health Planning and Advisory Council. When choosing new members, the Membership Committee pays particular attention to ways each applicant will increase the diversity of voices and experiences on the Council.

In October 2007, the Membership Committee chose to emphasize the importance of diversity by including a diversity statement on the membership application. The statement reads as follows:

The Kentucky Mental Health Planning and Advisory Council has an ongoing commitment to advancing diversity within its membership. We acknowledge that diversity includes any aspect of an individual that makes him or her unique. Our Council values and actively promotes diverse and inclusive participation by its officers, members, and staff. We recognize that diversity is vital to all elements of our mission.

In July 2008, the Membership Committee decided to include space on the membership application for applicants to include information about how they would contribute to the diversity of the Council. The current membership application includes the above language plus the following additional sentence:

At your option, you may state how you would contribute to the diversity of the Council. Most applicants (86 percent of applicants reviewed in January 2013) choose to answer this question and Committee members find the information valuable as they consider membership. A tool that the Membership Committee uses to ensure geographic diversity is a state map with the residences of current members indicated. The Committee gives greater consideration to applicants who would represent an area of the state that is not currently represented.

The Council also values the voices and experiences of transition-age youth and young adults. In 2001 a transition-age youth was added as a voting member of the Council. Today the name of this

membership seat is Young Adult in Recovery and applicants must be 18-25 years of age to be considered.

**Please describe the duties and responsibilities of the Council.**

The following is an excerpt from the Bylaws of the Council duties:

**Duties:** The Council shall do all of the following:

- Report directly to the Commissioner of the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (BHDID).
- Assist BHDID in designing a comprehensive, recovery-oriented system of care.
- Advise BHDID on the use of Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funds and Mental Health Block Grant (MHBG) funds and on the quality of statewide, recovery-oriented behavioral health services.
- Review the biennial combined SAPTBG and MHBG Application and annual Implementation Report pursuant to Public Law 102-321, Section 1915 (a) and to submit recommendations to BHDID, prior to the April 1 and December 1 due dates, respectively.
- Advocate for individuals in recovery, children and youth with behavioral health challenges, and family members.
- Monitor, review, and evaluate, not less than once a year, the allocation and quality of statewide, recovery-oriented behavioral health services.

Historically in Kentucky, approximately 75-80 percent of MHBG funds and 77 percent of SAPT funds are allocated to the Regional Boards. Each April, the Finance Committee reviews the following applications for funding for each Regional Board:

- Form 115, Adult System of Care Application;
- Form 117, CMHC Spending Plan; and
- Form 118, Children’s System of Care Application.

In November, the Council officially became the planning and advisory body for the substance abuse prevention and treatment system of care as well so the Finance Committee will review the following two additional applications for funding:

- Form 167, Substance Abuse and Co-Occurring Disorder System of Care Application; and
- Form 169, Substance Abuse Treatment Spending Plan.

Members review the applications and note strengths and gaps in the service system. After the review, members discuss their impressions and decide what, if any, recommendations they would like to make to the Commissioner of the Department. Members’ comments on strengths and gaps are provided to department program staff.

The Executive Committee schedules presentations with representatives of block grant funded entities for the Finance Committee and Council meetings. Funded entities report on the goals and deliverables for the funds. In fiscal years 2012 and 2013, the Council heard from the following three entities:

- Office of Vocational Rehabilitation;
- NAMI Kentucky; and
- Kentucky System Transformation – Advocating Recovery Supports (KY STARS).

Traditionally, the Council would have heard from more funded entities than three in two years; however, discussing and making decisions regarding new reporting requirements, new Council requirements, and health reform at the national and state (Medicaid managed care) levels have kept the Council quite busy.



## **Overview of the Kentucky Behavioral Health Planning and Advisory Council**

### **Vision**

The Council is the active voice promoting awareness of and access to effective, affordable, recovery-oriented and resiliency-based services in all communities.

### **Mission**

We believe that all children, adolescents, and adults in the Commonwealth have the right to excellent, recovery-oriented behavioral health services that are affordable, consumer driven, value their individuality, assists them to achieve their fullest potential, and enables them to live and thrive in their community.

### **Meetings**

The Kentucky Behavioral Health Planning & Advisory Council meets at least four times per year. The Council uses one quarterly meeting to review and comment on the state's Plan and another to review and comment on the state's Implementation Report, including the URS tables.

### **Members**

The Council currently has 35 members. Nineteen of those members are parents, consumers, and family members. Four are representatives of statewide advocacy organizations. One is a provider representative, and 11 members represent state agencies. The Council is fortunate to have broad representation and involvement from other state agencies beyond those members mandated by federal law (e.g., Department for Aging and Independent Living, Protection and Advocacy, Department of Juvenile Justice and Department for Public Health).

### **Officers**

The Council has the following offices:

- Chair - Mary Singleton
- Vice Chair - Rebecca Garrett
- Secretary - Gayla Hayes

Per Kentucky's Council Bylaws, officers of the Planning Council must be consumers and family members. They serve two-year terms, with a limit of two consecutive terms.

### **Committees**

The Council currently has an active Executive Committee, Membership Committee, Bylaws Committee and Finance Committee.

The committees are led by the following officers:

- Bylaws Committee – Steve Shannon, Chair
- Executive Committee – Mary Singleton, Chair
- Finance Committee – Betty Jo Moss, Chair
- Membership Committee – Mary Singleton, Chair

### **Website**

Department staff are committed to maintaining a useful, current Council website that serves to share information with members, potential applicants and the public. The website contains a membership list, membership application, Council and committee meeting summaries, Council brochure, an archive of Block Grant Applications and Implementation Reports, Council Bylaws and a calendar of events. You may access the site at the following address: <http://dbhdid.ky.gov/dbh/kmhpac.asp>.

## IV: Narrative Plan

### Behavioral Health Advisory Council Members

Start Year:   
 End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Joy Varney	Others (Not State employees or providers)		Kentucky Partnership for Families and Children, 207 Holmes Street Frankfort, KY 40601 PH: 502-875-1320	joy@kypartnership.org
Cathy Epperson	Others (Not State employees or providers)		NAMI Kentucky, 808 Monticello Street Somerset, KY 42501 PH: 606-451-6935	kepperson0009@kctcs.edu
Kelly Gunning	Others (Not State employees or providers)		Participation Station, 869 Sparta Court Lexington, KY 40504 PH: 859-309-2856	kelly@namilex.org
Michael Barry	Others (Not State employees or providers)		1425 Story Avenue Louisville, KY 40206 PH: 502-552-8573	mike@peopleadvocatingrecovery.org
Carla Crane	State Employees		Department for Aging and Independent Living, 275 E. Main Street, 3E-E Frankfort, KY 40621 PH: 502-564-6930	Carla.Crane@ky.gov
Artye Dulaney	State Employees		Department of Education, 500 Mero Street, 8th Floor Frankfort, KY 40601 PH: 502-564-4970	Artye.Dulaney@education.ky.gov
Deborah Coleman	State Employees		Department of Corrections, 3001 W. Hwy 146 LaGrange, KY 40032 PH: 502-222-9441	Deborah.Coleman@ky.gov
Bill Heffron	State Employees		Department for Juvenile Justice, 1025 Capital Center Drive, Bldg 3 Third Floor Frankfort, KY 40601 PH: 502-573-2738	BillM.Heffron@ky.gov
Helen Vogelsberg	State Employees		Department for Medicaid Services, 275 E Main Street Frankfort, KY 40621 PH: 502-564-7540	Helen.Vogelsberg@ky.gov
Lou Kurtz	State Employees		Department for Behavioral Health, Developmental and Intellectual Disabilities, 100 Fair Oaks Lane, 4E-D Frankfort, KY 40621 PH: 502-564-4456	Louis.Kurtz@ky.gov
Shelley Adams	State Employees		Department for Public Health, 275 E Main Street, HS2WA Frankfort, KY 40621 PH: 502-564-2154	Shelley.Adams@ky.gov
Jim Sparks	State Employees		Kentucky Housing Corporation, 1231 Louisville Road Frankfort, KY 40601 PH: 502-564-7630	Jsparks@kyhousing.org

Jan Powe	State Employees	Kentucky Protection and Advocacy, 100 Fair Oaks Lane, 3rd Floor Frankfort, KY 40601 PH: 502-564-2967	Jan.Powe@ky.gov
Julie Wade	State Employees	Office of Vocational Rehabilitation, 650 N. Main Street, Suite 230 Somerset , KY 42501 PH: 606-677-4116	Julied.Wade@ky.gov
Kalon Bagby	State Employees	275 E. Main Street, 3E-B Frankfort, KY 40601 PH: 502-564-2136	Kalon.Bagby@ky.gov
Steve Shannon	Providers	Kentucky Association of Regional MHMR Boards, 152 W. Zandale Drive, Suite 201 Lexington , KY 40503 PH: 859-272-6700	SShannon.KARP@iglou.com
Steven Lyons	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	96-9th Street Shelbyville, KY 40065 PH: 502-633-4178	Lyonssadsack@aol.com
Carmilla Ratliff	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	107 Northwood Road, Apt. 2 Frankfort, KY 40601 PH: 606-369-6896	Carmilla@kypartnership.org
Mary Singleton	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	3565 W. Hwy 221 Bledsoe, KY 40810 PH: 606-273-7397	Angels2830@gmail.com
Gayla Hayes	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	401 Pebblen Avenue Franklin , KY 42134 PH: 270-586-3367	
Betty Jo Moss	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	4029 Briar Creek Drive Lawrenceburg, KY 40342 PH: 502-839-6413	mss_bttyi@yahoo.com
Sherry Sexton	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	222 Forge Hill Road Owingsville , KY 40360 PH: 606-336-4106	
Brandon Kelley	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	5704 Hicks Road Ashland , KY 41102 PH: 606-928-6238	
Lynn Haney	Family Members of Individuals in Recovery (to include family members of adults with SMI)	9773 Windsor Way Florence , KY 41042 PH: 859-282-9166	HaneyL@fuse.net
Matthew Smith	Family Members of Individuals in Recovery (to include family members of adults with SMI)	2980 Trailside Drive Louisville , KY 40511 PH: 859-233-1243	smithski126@aol.com
Becky Clark	Family Members of Individuals in Recovery (to include family members of adults with SMI)	32 E. Willowdell Drive Ewing , KY 41039 PH: 606-267-4101	
Rebecca Garrett	Family Members of Individuals in Recovery (to include family members of adults with SMI)	461 Jack Arnett Br. Prestonsburg , KY 41653 PH: 606-889-0258	
Mary Sue Klusman	Family Members of Individuals in Recovery (to include family members of adults with SMI)	3004 Piedmont Drive Louisville , KY 40205 PH: 502-459-0581	
Steve Liles	Parents of children with SED	149 Wheaton Drive Lawrenceburg, KY 40342 PH: 502-839-3180	Sml811@bellsouth.net

Yolonda  
Clay Parents of children with SED

355 McConnell's Trace #101  
Lexington, KY 40511  
PH: 859-305-6436

Jim Reed Parents of children with SED

367 Park Lane  
Science Hill , KY 42553  
PH: 606-802-2588

Eagle2719501@aol.com

Siena  
Kennedy Parents of children with SED

656 Canterbury Lane  
Edgewood , KY 41017  
PH: 859-344-1059

Footnotes:

## IV: Narrative Plan

### Behavioral Health Council Composition by Member Type

Start Year:

End Year:

Type of Membership	Number	Percentage
Total Membership	35	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	7	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	5	
Parents of children with SED*	4	
Vacancies (Individuals and Family Members)	<input type="text" value="3"/>	
Others (Not State employees or providers)	4	
Total Individuals in Recovery, Family Members & Others	23	65.71%
State Employees	11	
Providers	1	
Federally Recognized Tribe Representatives	0	
Vacancies	<input type="text" value="0"/>	
Total State Employees & Providers	12	34.29%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="5"/>	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="2"/>	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	7	
Persons in recovery from or providing treatment for or advocating for substance abuse services	<input type="text" value="15"/>	

\* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Department staff drafts the Unified Substance Abuse Prevention and Treatment and Community Mental Health Services Block Grant Plan and Council members and the public are provided with opportunities to provide written or verbal feedback. Council members are notified of the date of the Public Forum (March 20th) and invited to attend; however, travel reimbursement and stipend are not offered for that event. Staff provides the same presentation to the Council (March 21st) as was provided at the Public Forum. Staff provides the Plan and Implementation Report to the Council at least 10 days prior to the quarterly meeting. Time is given on the agenda for comment on the Plan and the Council creates a letter confirming their participation and opportunity to review and provide feedback regarding the drafted Plan. At the Public Forum and Council meeting, staff encourages the public and members to continue to submit feedback and provides information about how to

submit comments via mail, fax, email, and telephone. Comments are welcome up to the submission date. Comments are included in the appendices.

Footnotes:

## IV: Narrative Plan

### X. Enrollment and Provider Business Practices, Including Billing Systems

Narrative Question:

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Each state is asked to set-aside three percent each of their SABG and MHBG allocations to support mental and substance use service providers in improving their capacity to bill public and private insurance and to support enrollment into health insurance for eligible individuals served in the public mental and substance use disorder service system. The state should indicate how it intends to utilize the three percent to impact enrollment and business practices taking into account the identified needs, including:

- Outreach and enrollment support for individuals in need of behavioral health services.
- Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA.
- Development, redesign and/or implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance.
- Third-party contract negotiation.
- Coordination of benefits among multiple funding sources.
- Adoption of health information technology that meets meaningful use standards.

**Footnotes:**

This section was left blank intentionally.

## IV: Narrative Plan

### Y. Comment on the State BG Plan

Narrative Question:

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Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the State BG Plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to the Secretary of HHS.

Footnotes:



**PUBLIC COMMENTS ON KENTUCKY’S STATE APPLICATION FOR FFY 2014-2015  
COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT (MHBG) AND SUB-  
STANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT (SABG) FUNDS**

**Department for Behavioral Health, Developmental and Intellectual Disabilities**

(1) A public forum on Kentucky’s FFY 2014-2015 State Application was held on March 20, 2013, at 10:00 a.m. at the Department for Behavioral Health, Developmental and Intellectual Disabilities, 4<sup>th</sup> Floor, Large A&B Conference Room, 100 Fair Oaks Lane, Frankfort, Kentucky.

(2) The following people submitted verbal comments at the Public Forum:

<u>NAME AND TITLE</u>	<u>AGENCY/ORGANIZATION/ENTITY/OTHER</u>
Carl Boes Policy Advisory	Kentucky Association of Regional Programs 152 W. Zandale Drive, Suite 201 Lexington, KY 40503
Steven Lyons Individual in Recovery	96 – 9 <sup>th</sup> Street Shelbyville, KY 40065
Robert Stuckey Chairperson	Kentucky Commission for the Deaf and Hard of Hearing 632 Versailles Road Frankfort, KY 40601
Bill Thompson Substance Abuse Treatment Director	Cumberland River Comprehensive Care Center 1203 American Greeting Card Road P.O. Box 568 Corbin, KY 40702

(3) The public and members of the Kentucky Behavioral Health Planning and Advisory Council were provided an opportunity to provide comments at their quarterly meeting on March 21, 2013, from 10:00 a.m. – 2:00 p.m. at the Department for Behavioral Health, Developmental and Intellectual Disabilities, 4<sup>th</sup> Floor, Large A&B Conference Room, 100 Fair Oaks Lane, Frankfort, Kentucky.

*Note: The original due date for the application was April 1, 2013 and later it was advised that it was due no later than September 3, 2013. Approved instructions for the application were not received until July of 2013.*

(4) The following people submitted verbal and written comments during the quarterly meeting of the Kentucky Behavioral Health Planning and Advisory Council:

<u>NAME AND TITLE</u>	<u>AGENCY/ORGANIZATION/ENTITY/OTHER</u>
Yolonda Clay Parent of a Child with BH Challenges	124 Homestead Drive Nicholasville, KY 40356
Mary Sue Klusman Family Member of Individ. in Recovery	3004 Piedmont Drive Louisville, KY 40205
Betty Jo Moss Individual in Recovery	4029 Briar Creek Drive Lawrenceburg, KY 40342
James Reed Parent of Child with BH Challenges	367 Park Lane Science Hill, KY 42553
Steve Shannon Executive Director	Kentucky Association of Regional Programs 152 W. Zandale Drive, Suite 201 Lexington, KY 40503
Mary Singleton Individual in Recovery	3565 W. Hwy 221 Bledsoe, KY 40810
Helen Vogelsberg Nurse	Department for Medicaid Services 275 E. Main Street Frankfort, KY 40601

(5) The public was informed of other methods to submit comments on the State Application. Those methods include email, US mail and facsimile. Comments were accepted until close of business Friday, August 30, 2013. An information sheet modeled after the Nebraska Department of Health and Human Services' document was developed to inform the public of submission options (see attached).

(6) The following people submitted comments via the public comment process:

<u>NAME AND TITLE</u>	<u>AGENCY/ORGANIZATION/ENTITY/OTHER</u>
Marsha Hockensmith Director	Kentucky Protection and Advocacy 100 Fair Oaks Lane, 3 <sup>rd</sup> Floor Frankfort, KY 40601

### **SUMMARY OF COMMENTS**

(a) It appears that SAMHSA is expanding its priority populations. It is difficult when priorities expand without additional funding attached.

(b) My opinion is that the Block Grant is going to go away. I think the department should take every opportunity to demonstrate that this money is necessary for the continuation of community-based services and to fund the changes required by the Affordable Care

Act. These funds are imperative to our community treatment system.

(c) For us (Planning Council members), we distribute the funds around and it would be nice if the funds were unlimited, but they are not. Eliminating or reducing the funds would be a big mistake.

(d) At our community mental health center substance abuse treatment program, we have lost some populations in the last year or so. The bulk of our clients are mandated clients, such as drug court, DCBS (child welfare), DUIs, etc. We seem to have fewer and fewer walk-in clients that are seeking services. Where have those clients gone? Have we lost them to private providers? Suboxone clinics? The number of suboxone clinics in Kentucky has grown dramatically and they have taken many of the treatment clients from within the CMHCs. Managed care organizations may be another issue. Definitely more of them are being diagnosed as co-occurring, so perhaps they are receiving their treatment through mental health. I am just wondering where our walk-in clients have gone. We serve a lot of people who fall between the cracks, especially men, who do not have insurance coverage and we use block grant funds to be able to provide services to them.

(e) I would like to see the funding be stable to allow for more future staffing positions to deal with issues affecting deaf and hard of hearing individuals. We need to have additional interpreters to be able to go with deaf and hard of hearing clients to support services, such as vocational rehabilitation. We have two therapists who sign in Lexington and two therapists who are deaf that work for Seven Counties in Louisville, but we need more therapists who can communicate directly with clients who are deaf or hard of hearing. I'd like to see a continuation of outreach to the deaf and hard of hearing, just like the military outreach you are doing. I would like for us to be able hire additional staff to provide outreach and to train employees.

(f) Meeting have been very informative. All questions answered to my satisfaction. Review of SAMHSA's block grant application process was detailed and agency is following guidelines.

(g) Do the numbers of clients served by the CMHCs include clients with insurance or all clients?

(h) We have \$20M for substance abuse prevention and treatment and only treating 15,388 clients in substance abuse services and when you think about it, that is a lot of money per person. I know we buy more than just treatment, but then for \$5.8M we serve a lot more in mental health services (160,064 clients).

(i) (Another member responding to above statement) The amount per clients for substance abuse services only comes out to about \$1,300 per person. On the mental health side, there are Medicaid funds. The state has not taken a stand to treat the number one problem facing the state of Kentucky and that is addiction. The number one problem is not education, not unemployment, it is addiction.

(j) What about the \$700,000 audit reserve? Is that like money in a savings account?

(k) How many of the 205 certified Peer Support Specialists are employed?

(l) This Council has discussed co-occurring disorders for many years and we were ahead of the game and even ahead of the federal government. Kudos to the Council. Those discussions prepared us for the changes that are taking place now as the Council integrates substance abuse prevention and treatment into its work.

(m) What is REACH of Louisville?

(n) Do we have someone now that is working on military initiatives? Can you tell us their names?

(o) Even with insurance expansion, we do not yet know what services will be covered.

(p) Kentucky Protection and Advocacy (P & A) provides the below comments regarding Kentucky's Applications for FFY 2014-2015 Community Mental Health Services Block Grant and Substance Abuse Prevention and Treatment Block Grant funds.

P&A recognizes the required planning process for this funding application and applauds the State Priorities listed for Kentucky's publicly funded behavioral healthcare system.

P&A and those served by and eligible to be served by P&A are thrilled that Kentucky has indicated 100% of all block grant funds for individuals with SMI must be used for one of the following evidence based practices: Supported Employment, Supported Housing, Peer Support or Assertive Community Treatment.

The block grant application references the continuance of training to be a Peer Specialist. While this is an evidence based practice and much needed service and support, Peer Specialist services are not a billable service under Kentucky Medicaid. Perhaps along with the continuance of training to be a Peer Specialist or instead of the continuance of training to be a Peer Specialist, Kentucky might consider use of block grant money to offer the Peer Specialist service to persons and reimburse the approved Peer Specialist providing the service.

The block grant application references training provided by the CMHCs to a number of entities in the criminal justice system. There is specific mention of the Crisis Intervention Training (CIT) Program in Jefferson County. However there appears to be a lack of information about the CIT Program or similar initiatives in other, including rural, areas of the state.

Perhaps the CIT Program or similar initiatives could be offered to other law enforcement agencies, including the Kentucky State Police, to ensure that individuals living across Kentucky have a better chance of interfacing with law enforcement agencies who better

understand trauma.

The block grant application references the Olmstead Housing Initiatives (OHI) and continued funds toward this initiative in FFY 2014-2015. While options for housing, such as the OHI, are a must, the current requirement for an individual to have a case manager in order to access funds and services via the OHI may at times be an unnecessary barrier for some individuals seeking and in need of these services.

Perhaps the Department could further strategize on removal of this, often times a barrier to individuals living at Personal Care Homes in Kentucky, many of whom do not currently receive case management services. We would also suggest more be done in way of education and outreach regarding the availability of the OHI.

The block grant application references the Recovery Malls currently available at three of the four state owned or operated psychiatric hospitals in Kentucky. Perhaps all four of the state owned or operated psychiatric hospitals implement a recovery mall.

P&A and those served by or eligible to be served by the P&A were hopeful to see mention of problems, including strategies for resolution, regarding implementation of Managed Care in Kentucky as this has had a profound impact on both the availability of services and receipt of services to children, youth, and adults with behavioral health needs.

P&A strongly encourages the Department to review and build upon "Continuity of Care" in the service/support world for children and youth with behavioral health needs.

Finally, given the Department's heavy reliance on the Community Mental Health Centers, P&A, and those served by or eligible to be served by the P&A, encourage the Department to acknowledge the waiting period for individuals to even initiate needed services and supports.

We appreciate the opportunity to provide the above comments.

## **SAMHSA Combined Substance Abuse Prevention and Treatment Block Grant and Community Mental Health Services Block Grant**

### **Kentucky's FY 2014-2015 Behavioral Health Assessment and Plan (Application)**

#### **Public Comments on the State Assessment and Plan (Application)**

The Substance Abuse and Mental Health Services Administration (SAMHSA) is accepting State Applications for FFY 2014-2015 Community Mental Health Services Block Grant (MHBG) and Substance Abuse Prevention and Treatment Block Grant (SABG) funds. The Applications are due September 3, 2013.

Kentucky's Applications and Implementation Reports from previous years are posted on the website of the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities. These documents have been approved by SAMHSA.

[http://dbhdid.ky.gov/dbh/kmhpac\\_bg.asp](http://dbhdid.ky.gov/dbh/kmhpac_bg.asp)

A preliminary draft of Kentucky's FFY 2014-2015 Behavioral Health Assessment and Plan is available for review. For questions or to request a copy of the Application, please contact the State Planner, Michele Blevins, at [Michele.Blevins@ky.gov](mailto:Michele.Blevins@ky.gov). Public Comments on Kentucky's FY 2014-2015 Application are welcome and encouraged. <http://dbhdid.ky.gov/> (under Hot Topics)

There are several approaches one may use to comment on the Application:

1) Attend the Public Forum on Wednesday, March 20, 2013 from 10:00 a.m. to 12:00 p.m. at the Department for Behavioral Health, Developmental and Intellectual Disabilities, 100 Fair Oaks Lane, 4<sup>th</sup> Floor, Frankfort, Kentucky 40601.

2) Attend the Kentucky Behavioral Health Planning and Advisory Council on Thursday, March 21, 2013 from 10:00 a.m. to 2:00 p.m. at the Department for Behavioral Health, Developmental and Intellectual Disabilities, 100 Fair Oaks Lane, 4<sup>th</sup> Floor, Frankfort, Kentucky 40601.

Individuals wishing to attend a public meeting can request accommodations such as American Sign Language interpreters or CART at least one day in advance by contacting [Michelle.Niehaus@ky.gov](mailto:Michelle.Niehaus@ky.gov) or calling the department at (502) 564-4456 (Voice).

3) By email to Michele Blevins at [Michele.Blevins@ky.gov](mailto:Michele.Blevins@ky.gov).

4) By U.S. Mail to the following address:

Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities  
Division of Behavioral Health  
Michele Blevins – State Planner  
100 Fair Oaks Lane, 4E-D Frankfort, KY 40601

5) By fax to Michele Blevins at (502)564-9010

KDBHDID staff have created a document to outline ways that the public may provide comments on Block Grant Plans and Reports. The language from the document is copied below. The document will be placed on the Planning Council webpage of hyperlinks to copies of Block Grant Plans and Reports. KBHDID will also link to the document when it is posted as a Hot Topic on the Department's homepage, which will be during the months of Mid-February, March and November at a minimum. This document states that KDBHDID welcomes and encourages public comments on plans and reports that are in draft, submitted or approved status.

How to Provide Public Comments on Kentucky's Annual Block Grant Plans and Reports  
The Substance Abuse and Mental Health Services Administration (SAMHSA) provides the Substance Abuse Prevention and Treatment Block Grant (SABG) and the Community Mental Health Services Block Grant (MHBG) to States to address their unique behavioral health issues. States use the Block Grant program for prevention, treatment, recovery supports and other services to complement services covered by Medicaid, Medicare, and private insurance. States submit a Behavioral Health Assessment and Plan annually on April 1st to describe their public behavioral health system of care and allocation of funds. On December 1st States submit SABG and MHBG Behavioral Health Reports to report data, initiatives and expenditures of funds. A detailed Block Grant calendar for Kentucky is provided below.

#### Status of Reports

Kentucky's current Plans and Behavioral Health Reports as well as Plans and Reports from previous years are posted on the website of the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID). The status of each document is indicated beside it (draft, submitted or approved). A Plan or Report which indicates "draft" means the document is being made public to solicit comments and has not been submitted to SAMHSA. A Plan or Report that indicates "submitted" means that the document has been submitted to SAMHSA for approval. At this point, SAMHSA has the opportunity to ask DBHDID to make any necessary revisions or clarifications. A Plan or Report that indicates "approved" means that the document has been reviewed by SAMHSA's staff and met eligibility for approval. BHDID welcomes and encourages the public to provide comments on Plans and Reports of any status.

#### 2014 and 2015 Block Grant Calendar

March 19, 2014 Block Grant Public Forum to Solicit Public Comments on Kentucky's 2015 Behavioral Health Assessment and Plan  
March 20, 2014 Kentucky Behavioral Health Planning and Advisory Council Meeting to Review Kentucky's 2015 Behavioral Health Assessment and Plan and Solicit Comments  
April 1, 2014 2015 Behavioral Health Assessment and Plan Due to SAMHSA  
November 20, 2014 Kentucky Behavioral Health Planning and Advisory Council Meeting to Review Kentucky's 2015 MHBG and SABG Behavioral Health Reports  
December 1, 2014 Kentucky's 2015 SABG Behavioral Health Report Due and 2015 MHBG Behavioral Report Due to SAMHSA  
March 18, 2015 Block Grant Public Forum to Solicit Public Comments on Kentucky's 2016-2017 Behavioral Health Assessment and Plan  
March 19, 2015 Kentucky Behavioral Health Planning and Advisory Council Meeting to Review Kentucky's 2016-2017 Behavioral Health Assessment and Plan  
April 1, 2015 Kentucky's 2016-2017 Behavioral Health Assessment and Plan Due to SAMHSA  
November 19, 2015 Kentucky Behavioral Health Planning and Advisory Council Meeting to Review Kentucky's 2016 SABG and MHBG Behavioral Health Reports  
December 1, 2015 Kentucky's 2016 SABG Behavioral Health Report Due and 2016 MHBG Behavioral Health Report Due

#### Providing Comments

There are several approaches one may use to comment on the Plans and Reports:

1) Attend a Public Forum. The Public Forums are held each year in March from 10:00 a.m. to 12:00 p.m. at BHDID, 100 Fair Oaks Lane, 4th Floor, Frankfort, Kentucky 40601. Individuals may provide oral and/or written comments. Information regarding

requesting accommodations is provided below. This is an open meeting.

2) Attend a meeting of the Kentucky Behavioral Health Planning and Advisory Council. The Council reviews Kentucky's Behavioral Health Assessment and Plan at their regularly scheduled quarterly meeting in March and Kentucky's SABG and MHBG Behavioral Health Reports at their regularly scheduled quarterly meeting in November. The meetings are held from 10:00 a.m. to 2:00 p.m. at BHDID, 100 Fair Oaks Lane, 4th Floor, Frankfort, Kentucky 40601. This is an open meeting. Individuals wishing to attend a public meeting can request accommodations such as American Sign Language interpreters or CART at least one day in advance by contacting Michelle.Niehaus@ky.gov or calling the department at (502) 564-4456, extension 4521 (Voice).

3) By email to Michele Blevins at Michele.Blevins@ky.gov.

4) By U.S. Mail to the following address:  
Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities  
Division of Behavioral Health  
Michele Blevins - State Planner  
100 Fair Oaks Lane, 4E-D  
Frankfort, KY 40601

5) By fax to Michele Blevins at (502)564-9010.

Thank you for your interest in Kentucky's behavioral health system of care and the individuals served by the Substance Abuse Prevention and Treatment Block Grant and the Community Mental Health Services Block Grant!