

Kentucky

UNIFORM APPLICATION

FY 2016/2017 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

SUBSTANCE ABUSE PREVENTION AND TREATMENT and COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 06/30/2018
(generated on 11/21/2017 4:50:29 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year 2016

End Year 2017

State SAPT DUNS Number

Number 927049767

Expiration Date 6/30/2018

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 275 East Main Street 4 W-G

City Frankfort

Zip Code 40601

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

First Name Michele

Last Name Blevins

Agency Name Cabinet for Health and Family Services

Mailing Address 275 East Main Street 4W-G

City Frankfort

Zip Code 40601

Telephone 502-782-6150

Fax 502-564-9010

Email Address Michele.Blevins@ky.gov

State CMHS DUNS Number

Number 927049767

Expiration Date 6/30/2018

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 275 East Main Street 4W-G

City Frankfort

Zip Code 40601

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

First Name Michele

Last Name Blevins

Agency Name Department for Behavioral Health, Development, and Intellectual Disabilities

Mailing Address 275 East Main Street 4W-G

City Frankfort

Zip Code 40621

Telephone 502-782-6150

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

Submission Date 9/1/2015 7:38:18 PM

Revision Date 3/28/2016 3:45:31 PM

V. Contact Person Responsible for Application Submission

First Name Michele

Last Name Blevins

Telephone 502-782-6150

Fax 5025649010

Email Address michele.blevins@ky.gov

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2016

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
 Funding Agreements
 as required by
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 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
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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
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ASSURANCES - NON-CONSTRUCTION PROGRAMS

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 Costal 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.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION 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). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. 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 Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. 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, day care, 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.

The authorized official signing for the applicant organization 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 sub-recipients shall certify accordingly.

The Department of Health and Human 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 DHHS mission to protect and advance the physical and mental health of the American people.

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.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Audrey Tayse Haynes

Signature of CEO or Designee¹: _____

Title: Secretary, Cabinet for Health and Family Services

Date Signed: _____

mm/dd/yyyy

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

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2016

U.S. Department of Health and Human Services
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Title XIX, Part B, Subpart II 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
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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.

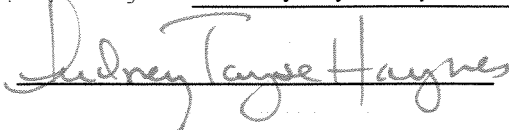
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I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Audrey Tayse Haynes

Signature of CEO or Designee: 

Title: Secretary

Date Signed: 8/27/15

mm/dd/yyyy



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

August 30, 2010

Ms. Barbara Orlando
Grants Management Officer
Division of Grants Management, OPS
Substance Abuse and Mental Health Services Administration
Department for Health and Human Services
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, to sign funding agreements and certifications, provide assurances of compliance to the Secretary, and to perform similar acts relevant to the administration of the Community Mental Health Services Block Grant until such time as this delegation of authority is rescinded.

Sincerely,

A handwritten signature in black ink, appearing to read "Steven L. Beshear".

Steven L. Beshear.

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2016

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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.
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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, day care, 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.

The authorized official signing for the applicant organization 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 sub-recipients shall certify accordingly.

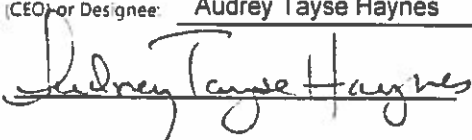
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I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for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

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Audrey Tayse Haynes

Signature of CEO or Designee:



Title: Secretary

Date Signed: 8/27/15

mm/dd/yyyy

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

Kentucky

Kentucky

Revised 03/22/2017 3:55 PM - Kentucky - OMB No. 0930-0168 Approved: 06/12/2015 Expires: 06/30/2018

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Page 10 of 11



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

August 31, 2015

Ms. Virginia Simmons
Grants Management Officer
Division of Grants Management, OPS
Substance Abuse and Mental Health Services Administration
Department for Health and Human Services
1 Choke Cherry Road, Room 7-1091
Rockville, Maryland 20857

Dear Ms. Simmons:

I hereby delegate authority to the Secretary of the Cabinet for Health and Family Services to sign funding agreements and certifications, provide assurances of compliance to the Secretary, and to perform similar acts relevant to the administration of the Community Mental Health Services and the Substance Abuse Prevention and Treatment Block Grants until such time as this delegation of authority is rescinded.

Sincerely,

A handwritten signature in black ink, appearing to read "Steven L. Beshear".

Steven L. Beshear

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2016

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
 Funding Agreements
 as required by
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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.
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Name of Chief Executive Officer (CEO) or Designee: Audrey Tayse Haynes

Signature of CEO or Designee¹: _____

Title: Secretary, Cabinet for Health and Family Services

Date Signed: _____

mm/dd/yyyy

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

Footnotes:

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Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2016

U.S. Department of Health and Human Services
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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 Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. 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, day care, 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.

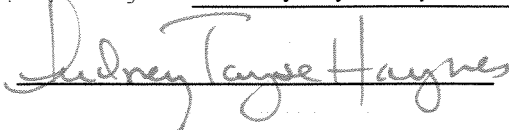
The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant 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 sub-recipients shall certify accordingly.

The Department of Health and Human 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 DHHS mission to protect and advance the physical and mental health of the American people.

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.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Audrey Tayse Haynes

Signature of CEO or Designee: 

Title: Secretary

Date Signed: 8/27/15

mm/dd/yyyy



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

August 30, 2010

Ms. Barbara Orlando
Grants Management Officer
Division of Grants Management, OPS
Substance Abuse and Mental Health Services Administration
Department for Health and Human Services
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, to sign funding agreements and certifications, provide assurances of compliance to the Secretary, and to perform similar acts relevant to the administration of the Community Mental Health Services Block Grant until such time as this delegation of authority is rescinded.

Sincerely,

A handwritten signature in black ink, appearing to read "Steven L. Beshear".

Steven L. Beshear.

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

Signature: _____ Date: _____

Footnotes:

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, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

II. Planning Steps

Step 1: Assess the Strengths and Needs of the Service System to Address the Specific Populations

(This section also addresses the first requirement in Criterion 1a for Adults and Children: Plan provides for establishment and implementation of an organized, community-based system of care for individuals with mental illness)

The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (KDBHDID) administers a comprehensive, community-based system of behavioral health care for adults with serious mental illness (SMI), children with severe emotional disabilities (SED), and their families, and adults and youth with substance use disorders. With guidance from SAMHSA's *Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015-2018*, 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.

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. The DBHDID receives state general funds allocated for the prevention and treatment of behavioral health (mental health and substance abuse) in a biennial budget and is charged with administering the funds annually to achieve its service and quality goals.

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. A Regional 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 each region and these generally align with the Area Development Districts (ADD) throughout the state. County and municipal governments do not provide community behavioral health services. A Regional Board is an independent, non-profit organization; that is governed by a volunteer board of directors that broadly represents stakeholders (including consumers and family members) and counties in the region; and is licensed by the Cabinet for Health and Family Services as a "Community Mental Health Center."

CMHC Regions In Kentucky



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 and a number of services may also be provided off-site in homes, school and community locations. In addition to the clinics, there are fourteen (14) Regional Prevention Centers established to provide technical assistance and training on evidence-based prevention strategies. While their main focus is aimed at Primary Prevention for substance abuse, they are also taking on some activities that are more targeted in nature (using funds other than those set aside for Primary Prevention).

With its available resources of state general funds, block grant/other federal funds, and awarded agency funds, DBHDID contracts with the fourteen private, not-for-profit CMHCs to provide services to citizens in all 120 counties of the state. These funds are awarded annually and contracts may be modified throughout the course of the year. The fiscal year of operation is July 1 through June 30. CMHCs are required to specifically describe their current systems of care for adults and children, including crisis care, and are required to report their plans for development regarding key system components, within an annual Plan & Budget process. DBHDID is committed to working collaboratively with CMHCs to continuously enhance continuity of care, implementation of evidence based practices and service effectiveness, and accountability. DBHDID contracts with a small number of other non-profit, community based, providers for additional targeted services.

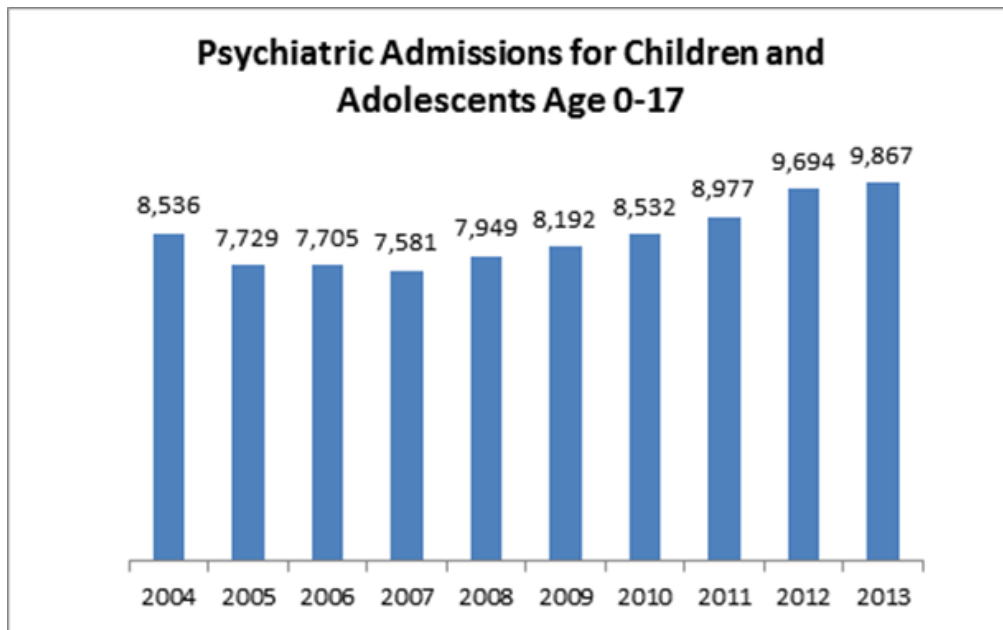
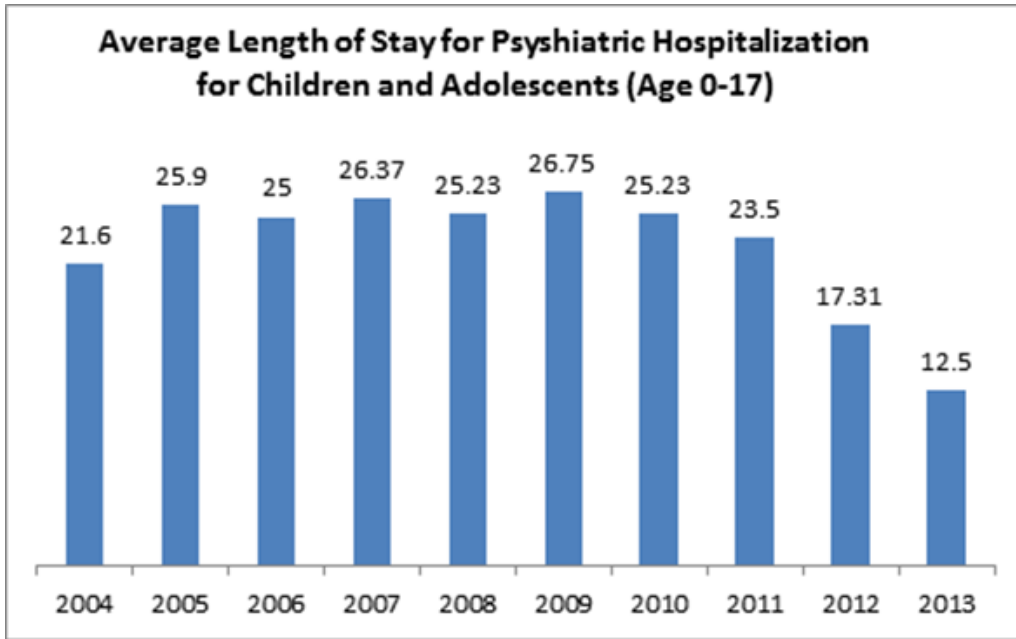
DBHDID also has authority for inpatient psychiatric care for the indigent and operates or contracts for several adult mental health inpatient facilities, as displayed in the table below. The majority of care in these facilities is provided with state general funds as three of the four are IMD designated facilities.

State Hospital	Location	Operation	SFY 2005	SFY 2013	SFY 2014 ADC	SFY 2015 ADC (Data not yet)

			ADC*	ADC		certified)
Western State Hospital	Hopkinsville	State operated	144	119	124	136
Central State Hospital	Louisville	State operated	108	59	55	46
Eastern State Hospital	Lexington	Contracted	162	127	119	119
Appalachian Regional Hospital (ARH) -Hazard Psychiatric Center	Hazard	Contracted	82	87	73	73
*ADC= Average Daily Census		TOTAL	496	392	371	362

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 CMHCs. The facility's average daily census in SFY 2014 was approximately 47people.

Kentucky does not operate any state funded inpatient facilities for children and youth under eighteen years of age. There are currently 625 available child psychiatric beds located in 14 hospitals that are geographically located in 9 of the 14 regions. The most current data available The average daily census for the 625 beds is 348 (56%) and the average length of stay for patients is 12.5 days (nearly half that of a few years ago). Other residential care for children includes Psychiatric Residential Treatment Facilities (PRTFs), Private Child Care (PCCs) facilities and Therapeutic Foster Care (TFC) contracted by the Department for Community Based Services, a sister agency to DBHDID in CHFS. The Office of Inspector General, an agency within CHFS, 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, or "care, custody and control" of children are a function of the Kentucky Department for Medicaid Services (DMS) or DBHDID.



Data Source: Kentucky Office of Health Policy <http://chfs.ky.gov/ohp/>

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 2016. To operationalize this, DBHDID reallocated funding from state psychiatric facilities to the 14 CMHCs to provide the intensive community services needed. These funds, combined with Mental Health Block Grant funds, provide Assertive Community Treatment (ACT), Supported Housing (SH), Supported Employment (SE), and Peer Support (PS). For Medicaid recipients, ACT and PS are covered services.

Currently, there is great need and much optimism for expansion of services, all along the continuum, for adults and youth with, or at risk of, substance use disorders. In addition to contracted outpatient/intensive outpatient services, DBHDID contracts with several CMHCs and a few other non-profit entities to provide specialized residential treatment for men, women, pregnant women and parents with dependent children, youth, individuals with SMI and SUD, and individuals who are homeless.

Kentucky has been applauded over the years for making a small amount of funding go a long way but ultimately the behavioral health system in Kentucky has been underfunded and unbalanced between community based services and inpatient/institutional care. Over the last decade, progress has been made to give more balance to the funding equation and increased access to much needed services in the community.

The availability and funding of behavioral health services in Kentucky is currently undergoing significant change due to a variety of factors. Since the time of deinstitutionalization in the 1960's, Kentucky's publicly-funded services system for community based, non-residential, mental health and substance use has relied, almost solely, on a network of fourteen Community Mental Health Centers (CMHCs) who provide a full continuum of behavioral health services to nearly five percent of the state's population of nearly 4.5 million people. However, within the past five years, a number of changes have impacted the behavioral health delivery system, including the implementation of Medicaid managed care, implementation of the Affordable Care Act with a state-run health exchange and expanded Medicaid coverage, several approved Medicaid State Plan amendments, an expansion of the behavioral health provider network and numerous new and amended state laws and regulations. Still, the CMHCs remain strong and viable safety net providers for Kentucky citizens enrolled in Medicaid or other insurance plans, as well as those that are uninsured, underinsured or transitioning onto and out of insurance coverage. The following offers a brief description of the change factors currently underway in Kentucky.

In November 2011, Kentucky transitioned its Medicaid program to managed care by initiating of contracts with three managed care organizations (MCOs) to provide services to approximately 540,000 Medicaid enrollees in seven of the Commonwealth's eight Medicaid regions. Behavioral health was included along with physical health in an effort to provide a more integrated service continuum to those it serves. Contracts were enacted for a 30-month period (through June 30, 2014). A subsequent procurement process was initiated and as of July 1, 2015, Kentucky's Department for Medicaid Services has contracts with five managed care entities for physical and behavioral health services for Medicaid enrolled citizens statewide. The contracted entities include Wellcare, Humana/CareSource, Coventry, Anthem and Passport Health Plan.

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. DMS and DBHDID staff also convene regularly scheduled meetings with the Behavioral Health Directors from each MCO (collectively) aimed at specifically addressing behavioral health coverage (coding, billing, and service system development issues).

In May 2013, the decision to expand Medicaid eligibility in Kentucky pursuant to the Affordable Care Act was announced, allowing individuals and families earning up to 138 percent of the federal poverty line to enroll in an insurance plan. Kentucky created Kynect, an on-line health insurance marketplace to allow citizens to learn about and select health insurance plans. The system allows for Medicaid eligible individuals to sign up for coverage through the marketplace. Medicaid coverage for the expansion population began Jan. 1, 2014. The first enrollment period added more than 310,000 Kentuckians to the Medicaid program and another

17,000, who were eligible but not previously enrolled under traditional Medicaid criteria, also signed up. To date, 403,125 Kentuckians have enrolled in health coverage under Medicaid expansion and an additional 105,877 have enrolled in coverage through a Qualified Health Plan. The initial research showed expanding Medicaid would create 17,000 new jobs and add \$15.6 billion to the state's economy between 2014 and 2021. A 2015 Gallup Poll showed that Kentucky had the second largest drop of uninsured adults in the country, decreasing more than 10 points from 20.4% to 9.8%. For more information about Kynect see: <https://kynect.ky.gov/>

The Kentucky Department for Medicaid Services has submitted a series of State Plan Amendments (SPAs) in recent years and several expand Medicaid benefits for clinic, rehabilitation and targeted case management services. Perhaps the most significant is the addition of coverage for services for substance use disorders. Historically, Kentucky was in the minority of states that did not have a Medicaid benefit for substance use treatment, except for pregnant women. Information about the Medicaid covered services under the approved SPAs is provided elsewhere in this application.

Along with developing new behavioral health services through the Medicaid SPAs, the decision was made to expand the eligibility of professionals and organizations that are eligible to apply for and become Medicaid providers. Today the behavioral health providers who are able to seek reimbursement for Medicaid payment, through the MCOs, is vastly larger than in the past. There are a greater number of licensed professionals who may apply to become Medicaid providers including, Licensed Clinical Social Workers, Licensed Marriage and Family Therapists, Licensed Professional Clinical Counselors, Licensed Psychologists, Licensed Art Therapists, Certified Behavioral Analysts, and most recently Licensed Alcohol and Drug Counselors are likely to be added to the list. Several new licensure categories have been created including, Behavioral Health Services Organizations (BHSOs) and Multi-Specialty Groups (MSGs). A few services are limited to the organizational categories (e.g., residential crisis units) but most services are open to all licensed professionals. A growing number of FQHCs, RHCs, and Primary Care Providers are developing new or expanded behavioral health services.

With the many changes that have occurred in the behavioral healthcare system, the need for a significant number of new laws and regulations has ensued. Another catalyst for new legislation and regulatory changes has been the escalation of the misuse of prescription drugs and heroin use in Kentucky. DMS and DBHDID, as well as many other state agencies have worked together to achieve mutual goals and negotiate differences. The Governor and the Cabinets' Secretaries have been instrumental in moving the system forward. The First Lady has taken a particular interest in ensuring that substance use prevention and treatment services, especially for women and youth, are being developed and made available statewide.

The following addresses Criterion 1b: Adults with SMI: Comprehensive Community Based Mental Health Services as required by the federal legislation.

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

HEALTH, MENTAL HEALTH, AND REHABILITATION SERVICES

Health, Mental Health and Rehabilitation (including Employment and Educational Services)

While DBHDID staff believes that behavioral health is essential to overall health and has been sharing this message far and wide, there is still a lot of work to be done in Kentucky. The health outcomes in Kentucky are among the poorest in the nation, with a ranking of 47th from the American Health Rankings latest report. Kentucky ranks 47th in the nation in overall health.

In an effort to improve the health and wellbeing of Kentucky citizens, the Governor has launched the *kyhealthnow* initiative to address a number of key health indicators. There are various detailed strategies to help achieve the goals and all staff within the Division of Behavioral Health was recently invited to participate in the review and revision of the strategies, particularly the last one that is directly aimed at behavioral health.

Ky Health Now 2019 goals

- Reduce Kentucky's rate of uninsured individuals to less than 5%
- Reduce Kentucky's smoking rate by 10%.
- Reduce the rate of obesity among Kentuckians by 10%.
- Reduce Kentucky cancer deaths by 10%.
- Reduce cardiovascular deaths by 10%.
- Reduce the percentage of children with untreated dental decay by 25% and increase adult dental visits by 10%.
- **Reduce deaths from drug overdose by 25% and reduce by 25% the average number of poor mental health days of Kentuckians.**

For more information, see: <http://governor.ky.gov/healthierky/kyhealthnow/pages/default.aspx> and <http://www.americashealthrankings.org/>

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

Regional Availability of Adult Community Support Services SFY 2015

	1	2	3	4	5	6	7	8	10	11	12	13	14	15
Services	Consumer and Family Support													
Consumer Support Group	X	X		X	X	X	X	X		X	X	X	X	X
Consumer Operated Program	X			X	X	X	X		X	X				X
Social Club Drop In					X	X	X		X					
Local NAMI Affiliates	X	X		X	X	X	X	X	X	X	X	X	X	X
Consumer Conferences			X		X	X			X		X		X	X
	Emergency Services													
Emergency-Help Line	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Walk-In Crisis Services	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Mobile Crisis Services	X			X			X	X	X	X	X	X	X	
Residential Crisis Stabilization	X	X	X	X	X	X			X	X	X	X	X	X
	Mental Health Treatment													
Community Medication Support	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Specialized Co-occurring Disorder Services	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Case Management Services														
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
Payee Services		X	X	X		X	X	X	X		X	X		X
Rehabilitation Services														
Therapeutic Rehabilitation			X	X	X	X		X	X	X		X	X	
Supported Employment	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Educational Services					X	X	X	X			X			X
Illness, Management, Recovery				X	X	X		X	X		X		X	
Peer Support Services	X		X	X	X	X	X	X	X	X	X	X	X	X
Assertive Community Treatment	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other* (Psychiatric Rehab)				X										
Housing Options														
Supported Housing Program		X	X	X		X	X		X	X	X	X		X
Residential Support		X				X		X	X	X	X			X
Housing Development		X			X	X				X	X	X	X	X

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 services. Every effort is made to place these outpatient clinics within close geographic proximity for consumers in order assure easy access to needed services. 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).

In January of 2014, a new Kentucky Medicaid state plan amendment was approved by CMS. Included as part of the new Medicaid billable package of services available for adults with SMI were such services as Assertive Community Treatment, Peer Support Services, Comprehensive Community Support Services, and Intensive Outpatient Treatment for mental health. The DBHDID restructured CMHC contracts to include many of these services as requirements. For example, each CMHC is now required to provide Assertive Community Treatment and Peer Support Services to individuals with SMI who qualify for those 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 individuals 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 DBHDID 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.

The DBHDID also promotes the use of SAMHSA's working definition of recovery, including the dimensions of health, home, purpose and community, as well as the ten guiding principles of behavioral health recovery. To date the DBHDID, Kentucky Medicaid, the Regional Boards, and other providers have not adopted, collectively, a specific model of practice but some programs have independently adopted a specific model. However, without system support, they 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. In January 2014, a new Kentucky Medicaid state plan amendment was approved by CMS. The DBHDID provided much consultation regarding the new service package for adults with SMI. Psychiatric rehabilitation was referred to specifically in several of the newly billable services.

The DBHDID supports the provision of key rehabilitative services at the regional level: **therapeutic rehabilitation, supported employment, supported education, illness management and recovery, peer support services** and **assertive community treatment**. While they each rely on psychiatric rehabilitation foundations, 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;
- Contracts with Regional Boards require designation of a regional Community Support Director and attendance at quarterly meetings;
- Technical assistance and training is provided 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;
- An interagency agreement with the Office of Vocational Rehabilitation that uses CMHS Block Grant funds to leverage supported employment services for adults with serious mental illness. As of SFY 2015, all regions across the state have supported employment programs utilizing the Individual Placement and Support (IPS) model, to support adults with SMI; and
- Contracts with Regional Boards require all regions to provide access to Assertive Community Treatment (ACT) and Peer Support services for adults with SMI. As of SFY 2015, all regions across the state have developed ACT teams and are providing ACT services to adults with SMI. In addition all regions across the state have hired at least one peer support specialist (most regions have hired several peer specialists) and are providing peer support as a service to adults with SMI.
- Seven (7) regions are providing access to Illness Management and Recovery services, an evidence based practice for adults with SMI;
- One (1) region has hired a psychiatric rehabilitation specialist to work in the agency, to assist in incorporating psychiatric rehabilitation principles into programming for adults with SMI; and
- Six (6) regions provide access to educational services to adults with SMI. 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 serious mental illness in accessing and maintaining employment, and can negatively impact their quality of life. Providing access to educational support services should remain a priority.

Plan and Budget submissions for SFY 2016 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 2015 only nine (9) of fourteen (14) regions provide access to therapeutic rehabilitation services;
- Seven (7) regions are providing access to Illness Management and Recovery services, an evidence based practice for adults with SMI;
- One (1) region has hired a psychiatric rehabilitation specialist to work in the agency, to assist in incorporating psychiatric rehabilitation principles into programming for adults with SMI; and
- Six (6) regions provide access to educational services to adults with SMI. 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 serious mental illness in accessing and maintaining employment, and can negatively impact their quality of life. Providing access to educational support services should remain a priority.

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.

The delivery of quality, timely rehabilitation services has been enhanced since approval of the new Medicaid state plan amendment in January 2014, and since Kentucky's adoption of Medicaid Expansion under the Affordable Care Act. Many of the rehabilitation services are now billable through Medicaid. However, quality, timely, delivery remains challenged by a number of factors including:

- Kentucky Medicaid rates for therapeutic rehabilitation, assertive community treatment, and peer support 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, assertive community treatment or peer support services, or else have challenging processes of reimbursement, so individuals without Medicaid have difficulty accessing this service;
- Some rehabilitation services are inconsistent and do not have a specific model of practice with stated values, principles, practice guidelines, and expected outcomes of service;
- Supported employment is not reimbursed by Medicaid and there is limited funding for the long term employment supports needed by adults with a serious mental illness;
- The advent of Managed Care, and Kentucky's contracts with five (5) separate Managed Care Organizations, has led to numerous difficulties with gaining authorization for therapeutic rehabilitation, assertive community treatment, and other rehabilitation services;
- 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 individuals who do not receive Medicaid.

Housing Services

The DBHDID 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.

KDBHDID and KHC have a long history of close cooperation, dating back to 1999 when KDBHDID and KHC jointly-funded the position of a Supportive Housing Specialist at KHC tasked with focusing on permanent supportive housing options for special needs populations. Currently, KDBHDID and KHC collaborate on several programs serving persons with a serious mental illness that will greatly expand the limited affordable housing opportunities currently available. These programs are:

Olmstead Housing Initiative –DBHDID continues to implement a plan to ensure that individuals with serious mental illnesses who have been institutionalized or are at risk of institutionalization have viable transition plans that ensure community-based housing and services. Assistance through the Olmstead Housing Initiative can come in the form of tenant-based rental assistance (TBRA), one-time security or utility deposit assistance, furnishings, and essential household goods necessary for the housing set-up.

HUD 811 Grant – This program will enable KHC, in partnership with DBHDID, to serve 150 very low-income persons with disabilities and to offer a wide array of service choices and opportunities, through project-based housing vouchers for persons exiting, or at risk of entering, personal care homes or other institutions. DBHDID will provide referral clients to the program in addition to offering a wide array of service choices and opportunities.

Multifamily Development – DBHDID works with KHC's Multifamily Department to assist with trainings for housing developers regarding set-aside units for the Olmstead population. These trainings include material on the Olmstead population, the CMHC system, services provided and local contacts within the CMHCs. DBHDID also facilitates contact between the developers and the CMHCs. CMHCs have agreed to refer a specified number of individuals to each development complex, and to provide the services needed, including ACT, to assist these persons in successfully transitioning to the community.

Other Housing Contracts

Wellspring – Wellspring promotes mental health recovery for adults with serious mental illness by providing quality housing and rehabilitative services for nearly 700 clients annually. Wellspring operates two Crisis Stabilization services and several Supported Housing programs in addition to affordable housing options throughout Jefferson County and a Shelby County site.

Activities include linking clients to services and activities of their choosing, accessing subsidies, locating suitable housing, negotiating leases, acquiring household items, moving the individual into the residence, teaching basic life skills and other skills that strengthen recovery and promote community integration.

New Beginnings –New Beginnings provides community-based, recovery-oriented housing and supportive services to persons with serious mental illness in the least restrictive environment possible; and offers a variety of housing programs ranging from staffed residences with 24 hour supervision to outreach services offering periodic supports to individuals living independently in the community.

Activities include linking clients to services and activities of their choosing, accessing subsidies, locating suitable housing, negotiating leases, acquiring household items, moving the individual into the residence, teaching basic life skills and other skills that strengthen recovery and promote community integration.

Staffed Residences – A Request for Applications was sent out to the CMHCs in January 2015 to fund approved proposals for staffed residences. Three CMHCs were awarded funding and provide supportive housing services to individuals with serious mental illnesses who meet Level of Care Utilization System (LOCUS) Level 5 criteria and are transitioning from an institutional setting to integrated community housing. These activities include linking clients to services and activities of their choosing, accessing subsidies, locating suitable housing, negotiating leases, acquiring household items, moving the individual into the residence, teaching basic life skills and other skills that strengthen recovery and promote community integration.

Regional Boards use a variety of strategies to develop housing options for individuals with serious 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 2016 reveals that:

- There are approximately 941 units in 61 projects operated by the CMHCs;
- All regions have a Housing Coordinator, and have developed a housing plan;
- All regions provide specialized housing training to agency staff;
- Ten regions have organized formal supported housing programs;
- Ten regions are involved in housing development; and
- Nine regions operate housing projects that provide residential support.

Goals for SFY 2016:

- To address a pressing need for housing for people who are currently in, or at risk of entering, institutions, such as psychiatric hospitals or personal care homes, or who have a history of frequent institutionalizations. By moving individuals from institutional settings to living independently in communities of their choice, Kentucky can better serve this population and implement the mandates of the Olmstead decision;
- To bring as many HUD 811 housing units online as possible early into the program. Will then want to move individuals into these units as quickly as possible.; and
- Provide supportive housing opportunities for individuals with high service needs.

Goals for SFY 2017:

- To identify additional steps that we can take to achieve our goals around integrating Medicaid resources as supports for housing. Will work towards providing as many resources as possible through mainstream resources and have less reliance on general fund projects;
- Continue to work with housing developers to set-aside units for the Olmstead population and to develop additional housing opportunities across the state;
- Continue to promote establishing local SSI/SSDI Outreach, Access and Recovery (SOAR) and other initiatives, and monitor and support existing initiatives.

Substance Abuse Services (Includes an overview of the Substance Abuse Treatment and Prevention System)

The new Medicaid State Plan Amendment (SPA) also added benefits for individuals with substance use disorders. The full array of outpatient services (e.g., Screening, Assessment, Individual and Group Therapy, Peer Support and crisis services, etc.) became available for individuals with substance use disorders, as well as additional services aimed at addressing substance use disorders specifically, including: Residential

Services for Substance Use Disorders; Screening, Brief Intervention and Referral to Treatment (SBIRT); and Medication Assisted Treatment. In response to these changes, DBHDID has been restructuring contracts to provide these services, restructuring data systems to define and collect data for all new services, and providing guidance to providers through the development of service standards and other technical assistance.

On-going and new substance use specific services provided primarily through contracts with Regional Boards, utilizing state and federal funds 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;
- Detoxification centers, residential treatment programs, intensive outpatient treatment services, other outpatient services including peer support and targeted case management;
- Specialized treatment services for pregnant women, adolescents and intravenous drug users; and
- Medication Assisted Treatment to opiate dependent persons who are high-risk for Hepatitis and 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 to address the needs of individuals with alcohol and other drug use concerns.

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 (Driving Under the Influence-DUI assessment, education and treatment) and KRS 218A.410 (drug forfeiture).

Effective prevention and treatment of alcohol and other drug use can 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 affected by alcohol or drug use.

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, including:

- Restructuring the Plan and Budget process to include plans for substance use disorder treatment, including planning for services for individuals with co-occurring mental health and substance use disorders;
- Including language in required Plan and Budget forms that address having programming that is co-occurring capable;
- Rewriting SFY 2016 contracts with Regional Boards to include a requirement for all programs, established by CMHCs to be Co-Occurring Capable as measured by either the Dual Diagnosis Capability in Addiction Treatment (DDCAT) or Dual Diagnosis Capability in Mental Health Treatment (DDMHT) tools;

- Requiring in SFY 2016 contracts with Regional Boards that all regions hire at least 2.0 Full Time Equivalent (FTE) peer support specialists with lived experience in substance use disorders or co-occurring substance use and mental health disorders;
- Providing some workshops at Kentucky School (which has traditionally been designed for substance use disorder staff only) that focus on providing mental health training to substance use disorder staff and substance use disorder training to mental health staff. (e.g. Motivational Interviewing; Peer Support); and
- Contracting with Case Western Reserve University to provide training on Integrated Dual Diagnosis Treatment (IDDT) to all staff providing Assertive Community Treatment (ACT) services across the state.

Between SFY 2009 and SFY 2015, a team of integration specialists was developed by DBHDID to use DDCAT and DDMHT tools and to visit regional programming and assess co-occurring capabilities. All programs were offered the opportunity to use the data from their DDCAT/DDMHT 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 considered co-occurring capable. The DBHDID provided technical assistance during this time period, regarding change projects as well as DDCAT/DDMHT fidelity assessments. A Transformation Transfer Initiative (TTI) grant, as well as securing a national consultant (Heather Gotham, co-creator of the tools), were instrumental in supporting regions in working towards co-occurring capability in their programming for adults. DBHDID continues to provide technical assistance or help with fidelity assessments as requested.

As a result of these statewide assessments, it became clear that programs did not include many peer led mutual support groups. Mutual support and mutual aid groups are identified as one of the ten guiding principles of recovery from SAMHSA. DBHDID leveraged funds from the TTI grant and later from the block grant, for purposes of hiring an individual in recovery from co-occurring disorders to consult with DBHDID staff, regional staff and peers, and develop co-occurring mutual support groups in many regions across the state. Specifically, this individual in recovery assisted with development of Double Trouble in Recovery (DTR) mutual support groups across the state. DTR is a twelve-step self-help group that is facilitated by individuals in recovery from both mental health and substance use disorders. DTR is considered a best practice. At present, there are at least nine (9) regions that provide DTR as a support for individuals and more groups are continuing to develop. DBHDID continues to offer technical assistance and materials to assist with the development of this support across the state.

During the 2015 legislative session in Kentucky, HB 92 passed into law. This law created a licensure category for Clinical Alcohol and Drug Counselors (CADC) and created a Registered Alcohol and Drug Peer Support Specialist. These new categories were directed to be defined and placed under the CADC Board in Kentucky. As a new licensure category for providers, the Licensed CADC was included as a new billable professional in the new Medicaid state plan amendment for Kentucky that went into effect in 2014.

DBHDID has been working since SFY 2014 to implement Assertive Community Treatment as a service across the state for individuals with SMI. However, in working with ACT teams it became apparent that a large number of the individuals being served also had co-occurring substance use disorders. ACT teams have been ill prepared to provide good treatment to these individuals. In SFY 2015, the Department contracted with Case Western Reserve University to provide a series of training in Integrated Dual Diagnosis Treatment (IDDT), an evidence based practice that has been renamed Integrated Treatment for Co-Occurring Disorders by SAMHSA. Case Western provided three (3) separate training events in various parts of the state. Each training event consisted of three (3) days of training. All staff members of Assertive Community Treatment (ACT) teams across the state were trained in IDDT. At present, seventeen (17) ACT teams were trained in this model.

Kentucky has been training peer support specialists since 2006. However, initially, peers were only trained who were in recovery from mental health or co-occurring disorders. During the last few years, the DBHDID has been training peers in recovery from substance use disorders as well. When the new Medicaid state plan amendment was approved by CMS in January 2014, peer support was included as a billable service. The DBHDID changed the language in its peer support regulation to support training individuals in recovery from mental health, substance use or co-occurring disorders to become peer support specialists. Peer support for all populations is now a billable Medicaid service.

Goals/Objectives for SFY 2016/2017:

- To monitor the status of providing integrated care through co-occurring capable programs in the regions across the state;
- Continue to provide more cross training opportunities through Kentucky School and other training events, and more training on co-occurring topics in general;
- Continue to require the use of evidence based treatment practices, including Integrated Dual Diagnosis Treatment (IDDT);
- Provide technical assistance to ACT teams regarding IDDT through the use of fidelity assessments, consultations and continued training, until IDDT is implemented with fidelity through all ACT services;
- Increase the number of peer specialists in recovery from co-occurring disorders hired by providers and improve supervision and support for peer specialists who are employed; and
- Continue to support and facilitate new peer led mutual support groups.

Medical Services

Kentucky is a relatively unhealthy state and struggles with poor health outcomes overall. 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.

Under the umbrella of the Regional Boards are Community Mental Health Centers (CMHCs) that are required, during the intake process and at least annually thereafter, to assess the physical health of each individual served. 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 behavioral health care.

Several CMHC across the state have been working on integrating behavioral and physical health care. One CMHC in western Kentucky (Pennyroyal) received a SAMHSA grant to assist with developing primary care services within the CMHC in an effort to integrate care for adults with SMI. This funding consisted of \$500,000 over a four (4) year period, ending September 30, 2013. Pennyroyal created a separate entity called Pennyroyal Healthcare Services, to provide physical health care to individuals, and co-located behavioral health services. At present, a staff psychiatrist from Pennyroyal behavioral health is located at the healthcare center and provides behavioral health services. Targeted case managers for adults with SMI provide case management services to individuals receiving care from both centers. Pennyroyal Center has since received a New Access Point (NAP) grant from Health Services Resources Administration (HRSA), and Pennyroyal Healthcare Services (one clinic in Princeton, Kentucky and one clinic in Hopkinsville, Kentucky) has been designated as a Federally Qualified Health Center (FQHC).

One CMHC in Northern Kentucky (Comprehend) has received several integration grants over the years and has been working for several years with local medical providers to integrate behavioral health care through

co-location projects. As of SFY 2015 they have co-located staff at one local hospital and are working with two (2) other local hospitals and numerous local primary care providers regarding integrated care.

One CMHC in eastern Kentucky (Mountain) was awarded a grant in SFY 2013 regarding health care for individuals who are homeless. A "Homeplace Clinic" was located in the lower level of the CMCH outpatient clinic in Johnson County, a very rural location in Kentucky, and provides services to individuals from surrounding counties. These services began in November of 2012. This collaboration project has made an integrated, holistic approach possible for individuals served in this area. Services provided thus far include preventative care, disease management, basic laboratory services, health education, medication management, patient assistance programs, mental health and substance abuse services, as well as referrals to other medical providers for dental, vision, and specialized medical care. Referrals for behavioral health services require either a phone call or simply walking an individual down the hall. The current clinic team consists of a nurse practitioner, two nurses, three case managers, two support staff, program director and a consulting medical director. Mountain developed a Homeplace Clinic within the CMHC outpatient clinic in Floyd County, and is working to develop a clinic that will serve Lawrence and Pike Counties. They have also applied for funding for a clinic in Pike County that will focus on integrated care specifically for individuals with SMI.

Another region in Northern Kentucky (NorthKey) is working to integrate care for individuals with SMI during the fall of 2015. They are planning to convert some meeting space at an outpatient clinic to physical health examination rooms/offices and have hired a nurse practitioner with a specialization in primary care to staff the new clinic. They are working to educate existing staff on integrated care for the population. NorthKey already has collaborative agreements with a local hospital and the FQHC in their area to assure prompt referrals for specialty services. They have also received letters of agreement from the local health department and other community partners who have agreed to support the program with referrals. They plan to track health indicators such as blood pressure, smoking status, body mass index (BMI), etc.

With the expansion of behavioral health providers able to enroll as Medicaid providers, it is likely that those entities whose main function has been to provide physical health care will begin to provide behavioral health care. Local health departments, as well as FQHCs and Rural Health Clinics have been the offering a small amount of behavioral health care and may increase these services.

Dental Services

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.

Support Services (for Individuals in Recovery and Family Members)

Since the mid-1980s, the DBHDID has been convinced of the importance of involvement by individuals in recovery and family members in program development and service delivery. In February of 2011, the

DBHDID hired a full time Recovery Services Coordinator who is a self-identified individual in recovery from behavioral health issues.

In addition, the Department provides funds for a variety of statewide and local support initiatives for individuals in recovery and family members. 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 recommendations from individuals in recovery and family members to rewrite contracts to be awarded to statewide groups. Two (2) of these contracts, the Recovery Oriented Training and Technical Assistance contract and the Recovery Oriented Family Support Services contract 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 each of these contracts.

The Recovery Oriented Family Support Services contract was awarded to the National Alliance on Mental Illness (NAMI) Kentucky and the contract for SFY 2016 includes the following requirements:

- Provide a series of recovery oriented supports for family members across the state;
- Utilize established training modalities and implement other support groups across the state that are established as best and promising practices;
- Provide at least one (1) "Train the Trainer" session per year to individuals who are targeted to provide family support groups;
- Provide signature advocacy training across the state to NAMI affiliates as well as other organizations, that pertains to individuals with serious mental illness and their family members;
- Collaborate with other agencies and organizations with the goal of supporting improved and evidence based practices such as supported employment, stigma reduction and recovery;
- Assess regional needs with regards to mental health treatment and family member involvement and inclusion and diversity;
- Provide diversity awareness trainings to all NAMI affiliates and ensure all NAMI Kentucky recruiting and programming reflect principles of diversity;
- Maintain a NAMI affiliate in every CMHC region across the state;
- Provide at least monthly contact with all NAMI affiliates across the state in an effort to enhance community integration and inclusion and ensure coordination of family support services and outreach; and
- Maintain a mental health recovery listserv to promote health and wellness and to increase positive communication between stakeholders.

Since SFY 2012, NAMI Kentucky has maintained a NAMI affiliate in each CMHC region across the state. The most recent affiliate developed was in the Mountain region in Eastern Kentucky. NAMI Kentucky continues to provide an annual "Train the Trainers" for family support group facilitators and affiliates have provided dozens of Family to Family (NAMI signature family support) classes across the state, with hundreds of family members graduating. NAMI Kentucky continues to make contact with all affiliates with a monthly conference call, and has provided training across the state on ADMHT and other topics. NAMI Kentucky continues to assist with Individual Placement and Support (IPS) Supported Employment programs across the state by participating as a Kentucky IPS team member, and is instrumental in ensuring individuals in recovery and their family members are involved in the supported employment initiative. Several individuals from Kentucky have been sent by NAMI Kentucky to national training in support group facilitation. And over 2000 individuals from across the state have been included in a mental health listserv that is staffed by NAMI Kentucky.

During SFY 2015, NAMI Kentucky agreed to coordinate efforts for the DBHDID award of a Transformation Transfer Initiative (TTI) grant, related to utilizing peer support specialists in bridging services for individuals with mental illness transitioning in and out of psychiatric hospitals.

Goals for NAMI Kentucky for SFY 2016/2017 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;
- Increase the number of teachers and facilitators for NAMI signature programs;
- Enhance leadership in advocacy activities by providing advocacy training and opportunities to persons with serious mental illness and their family members;
- Working on growing and strengthening NAMI family advocates of the Individual Placement and Support (IPS) Supported Employment Team for Kentucky by strengthening communication and involvement of family advocates in the IPS initiative; and
- Increasing communication between family members, individuals with mental health disorders, and providers of mental health services, as well as promoting health and wellness for individuals by sending communications such as NAMI updates, information on various mental health topics, advocacy alerts and a quarterly newsletter to the public.

The Recovery Oriented Training and Technical Assistance contract was awarded to the National Alliance on Mental Illness (NAMI) Lexington affiliate, and initially required the development of a Technical Assistance Center for individuals in recovery and the provision of recovery oriented trainings across the state. Stakeholders were gathered from across the state, including individuals in recovery, family members and providers, and consensus was developed regarding formation of Kentucky System Transformation, Advocating Recovery Supports (KYSTARS), a training and technical assistance center focusing on statewide recovery oriented mental health services.

The contract for SFY 2016 includes the following requirements:

- Maintain the statewide training and technical assistance center with the goal of incorporating recovery principles throughout the public mental health system;
- Provide statewide evidence based recovery oriented training and support activities for individuals in recovery including Wellness Recovery Action Plan (WRAP) trainings, support groups, Advance Directive for Mental Health Treatment (ADMHT) training, education and skill building for individuals in recovery, etc.;
- Assess statewide needs regarding mental health recovery;
- Conduct at least two (2) Leadership Academy trainings across the state;
- Provide a statewide recovery oriented conference annually;
- Provide recovery oriented training for staff of Regional Boards and state psychiatric facilities; and
- Provide technical assistance to all programs with start-up funds to develop consumer operated service programs (COSP).

KYSTARS is located within Participation Station, one of the first peer run centers in Kentucky. During SFY 2012, after the SAMHSA COSP toolkit was developed, KYSTARS assisted Participation Station in adopting and implementing the Consumer Operated Service Toolkit with fidelity. Participation Station uses the Fidelity Assessment Common Ingredients Tool (FACIT) to measure fidelity and the Peer Outcomes Protocol (POP) to measure outcomes. Both of these instruments are from the SAMHSA toolkit. This experience by

KYSTARS led the DBHDID to contract with KYSTARS to provide technical assistance to all newly developed COSPs across the state.

The COSPs typically provide a drop-in service, psychoeducational groups, support groups and other new and frequently innovative peer support services. During SFY 2014/2015, KYSTARS provided educational classes and technical assistance in implementing and developing policies and procedures, form development, grant writing and fundraising, program evaluation, and other issues, to the COSPs across the state.

During SFY 2014/2015, KYSTARS conducted a comprehensive training needs assessment for four (4) regions awarded start-up funds for COSPs. This needs assessment focused on four (4) primary areas that were determined critical to a COSPs success and sustainability: 1) Safety; 2) Recovery Philosophy; 3) Group Process; and 4) Leadership. This needs assessment corresponded with baseline fidelity reviews of each COSP. Fidelity for the COSP was measured through the Fidelity Assessment Common Ingredients Tool (FACIT), part of the COSP toolkit from SAMHSA. The methodology of this needs assessment consisted of interviews with program directors, program leaders, and participants in each program, examination of training records as available, and FACIT reviews. Results determined training needs for each program, with regards to the primary areas measured. All programs were determined to have a need for safety training, such as skills in handling safety issues for individuals experiencing a mental health crisis. Potential training identified in this area included Mental Health First Aid, Non-violent Crisis Prevention and Intervention, Question, Persuade and Refer, Cardio-Pulmonary Resuscitation, and First Aid. With regards to Recovery Philosophy, 60% of the programs were found to have a need for refresher training on recovery orientation and principles of recovery. While each program was found to have some recovery principles at the heart of programming, some recovery principles were not clearly demonstrated in all programs. With regards to Group Process, it was determined that 80% of the programs could benefit from training on group dynamics and Wellness Recovery Action Planning (WRAP) facilitation. With regards to Leadership, it was determined that 80% of the programs could benefit from training on administrative skills to assist with better everyday operations and sustainability.

As a result of this needs assessment, KYSTARS included a tract of workshops, specifically designed for individuals in recovery working at COSPs in their annual conference that occurred in May of 2015.

During SFY 2014/2015, KYSTARS provided education and technical assistance to individuals admitted to state psychiatric facilities, individuals in treatment at Regional Boards, staff of two (2) state psychiatric hospitals, staff of Regional Boards, and to peer support specialists and leadership academy graduates.

During SFY 2014/2015, KYSTARS provided four (4) Leadership Academy trainings across the state. The Leadership Academy is a three (3) day educational program for persons in recovery from 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. 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.

In addition, KYSTARS 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. KYSTARS revised an existing curriculum and developed the KYSTARS Recovery Support Group, a general recovery

based group targeted individuals with SMI. Groups have developed across the state and KYSTARS provides some financial assistance in the form of stipends and training for facilitators.

KYSTARS has presented a statewide recovery conference each year since SFY 2011. This conference is always very well attended by individuals in recovery across the state, including peer support specialists, individuals working in COSPs, and other individuals in recovery. In SFY 2014, the annual conference was attended by approximately four hundred (400) individuals. There was a specific tract offered for continuing education for peer support specialists. The conference in SFY 2015 was attended by approximately four hundred (400) individuals and included a tract for providers who work with or support peer support specialists, which included providers who are involved with COSPs. In addition, beginning in SFY 2014, KYSTARS solicited a sponsor for an awards banquet, and began recognizing exemplary peers from across the state through Kentucky Peer Excellence Awards, where an award is presented to one peer in each region across the state. In addition, one award is provided for a peer that is recognized as having a Lifetime of Achievement in peer support and one award is provided for a person identified as a Supporter of peers. The Lifetime of Achievement award is named after Molly Clouse, who received the first award in May of 2014. Molly is a peer support specialist who has been instrumental in operationalizing peer support in Kentucky and has spearheaded recovery based legislative changes. Kentucky Peer Excellence Awards continued in SFY 2015, with a ceremony occurring the evening before the annual conference.

KYSTARS maintains a functional website as a resource for recovery based programming in the state, to share programs and support groups, recruit new peer support specialists and educate the public. KYSTARS has experienced significant annual growth in website usage and has plans to expand their online support component.

Goals for KYSTARS for SFY 2016/2017 are to continue to provide the required elements of their contract with DBHDID, while continuing to expand recovery informed services across the state in a variety of ways.

Kentucky Peer Specialist Training is a thirty (30) hour intensive training program for persons in recovery from a mental health, substance use or co-occurring mental health and substance use disorder. The training program in Kentucky was traditionally modeled after the Georgia and South Carolina models of Peer Support. The training prepares individuals in recovery to provide peer support services to other individuals in the behavioral health service system.

In January of 2014, a new Medicaid state plan amendment was approved by CMS. Included in this package of newly billable services was peer support. In addition, due to Medicaid Expansion in Kentucky and a workforce capacity study by Deloitte in May of 2013, the network of behavioral health providers through Medicaid was expanded in Kentucky as well. Due to the overwhelming number of potential behavioral health providers, many changes have taken place.

The manner in which individuals in recovery receive certification training to become billable peer support specialists has changed into the following model:

- A curriculum rubric has been developed by the DBHDID, outlining the required thirty (30) hours of training, based on the core competencies listed in the Medicaid state plan amendment and subsequent regulations;
- Agencies across the state will be able to submit curriculum, based on the rubric, for approval by the DBHDID;
- Once approved, agencies may provide their own certification training for peer support; and
- Agencies are required to submit names and numbers of peer support specialists who are certified.

Kentucky is now able to provide three (3) types of peer support that is billable through Medicaid: adult peer support; youth peer support; and family/parent peer support. Each type of peer support is representative to

individuals with lived experience in either mental health, substance use, or co-occurring mental health and substance use disorders.

During SFY 2013, the DBHDID decided to provide start-up funding to Regional Boards to begin development of Consumer Operated Services Programs (COSP) in various regions. These COSPs would be required to meet fidelity of the SAMHSA Consumer Operated Services toolkit. The DBHDID issued a Request for Application (RFA) process to establish COSPs in four (4) regions during SFY 2013 (Communicare; Lifeskills; Mountain; and Four Rivers). Participation Station in Lexington, Kentucky, and the Personal Involvement Empowering Recovery (PIER) program in Northern Kentucky existed prior to this RFA process. During SFY 2014 and 2015, three (3) additional Regional Boards were awarded start-up funds for COSPs (Seven Counties; NorthKey; and Pathways). All new programs are continuing to work on development and strive towards fidelity. After peer support became a billable service, many regions began working toward making these programs billable as a peer support service.

The DBHDID and the Regional Boards encourage the participation of individuals in recovery family members in planning, evaluating, and service delivery. Priorities for SFY 2016/2017 include:

- Continue to encourage the involvement of individuals in recovery and their family members in the Behavioral Health Block Grant planning process and other DBHDID planning events;
- Continue to design and support statewide programs, trainings, and outcome measures that incorporate recovery principles;
- Continue to require the hiring of peer support specialists across the state;
- Develop more education and support for peer support specialists who are employed, through supervision training and continued training in recovery principles;
- Support the existing COSPs, ensuring fidelity to the SAMHSA model as well as ensuring a recovery oriented service in communities across the state; and
- Continue to support the development of additional peer run services in a manner that is sustainable;

While the DBHDID and the Regional Boards have come a long way in fostering involvement by individuals in recovery and family member in planning, evaluation, and service delivery, many challenges remain, including:

- Not enough access to peer run programming;
- Lack of education and understanding for providers regarding impact and importance of recovery oriented services, including peer support;
- Limited support for individuals providing peer support as a service;
- Few programs that fully incorporate recovery principles; and
- Transportation barriers for individuals to attend meetings and other events.

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 serious mental illness who are involved in the criminal justice system, by collaboration between KDBHDID, law enforcement agencies, 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 (nine) 9 years and has successfully diverted thousands of individuals into care. In SFY 2014, 96 (ninety-six) Louisville Metro Officers received CIT certification. The total number of Louisville Metro Officers trained to date is nine hundred, eighty-eight (988), and represents over 50% their total police force. Their goal is to make sure at least one (1) CIT trained officer is on each shift in each division of the city. 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 boards to operate post-booking interventions to divert many individuals 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 Bureau of Justice Assistance 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 (ACT). Programming continues to include: Illness Management and Recovery (IMR), Integrated Dual Diagnosis Treatment (IDDT), and 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 are trained in a "model curriculum" and expected to train the staff in their local jails. In addition to this training, Regional Boards are encouraged to improve their working relationships with the local jails to assure mental health needs are 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. KDBHDID has budgeted \$1,200,000 for SFY 2016, the program has more than doubled in size and scope since SFY 2014. Regional Boards have entered into formal agreements with local jails in eighty-six (86) 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 2016/2017 is to continue to expand CIT trainings throughout the state, and to create regional Crisis Advisory Committees in the two regions that don't currently have them. In SFY 2014, two hundred, ninety-nine (299) Kentucky Law Enforcement Officers, outside of Jefferson County, received CIT certification. Over one thousand, nine hundred, forty-four (1,944) Kentucky law enforcement officers (including sheriff's departments, local police departments, state police officers, etc.), outside of Jefferson County, have been trained as members of Crisis Intervention Teams since the program's implementation. Twelve of fourteen regions to date have CIT Advisory Committees, with trainings scheduled in the remaining

two areas in the fall of 2015. CIT Advisory Committees 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-integration project, partially funded by block grant funds. This program allows for strategic planning and case management for inmates with serious mental illness who are exiting Kentucky prisons and returning to their communities. The Boundary Spanner project employs a re-integration 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. In SFY 2014, twenty-six (26) individuals with serious mental illness received intensive case management services. 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.

DBHDID also provides 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. An individual in recovery from a behavioral health disorder participates as an instructor in this training.

Other projects that the Department is involved in include a diversion program being led by the Kentucky Department for 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 includes individuals within the Department of Corrections' Correctional Psychiatric Treatment Unit (CPTU), an all-male unit within the Kentucky State Reformatory and the Psychiatric Care Unit (PCU), an all-female unit within the Kentucky Correctional Institute for Women, who are serving out or being paroled, to be designated as a priority population by the Regional Boards. This will allow high risk individuals who are serving out or being released from the CPTU and PCU to be seen within fourteen (14) days of release at a CMHC for mental health services. By designating this group a priority, the goal is that this population can maintain a stable lifestyle in the community after incarceration. KDBHDID's Adult Mental Health Services and Recovery 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 2016/2017 are to continue to collaborate with state and local behavioral health, housing, employment, peer support, community based services, kynect (Affordable Care Act), and physical health 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. Another goal is to continue to provide Mental Health 101 training to law enforcement officers through DOCJT.

Services to Persons who are Deaf and Hard of Hearing

"The need and right to communicate is the most fundamental of human rights. To deny it is to harm the human spirit; to foster communication is to reveal all of the possibilities of life." –Lawrence Siegel, 2000

“Psychiatry is unique among the medical fields in that most of the symptoms are conveyed by or through communication, and communication is also the primary method and nature of treatment.” –Robert Pollard, Ph.D.

Availability of direct services in American Sign Language (ASL) to individuals who are Deaf decreased in the past two years with the loss of one .2 FTE at Seven Counties Services. In the CMHC system, there are currently four (4) therapists who are Deaf or fluent in ASL and one (1) part-time case manager who specializes in work with the population. Despite the Medicaid provider network expansion during SFY 2015, no new providers have been identified to develop or sustain private services.

Efforts have focused on improving the quality and availability of a trained workforce, addressing the unique needs of individuals who are Hard of Hearing, and using the System of Care approach to bring together traditional Deaf-Services providers with those serving in state agencies and partner organizations.

Highlights:

- A Deaf and Hard of Hearing Services (DHHS) “Point Person” is now required as part of each contract with the Regional Boards.
- Seven (7) additional interpreters have completed Mental Health Interpreter Training in Alabama.
- Five (5) AmeriCorps members completed 1,873 service hours before funding was eliminated.
- One (1) Master’s level psychologist completed an internship at the Kentucky School for the Deaf with a stipend from the department and earned his degree.
- The Kentucky Initiative for Collaborative Change (KICC) sponsored a Deaf and Hard of Hearing services track at the 2015 System of Care Conference. For the first time, providers from the Statewide Educational Resource Center on Deafness, Commission for Children with Special Healthcare Needs, Commission on the Deaf and Hard of Hearing, Lexington Speech and Hearing Center, Vocational Rehabilitation, Department of Community Based Services, and Community Mental Health Centers came together to address systems issues in serving the population. Relationships were generated and renewed and partnerships were developed.
- The DHHS Program Administrator was appointed to the Early Hearing Detection and Intervention (EHDI) Statewide Advisory Committee providing a voice on the impact of hearing loss on social and emotional development and opening doors to collaboration with audiologists, speech language pathologists, early interventionists, and researchers at universities.
- A partnership with the KentuckyOne Health Culture and Language Services department has led to joint trainings for interpreters, shared resources, and creative problem-solving for Deaf individuals with limited resources for discharge. Ongoing collaboration to address the lack of a specialized acute unit for individuals who are Deaf is planned.
- A monthly support group for individuals who are Hard of Hearing has been offered continually since April 2014.
- The first two classes of Mental Health First Aid in ASL were offered in June 2015 as a means to educate non-mental health-focused Deaf Services providers and to reduce stigma in the Deaf community.

Plans for FY2016-FY2018

The Advisory Committee on the Need for Services for Individuals who are Deaf or Hard of Hearing would like the DBHDID to focus on the following:

- Reviewing the use of department, state general, and federal block grant funds to focus on supporting direct services in ASL and purchasing services that are non-billable under Medicaid but necessary to the cultural and linguistic integrity of equal service provision for the Deaf community;
- Supporting the ongoing efforts of the Hearing Loss Association of America through sponsoring Michael Harvey and additional scholarships at the 2015 World of Resources conference;
- Offering Mental Health First Aid to interpreters and to the Hard of Hearing community using CART (Computer Assisted Real Time captioning);
- Re-applying for AmeriCorps positions for the SFY 2016 service year;
- Advocating for an increase in staffing for DHHS within the Department; and
- Focusing on holding contracted agencies accountable for ensuring effective communication at all points of service.

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 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). 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 behavioral healthcare system to provide a continuum of care for those individuals being served.

Targeted Case Management Services

Targeted case management is an essential Community Support Service because it individualizes and coordinates an individual's array of services and supports and makes maximum use of available formal and informal services and supports received. Targeted case management has been available through Regional Boards since 1985 and was first covered by Kentucky Medicaid in 1991. Adults with serious mental illness who have the greatest difficulties accessing resources and those with more intense service needs are targeted by this service. 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). DBHDID has historically provided training and certified all targeted case managers in the state for adults with SMI and Children with SED but with the provider network opening, the role of the Department as the body responsible for certifying targeted case managers is changing. More information is provided in Criterion 5.

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

- The Division of Behavioral Health designates a statewide coordinator of targeted case management services for adults with SMI;
- KDBHDID approves curricula for agencies so they may provide their own certification training for targeted case managers to allow the provision of billable Medicaid services; and

- The KDBHDID provides additional training opportunities for case managers and case management supervisors.

Targeted case management services are available in all 120 of Kentucky's counties. During SFY 2014, targeted case managers employed by Regional Boards provided support to 7,534 individuals with serious mental illness.

Other Activities Leading to the Reduction of Hospitalization

CONTINUITY OF CARE

The Department believes that addressing the issue of continuity of care through a well-planned aftercare process is key to ensuring a successful transition from the hospital to the community. Providing appropriate aftercare following a hospital stay is critical to reducing readmission rates, and improving quality of life. Through contract, the Department requires a Regional Board to provide an outpatient appointment for adults with SMI within fourteen (14) calendar days of discharge from a state psychiatric facility. KDBHDID also requires the assignment of a targeted case manager and provision of targeted case management services to adults with serious mental illness who are discharged from a state psychiatric facility within fourteen (14) calendar days. Since SFY 2013, the DBHDID contract language with the Regional Boards has also included a requirement that individuals within the Department of Corrections' Correctional Psychiatric Treatment Unit (CPTU), an all-male unit within the Kentucky State Reformatory and individuals within the Psychiatric Care Unit (PCU), an all-female unit within the Kentucky Correctional Institute for Women, who have SMI and are serving out or being paroled, have an outpatient appointment within fourteen (14) calendar days of release.

The fourteen (14) 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. Continuity of Care meetings occur quarterly within each state operated/contracted psychiatric hospital, and include DBHDID staff, CMHC staff, other community partners, as well as hospital staff, in order to facilitate collaboration between the hospitals and the Regional Boards. The agenda for each meeting includes the following system wide issues:

- Admission and discharge processes;
- Community Medications Support Program;
- Olmstead planning;
- Continuity of care systems issues;
- Consumer issues;
- DBHDID Performance Indicators; and
- Other issues requested as they may arise among participants.

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

The DBHDID 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.

In May of 2015, DBHDID leadership convened a continuity of care summit, "Bridging the Gap", which included state psychiatric staff, CMHC staff, DBHDID staff and others. This summit focused on creating a "warm hand-off" approach for behavioral health care and the development or reaffirmation of policies and procedures that address this issue. Participants were challenged to develop a regional action plan that outlined the next steps for improving continuity of care.

Also in SFY 2015, the DBHDID was awarded the Transformation Transfer Initiative (TTI) grant to focus on working with state psychiatric facilities and Regional Boards to create partnerships in providing peer support at many levels in order to enhance continuity of care and bridge the transition in and out of higher levels of care.

The DBHDID also monitors the Kentucky Olmstead Initiative in each of the four state operated/contracted psychiatric hospital regions. Transition teams comprised of representatives from the hospital, the Regional Board, DBHDID staff, and other community stakeholders meet monthly to review transition plans that assure a smooth and timely discharge to the community for individuals identified through Olmstead. State General Funds are appropriated each year to each state hospital catchment area specifically for the Olmstead initiative. These funds are for individualized and specialized wraparound services to assure the community tenure for each Olmstead individual. Kentucky's statewide Olmstead Plan is in the process of being updated and is currently involved in obtaining comments from the public.

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 serious mental illness (SMI) 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;
- Crisis Intervention Services;
- 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, thirteen (13) of the fourteen (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).

In January of 2014, a Medicaid State Plan Amendment was approved which included crisis intervention services, mobile crisis services, and residential crisis stabilization programs as Medicaid billable services. Regions have been adjusting to this change and working to develop programming that meets the required standards.

The fourteen (14) 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 twenty-four (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 twelve (12) 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 nine (9) 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 individuals they serve, without disruption. Several regions 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. Substance abuse detoxification programs and substance abuse residential treatment programs were added as newly billable services in the Medicaid State Plan Amendment approved in January of 2014. This has allowed for a better service array for individuals with co-occurring substance use disorders.

The goals for SFY 2016/2017 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 individual in need a warm hand-off to that level of care. Regional boards in three (3) urban areas are 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 emergency room.
- 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. To date the Jail Triage program provides emergency mental health services to eighty-six (86) county jails in Kentucky.
- 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.

In January of 2014, a new Medicaid state plan amendment was approved by CMS. A new package of billable services for Kentucky was established. Regional Boards, through contracts with DBHDID, have been recreating the system of care for adults with SMI by developing newly billable services such as Assertive Community Treatment and peer support. Three (3) levels of crisis services became Medicaid billable as well as outpatient and residential service for individuals with substance use disorders. In addition, Kentucky adopted Medicaid Expansion through the Affordable Care Act and opened the network of behavioral health providers to include agencies other than CMHCs. Regional Boards have also been adjusting to Managed Care. Kentucky now contracts with five (5) Managed Care Organizations for behavioral health services and each Regional Board must develop contracts and negotiate with each company regarding procedures, processes and reimbursement rates. DBH leadership has been making efforts to clarify reimbursement procedures and improve relationships between stakeholders across the state.

Continuity of care is a major priority for the Department. Challenges include:

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

A project entitled DIVERTS (Direct Intervention: Very Early Treatment System) was implemented in the Western State Hospital Catchment area beginning in SFY 2007, as a partnership between the DBHDID, the four (4) respective Community Mental Health Centers (CMHC) in that catchment area, and the National Alliance on Mental Illness (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 (4) Regional Boards serving that hospital catchment area.

In August of 2013, the Cabinet for Health and Family Services entered into an Interim Settlement Agreement (ISA) with Kentucky Protection and Advocacy to avoid litigation concerning the institutionalization of individuals with SMI who resided in personal care homes. Estimates of individuals impacted under this agreement range as high as 2,300 statewide, with an original list of expressers (persons expressing their desire to live in the community) of approximately 130 people. Since that time, concerted efforts have been taken to establish a new and expanded service delivery system for adults with SMI that include ACT services, targeted case management, supported employment, supportive housing and peer support. The Adult Mental Health Services and Recovery Branch underwent a major reorganization in an attempt to better focus energies on developing these services across the state. In addition, agreements with the Department for Aging and Independent Living (DAIL), Department for Community Based Services (DCBS), and other agencies have been instrumental in developing necessary infrastructure for the ISA project.

DAIL, which includes the state guardianship office, has provided multiple training and technical assistance regarding individuals under the ISA who have been assigned state guardians. DCBS rewrote state supplementation guidelines and now the state supplement that traditionally supported individuals with SMI in personal care homes, now support the same individuals in their own home in the community.

As of January 2015, hospitals and other entities were able to directly refer individuals who were either living in personal care homes or at risk of being placed in personal care homes, through a web based data tracking system. At the end of SFY 2015, referrals in the tracking tool number over 1,000 persons who are awaiting transition to a community setting.

The original funding that had gone to Regional Boards in the Western State Hospital Catchment area was redirected to create services for the ISA population. In addition, during SFY 2014, approximately five (5) million additional dollars were reallocated from the state psychiatric facility budget to provide funding for community ISA services. At least six (6) million dollars of reallocated funding is guaranteed for ISA through SFY 2016. Discussions are taking place to possibly provide funding on a more permanent basis for this project.

During SFY 2014, the DBHDID redesigned contracts with Regional Boards to include the new package of services for adults with SMI. This package of services was called DIVERTS, but now included a very specific population with specific services across the state, not just in the western part of the state.

Regional Boards were required to develop ACT teams, hire peer support specialists, hire supported employment specialists and hire housing coordinators to provide services through DIVERTS. As ACT and peer support have become Medicaid billable services in Kentucky, Regional Boards have been adjusting to changes in reimbursement. National recognized experts and consultants were brought to Kentucky by DBHDID and were utilized across the state in implementation efforts through training, technical assistance and fidelity assessments. Full implementation efforts continue.

At the end of SFY 2015, two (2) state psychiatric hospitals were showing a substantial reduction in admissions. One (1) state psychiatric hospital in western Kentucky serves a largely rural population and appears to be trending towards a reduction in admissions. One (1) state psychiatric hospital in central Kentucky opened in a new facility in 2014 and is experiencing an upward trend in admissions, particularly because of an influx in admissions from the northern part of the state.

Goals for SFY 2016/2017 are to continue to strive for full implementation of all services across the state for individuals with SMI. The DBHDID intends to continue providing technical assistance in the form of national consultants, trainings, fidelity monitoring, data tracking systems and performance based contracting. Also, the DBHDID would like to see dedicated funding for the ISA.

The following addresses **Criterion 1b: Children with SED: Comprehensive Community Based Mental Health Services as required in the federal legislation.**

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;*
- *Educational services;*
- *Housing services;*
- *Substance abuse services;*

- *Services for persons with co-occurring (substance abuse/mental health) disorders;*
- *Medical and dental services;*
- *Support services;*
- *Services provided by local school systems under the Individuals with Disabilities Education Act;*
- *Case management services; and*

HEALTH, MENTAL HEALTH AND REHABILITATION SERVICES

Continuity of care between the physical healthcare system and the behavioral healthcare system is imperative if we are to adequately address and improve the overall health of children, youth and families. Regional Boards are required to conduct a physical health screening of all clients served. Department staff continues to assist contracted providers in improving tools used to assess physical health concerns and to encourage further assessment and integration of physical and behavioral healthcare. Behavioral health screening and referrals are also more commonplace in primary care clinics at the insistence of insurers.

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 2016 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:

- The CMHCs employ 359 Service Coordinators to provide targeted case management to children and adolescents with SED;
- Five of the fourteen regions offer Day Treatment 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;
- Five regions employ a certified Youth Peer Support Specialist; and
- Ten of the 14 regions employ at least one certified Family Peer Support Specialist (total of 29.75 FTE certified Family Peer Support Specialists)

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 support 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. There is currently vast change occurring in the Children’s Targeted Case Management program and there are plans in SFY 2016 and 2017 to train and certify at least 100 Targeted Case Managers and supervisors in the nationally recognized Wraparound model. The table below represents an overview of the Available Services Array for Children provided by each of the fourteen Regional Boards across the state. *Note that an “x” denotes the service is available in at least some area of the region and “0” means that it is not available in that region. Many regions have multiple providers/sites where the services are available.*

Children's Array of Services: Service Availability by Region for SFY 2016

Regions	1	2	3	4	5	6	7	8	10	11	12	13	14	15
Screening	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Assessment	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Psychological Testing	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Outpatient Clinical: Individual	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Outpatient Clinical: Collateral	x	0	x	x	x	x	x	x	x	x	x	x	x	x
Outpatient Clinical: Group	x	0	x	x	x	x	x	x	0	0	x	x	x	x
Outpatient Clinical: Family	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Psychiatric Services (provided by a Child Psychiatrist-with at least one year of specialized child training)	x	x	x	x	x	x	x	x	0	x	x	x	x	x
School-Based Services	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Intensive In-Home Services	0	0	x	0	x	x	x	0	x	x	x	x	x	x
Intensive Outpatient Program (IOP)	x	0	x	x	x	x	x	0	x	0	0	x	x	0
After School Program	0	0	0	0	x	0	0	0	0	0	x	x	0	0
Day Treatment Program	x	0	0	0	x	x	x	0	x	0	0	0	0	0
Partial Hospitalization	x	0	x	0	x	0	0	0	0	0	0	0	0	0
Mental Health/Substance Use Integrated Clinical Services	x	x	x	x	x	x	x	x	0	x	x	x	x	x
Specialized Summer Program	0	x	0	x	x	x	x	0	x	x	x	x	x	0
Comprehensive Community Support Services	0	0	x	x	0	x	x	0	x	0	x	0	0	0
Youth Peer Support	x	0	x	x	0	0	x	0	x	x	0	x	0	0
Parent/Family Peer Support	0	0	x	x	x	x	x	0	x	x	x	x	0	x
Respite Care	0	0	x	x	x	x	0	0	0	x	x	0	0	0
Service Planning	x	0	x	x	x	x	x	x	x	x	x	x	x	x

Targeted Case Management	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Therapeutic Foster Care	0	x	x	x	0	0	x	0	0	x	0	0	0	0
Other, Please specify		x		x		x								x

- Region 2 Other=Wraparound and Therapeutic Support Services
- Region 4 Other= Therapeutic child support
- Region 6 Other= Passport Intensive Wraparound is available for Committed Kids in Jefferson.
Services for Henry & Trimble are available at Oldham.
- Region 15 Other=Kids Recovery Grant

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.

KDHBID 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

KDHBID 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.

Psychiatric Inpatient Utilization - Statewide - Children 0-17 Years of Age						
Calendar Year	Licensed Beds	# of Psy Beds	Admissions	Inpatient Days	ADC*	ALOS**
2013	N/A	625	9,867	126,963	348	12.5
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

* ADC= Average Daily Census

**ALOS = Average Length of Stay

Educational Services (Including Services Provided by Local School Systems Under IDEA)

DBHDID 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 a true partnership that links the schools, family and children’s services, community mental health, juvenile justice, private providers, and institutions of higher learning. To accomplish the mission, all members of this statewide partnership must exemplify and publicly promote collaborative relationships with its partners and other associates.

School-Based Behavioral Health Screening Initiative

In January 2014, Attorney General Jack Conway announced legal settlements with two pharmaceutical companies totaling \$32 million. The funds have been used to expand substance use treatment throughout Commonwealth, including \$1 million for the Division of Behavioral Health (DBH) to implement school-based screening in collaboration with the Kentucky Department of Education (KDE) to intervene with students facing behavioral health challenges. The overall School-Based Behavioral Health Screening Initiative’s goal is to help schools recognize when a student might be showing signs of a behavioral health need, respond to that student

appropriately, refer them to a designated trained school-based screener for screening, and then based on identified need, refer for services, supports or further assessment, when appropriate. This initiative is currently being expanded across the state.

Project AWARE (Advancing Wellness and Resilience in Education)

In 2014, Kentucky's Department of Education was awarded a federal grant to address violence prevention and behavioral health promotion. The resulting program, designed to train school staff to identify students' behavioral health needs and to increase effective communication between school staff and behavioral health providers, is being piloted in three of the state's largest school districts. Kentucky's program includes an emphasis on Trauma-Informed Care, promoting this via learning collaboratives. The management team includes members from several different agencies including DBHDID and also includes young adult and family members with lived experience.

Targeted 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. DBHDID is currently working with providers to further enhance the implementation of Wraparound with high fidelity to the nationally recognized model and is allocating considerable resources to realizing this goal in the next two to three years.

Team Observation Measure

DBHDID has included the Team Observation Measure (TOM) as a CMHC contract deliverable for targeted case management for SED since SFY 2013. 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.

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). Since that time, the newly approved Medicaid State Plan Amendment makes services available to Medicaid eligible children/youth through the behavioral health benefit package.

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.

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 KDHDID 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's Crisis Services

Crisis stabilization programs are an integral 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 to ensure a viable safety net for all Kentucky children/youth in psychiatric crisis.

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 Units
- Intensive In-home Services
- Walk-in Crisis Services (Clinic based)
- 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. Additional information is available in the Environmental Factors # 15 of this application.

*The following addresses **Criterion 3a: Children with SED – Integrated Systems** (There is no Criterion 3 for Adults with SMI) as required by the federal legislation.*

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.*

Kentucky's State Interagency Council for Children

July 2014 brought about statutory changes in language regarding the name and role of the State Interagency Council. Previously known as the body responsible for the infrastructure associated with services for children with SED, the role broadened to include children with or at risk of developing behavioral health needs. The council's name changed from the State Interagency Council for Service to Children with an Emotional Disability to the State Interagency Council for Children. KDBHDID continues to promote activities that build the infrastructure for coordinated and integrated services for children under the purview of the State Interagency Council, 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 (SIAC) is a group of representatives from the primary child-serving agencies, a parent of a child with an emotional disability, and a youth with lived experience receiving services as a child with an emotional disability, who maintain and oversee a framework of collaborative services for children with or at risk of developing a behavioral health need. With the broadening of the language and concurrent changes to the Juvenile Justice System through SB200, additional opportunities for screening, assessment, and referrals for children and youth to receive behavioral health services have manifested. Kentucky's System of Care for children with or at risk of developing behavioral health needs has expanded to reach more children and youth through school based, child welfare, and diversion programming.

During FY 2015, the SIAC adopted an updated governance structure. Five design teams were formed to develop action-oriented recommendations to operationalize implementation of Kentucky's System of Care redesign and expansion. Design Teams included: Cabinet Leadership/ System Structure and Governance; Finance and Resource; Continuous Quality Improvement; and, Service Array. Design Teams submitted recommendations to SIAC and all were adopted, including establishing five Standing Committees based upon the four original Design Teams, adding a Training and Technical Assistance Standing Committee, and expanding membership on the committees to partners throughout Kentucky, above and beyond SIAC member agencies.

There are eighteen Regional Interagency Councils among the fourteen Regional Board service areas which operate 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 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.

The behavioral health system redesign continues into to FY2016 by expanding the charge of the RIACs, and LIACs to regional and local loci of accountability for SIAC. The regional and local councils will focus on tasks and projects related to system-level consultation, system-level continuous quality improvement, System of Care expansion, and promotion of System of Care. Training, technical assistance, and site visits will provide opportunities for RIAC and LIAC members to acclimate to a second generation model for Kentucky's System of Care.

Composition of Interagency Councils for Services for Children

SIAC Representative	Domain	RIAC Representative
Parent of a child with a severe emotional disability	Family Members	Parent of a child with a behavioral health need who has received state-funded services
Commissioner, KDBHDID	Behavioral Health	Director of Children's Services, Regional MHMR Board
Commissioner, Department for Community-Based Services (DCBS)	Child Welfare	Service Region Administrator or Regional Specialist, 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, Division of Juvenile Services, Administrative Office of the Courts	Courts/Diversion	Court Designated Worker selected by local district judges
Director, Family Resource and Youth Services Centers (FRYSCs)	Prevention and Early Intervention	FRYSC Directors or Coordinators who are located 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 state funded mental health services for an emotional disability

Executive Director, Commission for Children with Special Health Care Needs	Health	Not mandated
Executive Director, Office of Vocational Rehabilitation Workforce and Development Cabinet	Vocational Rehabilitation	Not mandated
Council on Postsecondary Education	Postsecondary Education	Not mandated

The collaborative nature of the state, regional, and local councils allow opportunities to problem-solve within a multidisciplinary context in which representatives are able to share expertise from their unique perspective. RIACs and LIACs are staffed by a Regional Board employee, the IMPACT Local Resource Coordinator (LRC). Historically the LRC has also served as the IMPACT program manager where they have had responsibilities for supervising targeted case managers utilizing the wraparound approach. Moving forward, the LRCs duties will focus primarily on system of care expansion tasks and projects, ensuring each council has the resources and tools necessary to be successful, and to serve as the primary mode of communication between SIAC, RIACs, LIACs, and the community.

Social Services

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). 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.

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 has met for years 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. However, there has not been a meeting in quite some time and the future of this group is uncertain at this time.

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

After two year of study by the bi-partisan Unified Juvenile Code Task Force (with assistance from the Pew Charitable Trusts), resulting legislation (Senate Bill 200, passed in 2014), continues to substantially overhaul Kentucky's juvenile justice system. One overarching aim of the legislation is to reduce the incarceration of children younger than 18 charged with noncriminal "status" offenses, such as skipping school or running away from home, by steering more young offenders into community-based assessment and treatment, while also discouraging recidivism rates and a path toward adult incarceration. Under the new law, before cases are referred to the county attorney, court designated workers must use evidence-based tools to screen and assess youth and make referrals for appropriate services. The reforms are expected to reduce the number of status and public offenders entering the court system. Reportedly, some Kentucky judges were sentencing such nonviolent offenders to detention centers, where they were housed with young people who have committed serious crimes. In 2010, for example, 1,541 youths were locked up in Kentucky for status offenses.

SB 200 requires new and amended law and policy for a number of child serving agencies including the Administrative Office of the Courts (AOC), the Department of Juvenile Justice (DJJ), the Justice and Public Safety Cabinet, the Cabinet for Health and Family Services (CHFS), and most especially the Kentucky Department for Education (KDE), and 173 local school districts (total of 1,233 public schools). Institutions such as the Courts, social services, and correctional facilities have uniform policies and procedures across the state, but Kentucky's public schools are not controlled or managed by a single administrative body.

The task force met for two years with juvenile justice and social service workers, court officials, school officials and other stakeholders and now an oversight council has been formed to manage implementation of the bill. The bill requires increased data collection on juvenile offenders and a state system to track juvenile recidivism rates. Although no appropriation was made for the implementation of SB 200 (2014), the measure created a financial incentive program through which a portion of any savings achieved is to be reinvested into community-based programs and services.

As part of the legislation requires, the Administrative Office of the Courts (AOC) continues to implement the Family Accountability, Intervention and Response (FAIR) teams. These teams function much like an enhanced case management team to assist families and youth by connecting them with community supports to prevent youth from ending up in the justice system. AOC is working diligently to make sure that FAIR teams are established in all judicial districts. The FAIR teams are working collaboratively with Regional Interagency Councils to ensure needs of the youth and families are met most appropriately and efficiently.

For more information about SB 200, see: <http://www.lrc.ky.gov/record/14RS/SB200.htm> and <http://education.ky.gov/school/sdfs/Pages/Senate-Bill-200.aspx>

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 runs 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 is comprised of state members that 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 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 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.

Kentucky anticipates a no cost extension of this grant and continues to work on the goals set forth in the grant.

Highlighted accomplishments of the KAT-ED grant include the following:

Over the course of the grant, the KAT-ED team reviewed a previous SAMHSA-funded workforce mapping survey from the State Adolescent Coordinator (SAC) grant as well as a comprehensive statewide healthcare workforce study completed by the Deloitte group. The state implementation team surveyed treatment providers again by expanding on the previous SAC Grant workforce survey. The survey was sent out to many listservs, including one that reached participants of the annual KY School for Alcohol and Drug Studies. It was also handed out at several training events, the System of Care Academy, and KY Adolescent Substance Abuse Consortium training.

The survey gathered information about direct service providers and included such elements as characteristics of youth treatment providers and types of services provided. It also gathered training needs in behavioral health topics and the use of and training in evidence-based assessments and interventions. Survey results were reviewed by the implementation team and a training plan was set in motion.

In order to enhance and disseminate the grant-specific evidence-based assessment and treatment approaches, the remaining community mental health providers (N=12) and three private providers were invited to participate in in-state and distance-learning events for both A-CRA and GAIN. Agencies were asked to sign an agency commitment form that outlined their understanding and support of the clinicians chosen to become trainers in above practices and indicated their support to have that clinician continue to

train in-house more of their youth serving clinical staff. The funding to do this was a welcomed and added benefit of an approved carry forward amount from year one of the KAT-ED grant.

The implementation team and grant funding also supported the training and expansion of the use of the GAIN assessment instrument for the Administrative Office of the Courts as a first-line of defense in obtaining identified services for youth with substance use and/or co-occurring disorders and preventing them from entering further into the juvenile justice system. Carry forward was also used to provide Youth Mental Health First Aide community trainings that encompassed local providers, education, juvenile justice, and child welfare across the state.

The KAT-ED is also working with the System of Care Expansion Implementation Grant to be part of a System of Care Academy and the annual KY School on Alcohol and Other Drugs. KAT-ED, at the first annual System of Care academy, covered the costs for a keynote speaker and workshops on addressing adolescent substance abuse and co-occurring mental health and substance use treatment. An Adolescent-specific Treatment Track has been developed for the 2015 KY School on Alcohol and Other Drugs. The Kentucky Adolescent Substance Abuse Consortium is also working with the KAT-ED Implementation Team to provide trainings to support the needs identified through the KAT-ED Workforce Treatment Provider Survey. This survey has also been shared with the University of Kentucky Adolescent Health and Recovery Treatment and Training (AHARTT) Project. One priority of the project was to complete a comprehensive needs assessment to identify current and anticipated training and service needs. The collaboration with KAT-ED has helped to provide a cross state training approach that benefits the youth and families as well as the treatment providers without duplicating efforts and ensuring coverage and opportunities to evidence based treatment modalities

Financial mapping was first completed in fall of 2013 and presentation and release of the findings were provided to the Secretary of the Cabinet of Health and Family Services along with Commissioners of Medicaid, Department for Behavioral Health, Department of Community Based Services (child welfare), and Department for Juvenile Justice and the State Interagency Council. This has started the conversation among child-serving agencies to look at their services and billing in order to coordinate to avoid duplication, but to also look at expansion of services---findings from this report prompted some significant changes in January 2014 to the KY Medicaid state plan and its services for substance use treatment. Further, Kentucky has received several new grants that require financial mapping, and as such, the KAT-ED financial map has served as a foundation for future financial mapping efforts. The second financial mapping required from the grant has begun as of August 2015 with thoughts to compare any changes and to again present and release findings to Cabinet level and Commissioners of Child Serving state agencies.

KAT-ED has identified and partnered with the Kentucky Partnership for Families and Children (KPFC). KPFC is the state chapter for the Federation of Families for Children's Mental Health. Its mission is to provide education, advocacy, and outreach to families of children and youth with behavioral health and substance use challenges. KPFC coordinated the 2014 Children's Mental Health Awareness Day event with a theme focused on prevention, treatment and recovery of youth with substance abuse and substance abuse and co-occurring mental health and substance abuse issues. KPFC, in support of KAT-ED, is providing outreach and training to families of youth with co-occurring mental health and substance use challenges including, but not limited to, the two selected implementation sites, and strengthening regional youth council development. KPFC has met with local implementation sites and worked with parents and other caregivers to invite them to attend the KY Family Leadership Academy. They report having had both youth and parents attend the academy. KPFC is also sending parents to the Partnership for Drug Free Kids Craft -based Parent Peer support training in May 2015 in order to begin the process of developing this model for use in Kentucky. KPFC further worked with the

local sites and provided a walk-through at each site with a parent and youth to assist the sites in identifying any procedure or process changes in their system of getting a youth screened, assessed and placed in services. KAT-ED is now working to partner with Youth in Recovery to develop statewide chapters.

Substance Use Services

State Interagency Council

1. 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. The following language has been added to the Signed SIAC MOU:

Whereas, SIAC promotes comprehensive and integrated services for children with behavioral health disabilities, including substance use. This interagency agreement reflects the collaborative spirit in which various state agencies, entities, and parent and youth representatives join together in an effort to identify service gaps, develop effective strategies, and support state and local implementation plans that cultivate a seamless system of service delivery for the population of focus. Agree to: Identify and prioritize needs and participate in making annual policy recommendations that promote a healthy infrastructure of services for children with behavioral health disabilities to the Governor and the Legislative Research Committee.

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

Early Childhood Mental Health

Staff from the Department for Public Health and DBHDID meets regularly as they share oversight of the Early Childhood Mental Health Initiative and the designated Specialists. Additionally, Public Health and DBHDID staff oversees implementation of Moving Beyond Depression (MBD). The Moving Beyond Depression (MBD) program is a comprehensive approach to identifying and treating depression in mothers participating in home visitation. The MBD was developed to (1) establish a screening process to identify mothers in need of treatment, (2) provide an evidence-based treatment for depression that has been adapted for home visitation in order to optimize outcomes. The MBD is incorporated into HANDS (Kentucky's first –time parent home visitation program); HANDS home visitors administer the Beck Depression Inventory and when indicated, refer the mother for a comprehensive assessment and In-Home Cognitive Behavior Therapy with an intensively trained clinician within the local community mental health center. MBD provides a much needed service, as research indicates that depression in the postpartum period occurs in about 50% of populations served in home visitation programs. Depression can undermine effective and nurturing parenting, interferes with normal child development, and negatively impacts home visitation outcomes.

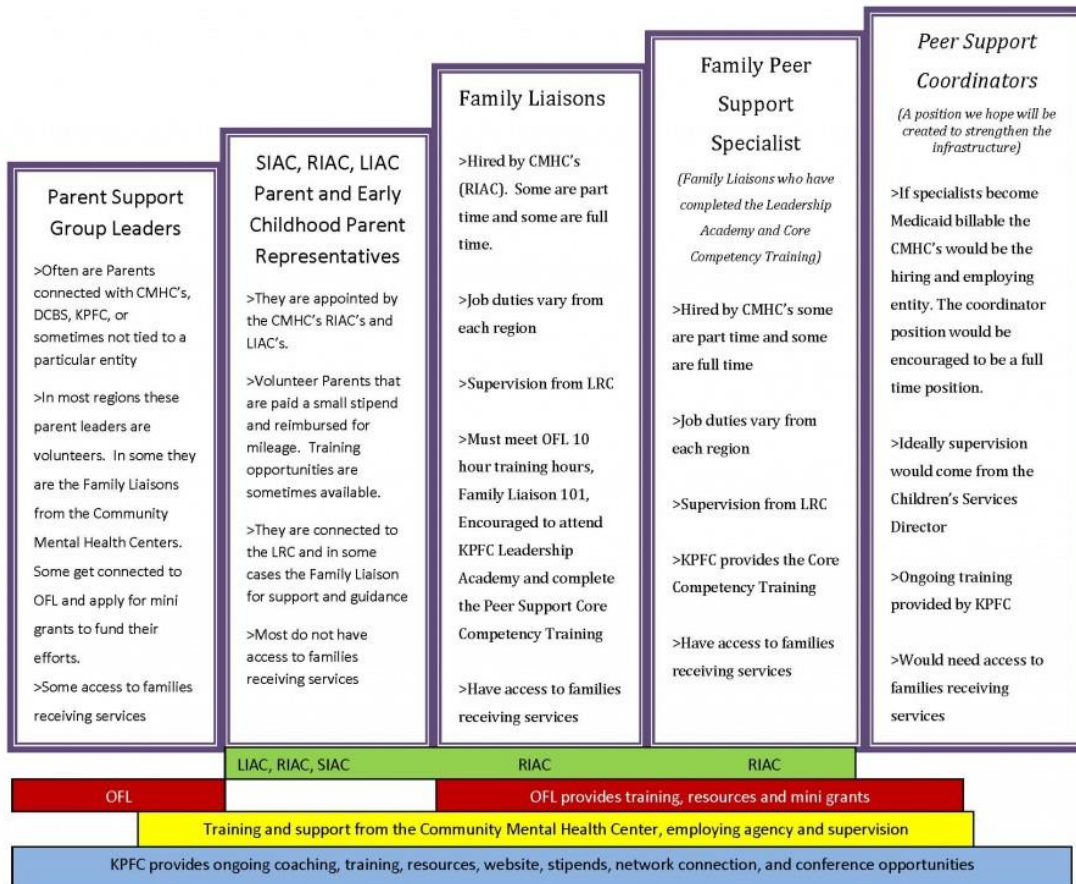
Kentucky Strengthening Families

Kentucky Strengthening Families (KYSF) represents a multi-disciplinary partnership of over 20 national, state and local, and public and private organizations dedicated to embedding six research-based Protective Factors into services and supports for children and their families. Supporting families is key strategy for promoting school readiness and preventing child abuse and neglect. All families experience times of stress, and research demonstrates that children grow and learn best in families who have the supports and skills to deal with those times. By supporting families and building their skills to cope with stressors, we can increase school readiness and reduce the likelihood abuse will occur in families. Kentucky Strengthening Families is using a nationally recognized strategy—Strengthening Families: A Protective Factors Framework – which is coordinated nationally by the Center for the Study of Social Policy.

KYSF is funded by the Governor's Office for Early Childhood through the Race to the Top/Early Learning Challenge Grant Program and the Kentucky Department for Public Health through the Early Childhood Comprehensive Systems Grant Program. KDBHDID staff serves on the KYSF Leadership Team, subcommittees, and training cadre. Additionally, KYSF protective factors have been embedded into CMHC contracts and Trauma Informed Care training.

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).



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, etc.
- 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
- Youth engagement and empowerment – strong partnerships with adults, understanding their diagnosis and symptoms as well as the services they are receiving or have access to.

*The following addresses Criterion 3b: Integrated Children’s Services - Geographic Area Definition
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.”



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 173 school districts across the state.

SUBSTANCE ABUSE TREATMENT AND PREVENTION OVERVIEW

In January of 2014, a new Kentucky state plan amendment was approved by CMS. In this new package of billable Medicaid services, services for individuals with substance use disorders were included. New billable services for substance use disorders include Residential Services for Substance Use Disorders; Screening, Brief Intervention and Referral to Treatment (SBIRT); Medication Assisted Treatment; and peer support. In addition, services such as Individual Therapy, Group Therapy, and an array of crisis services including crisis intervention, residential crisis stabilization services and mobile crisis services became available for individuals with substance use disorders. In response to these changes, the DBHDID has been restructuring contracts to provide these services, restructuring data systems to define and collect data for all new services, and providing guidance to providers through the development of service standards and other technical assistance.

Substance use specific services provided primarily through contracts with Regional Boards 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;
- Detoxification centers, residential treatment programs, intensive outpatient treatment services, other outpatient services including peer support and targeted case management;
- Specialized treatment services for pregnant women, adolescents and intravenous drug users; and
- Medication Assisted Treatment 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 individuals 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 use 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 affected by alcohol or drug use.

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.

Steps that have been taken by the Division include:

- Restructuring the Plan and Budget process to include plans for substance use disorder treatment, including planning for services for individuals with co-occurring mental health and substance use disorders.
- Including language in required Plan and Budget forms that address having programming that is co-occurring capable.
- Rewriting SFY 2016 contracts with Regional Boards to include a requirement for all programs, established by CMHCs to be Co-Occurring Capable as measured by either the Dual Diagnosis Capability in Addiction Treatment (DDCAT) or Dual Diagnosis Capability in Mental Health Treatment (DDMHT) tools.
- Requiring in SFY 2016 contracts with Regional Boards that all regions hire at least 2.0 Full Time Equivalent (FTE) peer support specialists with lived experience in substance use disorders or co-occurring substance use and mental health disorders.
- Providing some workshops at Kentucky School (which has traditionally been designed for substance use disorder staff only) that focus on providing mental health training to substance use disorder staff and substance use disorder training to mental health staff. (e.g. Motivational Interviewing; Peer Support).
- Contracting with Case Western Reserve University to provide training on Integrated Dual Diagnosis Treatment (IDDT) to all staff providing Assertive Community Treatment (ACT) services across the state.

Between SFY 2009 and SFY 2015, a team of integration specialists was developed by DBHDID to use DDCAT and DDMHT tools and to visit regional programming and assess co-occurring capabilities. All programs were offered the opportunity to use the data from their DDCAT/DDMHT 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 considered co-occurring capable. The DBHDID provided technical assistance during this time period, regarding change projects as well as DDCAT/DDMHT fidelity assessments. A Transformation Transfer Initiative (TTI) grant, as well as securing a national consultant (Heather Gotham, co-creator of the tools), were instrumental in supporting regions in working towards co-occurring capability in their programming for adults. DBHDID continues to provide technical assistance or help with fidelity assessments as requested.

As a result of these statewide assessments, it became clear that programs did not include many peer led mutual support groups. Mutual support and mutual aid groups are identified as one of the ten guiding principles of recovery from SAMHSA. DBHDID leveraged funds from the TTI grant and later from the block grant, for purposes of hiring an individual in recovery from co-occurring disorders to consult with DBHDID staff, regional staff and peers, and develop co-occurring mutual support groups in many regions across the state. Specifically, this individual in recovery assisted with development of Double Trouble in Recovery (DTR) mutual support groups across the state. DTR is a twelve-step self-help group that is facilitated by individuals in recovery from both mental health and substance use disorders. DTR is considered a best practice. At present, there are at least nine (9) regions that provide DTR as a support for individuals and more groups are continuing to develop. DBHDID continues to offer technical assistance and materials to assist with the development of this support across the state.

During the 2015 legislative session in Kentucky, HB 92 passed into law. This law created a licensure category for Clinical Alcohol and Drug Counselors (CADC) and created a Registered Alcohol and Drug Peer Support Specialist. These new categories were directed to be defined and placed under the CADC Board in Kentucky. As a new licensure category for providers, the Licensed CADC was included as a new billable professional in the new Medicaid state plan amendment for Kentucky that went into effect in 2014.

DBHDID has been working since SFY 2014 to implement Assertive Community Treatment as a service across the state for individuals with SMI. However, in working with ACT teams it became apparent that a large number of the individuals being served also had co-occurring substance use disorders. ACT teams have been ill prepared to provide good treatment to these individuals. In SFY 2015, the Department contracted with Case Western Reserve University to provide a series of training in Integrated Dual Diagnosis Treatment (IDDT), an evidence based practice that has been renamed Integrated Treatment for Co-Occurring Disorders by SAMHSA. Case Western provided three (3) separate training events in various parts of the state. Each training event consisted of three (3) days of training. All staff members of Assertive Community Treatment (ACT) teams across the state were trained in IDDT. At present, seventeen (17) ACT teams were trained in this model.

Kentucky has been training peer support specialists since 2006. However, initially, peers were only trained who were in recovery from mental health or co-occurring disorders. During the last few years, the DBHDID has been training peers in recovery from substance use disorders as well. When the new Medicaid state plan amendment was approved by CMS in January 2014, peer support was included as a billable service. The DBHDID changed the language in its peer support regulation to support training individuals in recovery from mental health, substance use or co-occurring disorders to become peer support specialists. Peer support for all populations is now a billable Medicaid service.

Goals/Objectives for SFY 2016/2017:

- To monitor the status of providing integrated care through co-occurring capable programs in the regions across the state;
- Continue to provide more cross training opportunities through Kentucky School and other training events, and more training on co-occurring topics in general;
- Continue to require the use of evidence based treatment practices, including Integrated Dual Diagnosis Treatment (IDDT);
- Provide technical assistance to ACT teams regarding IDDT through the use of fidelity assessments, consultations and continued training, until IDDT is implemented with fidelity through all ACT services;
- Increase the number of peer specialists in recovery from co-occurring disorders hired by providers and improve supervision and support for peer specialists who are employed; and
- Continue to support and facilitate new peer led mutual support groups;

SUPPORT FOR INDIVIDUALS IN RECOVERY AND FAMILY MEMBERS

Since the mid-1980s, the DBHDID has been convinced of the importance of involvement by individuals in recovery and family members in program development and service delivery. In February of 2011, the DBHDID hired a full time Recovery Services Coordinator who is a self-identified individual in recovery from behavioral health issues.

In addition, the Department provides funds for a variety of statewide and local support initiatives for individuals in recovery and family members. 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 recommendations from individuals in recovery and family members to rewrite contracts to be awarded to statewide groups. Two (2) of these contracts, the Recovery Oriented Training and Technical Assistance contract and the Recovery Oriented Family Support Services contract 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 each of these contracts.

The Recovery Oriented Family Support Services contract was awarded to the National Alliance on Mental Illness (NAMI) Kentucky and the contract for SFY 2016 includes the following requirements:

- Provide a series of recovery oriented supports for family members across the state;
- Utilize established training modalities and implement other support groups across the state that are established as best and promising practices;
- Provide at least one (1) "Train the Trainer" session per year to individuals who are targeted to provide family support groups;
- Provide signature advocacy training across the state to NAMI affiliates as well as other organizations, that pertains to individuals with serious mental illness and their family members;
- Collaborate with other agencies and organizations with the goal of supporting improved and evidence based practices such as supported employment, stigma reduction and recovery;
- Assess regional needs with regards to mental health treatment and family member involvement and inclusion and diversity;
- Provide diversity awareness trainings to all NAMI affiliates and ensure all NAMI Kentucky recruiting and programming reflect principles of diversity;
- Maintain a NAMI affiliate in every CMHC region across the state;
- Provide at least monthly contact with all NAMI affiliates across the state in an effort to enhance community integration and inclusion and ensure coordination of family support services and outreach; and
- Maintain a mental health recovery listserv to promote health and wellness and to increase positive communication between stakeholders.

Since SFY 2012, NAMI Kentucky has maintained a NAMI affiliate in each CMHC region across the state. The most recent affiliate developed was in the Mountain region in Eastern Kentucky. NAMI Kentucky continues to provide an annual "Train the Trainers" for family support group facilitators and affiliates have provided dozens of Family to Family (NAMI signature family support) classes across the state, with hundreds of family members graduating. NAMI Kentucky continues to make contact with all affiliates with a monthly conference call, and has provided training across the state on ADMHT and other topics. NAMI Kentucky continues to assist with Individual Placement and Support (IPS) Supported Employment programs across the state by participating as a Kentucky IPS team member, and is instrumental in ensuring individuals in recovery and their family members are involved in the supported employment initiative. Several individuals from Kentucky have been sent by NAMI Kentucky to national training in support group

facilitation. And over 2000 individuals from across the state have been included in a mental health listserv that is staffed by NAMI Kentucky.

During SFY 2015, NAMI Kentucky agreed to coordinate efforts for the DBHDID award of a Transformation Transfer Initiative (TTI) grant, related to utilizing peer support specialists in bridging services for individuals with mental illness transitioning in and out of psychiatric hospitals.

Goals for NAMI Kentucky for SFY 2016/2017 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;
- Increase the number of teachers and facilitators for NAMI signature programs;
- Enhance leadership in advocacy activities by providing advocacy training and opportunities to persons with serious mental illness and their family members;
- Working on growing and strengthening NAMI family advocates of the Individual Placement and Support (IPS) Supported Employment Team for Kentucky by strengthening communication and involvement of family advocates in the IPS initiative; and
- Increasing communication between family members, individuals with mental health disorders, and providers of mental health services, as well as promoting health and wellness for individuals by sending communications such as NAMI updates, information on various mental health topics, advocacy alerts and a quarterly newsletter to the public.

The Recovery Oriented Training and Technical Assistance contract was awarded to the National Alliance on Mental Illness (NAMI) Lexington affiliate, and initially required the development of a Technical Assistance Center for individuals in recovery and the provision of recovery oriented trainings across the state. Stakeholders were gathered from across the state, including individuals in recovery, family members and providers, and consensus was developed regarding formation of Kentucky System Transformation, Advocating Recovery Supports (KYSTARS), a training and technical assistance center focusing on statewide recovery oriented mental health services.

The contract for SFY 2016 includes the following requirements:

- Maintain the statewide training and technical assistance center with the goal of incorporating recovery principles throughout the public mental health system;
- Provide statewide evidence based recovery oriented training and support activities for individuals in recovery including Wellness Recovery Action Plan (WRAP) trainings, support groups, Advance Directive for Mental Health Treatment (ADMHT) training, education and skill building for individuals in recovery, etc.;
- Assess statewide needs regarding mental health recovery;
- Conduct at least two (2) Leadership Academy trainings across the state;
- Provide a statewide recovery oriented conference annually;
- Provide recovery oriented training for staff of Regional Boards and state psychiatric facilities; and
- Provide technical assistance to all programs with start-up funds to develop consumer operated service programs (COSP).

KYSTARS is located within Participation Station, one of the first peer run centers in Kentucky. During SFY 2012, after the SAMHSA COSP toolkit was developed, KYSTARS assisted Participation Station in adopting and implementing the Consumer Operated Service Toolkit with fidelity. Participation Station uses the

Fidelity Assessment Common Ingredients Tool (FACIT) to measure fidelity and the Peer Outcomes Protocol (POP) to measure outcomes. Both of these instruments are from the SAMHSA toolkit. This experience by KYSTARS led the DBHDID to contract with KYSTARS to provide technical assistance to all newly developed COSPs across the state.

The COSPs typically provide a drop-in service, psychoeducational groups, support groups and other new and frequently innovative peer support services. During SFY 2014/2015, KYSTARS provided educational classes and technical assistance in implementing and developing policies and procedures, form development, grant writing and fundraising, program evaluation, and other issues, to the COSPs across the state.

During SFY 2014/2015, KYSTARS conducted a comprehensive training needs assessment for four (4) regions awarded start-up funds for COSPs. This needs assessment focused on four (4) primary areas that were determined critical to a COSPs success and sustainability: 1) Safety; 2) Recovery Philosophy; 3) Group Process; and 4) Leadership. This needs assessment corresponded with baseline fidelity reviews of each COSP. Fidelity for the COSP was measured through the Fidelity Assessment Common Ingredients Tool (FACIT), part of the COSP toolkit from SAMHSA. The methodology of this needs assessment consisted of interviews with program directors, program leaders, and participants in each program, examination of training records as available, and FACIT reviews. Results determined training needs for each program, with regards to the primary areas measured. All programs were determined to have a need for safety training, such as skills in handling safety issues for individuals experiencing a mental health crisis. Potential training identified in this area included Mental Health First Aid, Non-violent Crisis Prevention and Intervention, Question, Persuade and Refer, Cardio-Pulmonary Resuscitation, and First Aid. With regards to Recovery Philosophy, 60% of the programs were found to have a need for refresher training on recovery orientation and principles of recovery. While each program was found to have some recovery principles at the heart of programming, some recovery principles were not clearly demonstrated in all programs. With regards to Group Process, it was determined that 80% of the programs could benefit from training on group dynamics and Wellness Recovery Action Planning (WRAP) facilitation. With regards to Leadership, it was determined that 80% of the programs could benefit from training on administrative skills to assist with better everyday operations and sustainability.

As a result of this needs assessment, KYSTARS included a tract of workshops, specifically designed for individuals in recovery working at COSPs in their annual conference that occurred in May of 2015.

During SFY 2014/2015, KYSTARS provided education and technical assistance to individuals admitted to state psychiatric facilities, individuals in treatment at Regional Boards, staff of two (2) state psychiatric hospitals, staff of Regional Boards, and to peer support specialists and leadership academy graduates.

During SFY 2014/2015, KYSTARS provided four (4) Leadership Academy trainings across the state. The Leadership Academy is a three (3) day educational program for persons in recovery from 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. 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.

In addition, KYSTARS 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. KYSTARS

revised an existing curriculum and developed the KYSTARS Recovery Support Group, a general recovery based group targeted individuals with SMI. Groups have developed across the state and KYSTARS provides some financial assistance in the form of stipends and training for facilitators.

KYSTARS has presented a statewide recovery conference each year since SFY 2011. This conference is always very well attended by individuals in recovery across the state, including peer support specialists, individuals working in COSPs, and other individuals in recovery. In SFY 2014, the annual conference was attended by approximately four hundred (400) individuals. There was a specific tract offered for continuing education for peer support specialists. The conference in SFY 2015 was attended by approximately four hundred (400) individuals and included a tract for providers who work with or support peer support specialists, which included providers who are involved with COSPs. In addition, beginning in SFY 2014, KYSTARS solicited a sponsor for an awards banquet, and began recognizing exemplary peers from across the state through Kentucky Peer Excellence Awards, where an award is presented to one peer in each region across the state. In addition, one award is provided for a peer that is recognized as having a Lifetime of Achievement in peer support and one award is provided for a person identified as a Supporter of peers. The Lifetime of Achievement award is named after Molly Clouse, who received the first award in May of 2014. Molly is a peer support specialist who has been instrumental in operationalizing peer support in Kentucky and has spearheaded recovery based legislative changes. Kentucky Peer Excellence Awards continued in SFY 2015, with a ceremony occurring the evening before the annual conference.

KYSTARS maintains a functional website as a resource for recovery based programming in the state, to share programs and support groups, recruit new peer support specialists and educate the public. KYSTARS has experienced significant annual growth in website usage and has plans to expand their online support component.

Goals for KYSTARS for SFY 2016/2017 are to continue to provide the required elements of their contract with DBHDID, while continuing to expand recovery informed services across the state in a variety of ways.

Kentucky Peer Specialist Training is a thirty (30) hour intensive training program for persons in recovery from a mental health, substance use or co-occurring mental health and substance use disorder. The training program in Kentucky was traditionally modeled after the Georgia and South Carolina models of Peer Support. The training prepares individuals in recovery to provide peer support services to other individuals in the behavioral health service system.

In January of 2014, a new Medicaid state plan amendment was approved by CMS. Included in this package of newly billable services was peer support. In addition, due to Medicaid Expansion in Kentucky and a workforce capacity study by Deloitte in May of 2013, the network of behavioral health providers through Medicaid was expanded in Kentucky as well. Due to the overwhelming number of potential behavioral health providers, many changes have taken place.

The manner in which individuals in recovery receive certification training to become billable peer support specialists has changed into the following model:

- A curriculum rubric has been developed by the DBHDID, outlining the required thirty (30) hours of training, based on the core competencies listed in the Medicaid state plan amendment and subsequent regulations;
- Agencies across the state will be able to submit curriculum, based on the rubric, for approval by the DBHDID;
- Once approved, agencies may provide their own certification training for peer support; and
- Agencies are required to submit names and numbers of peer support specialists who are certified.

Kentucky is now able to provide three (3) types of peer support that is billable through Medicaid: adult peer support; youth peer support; and family/parent peer support. Each type of peer support is representative to individuals with lived experience in either mental health, substance use, or co-occurring mental health and substance use disorders.

During SFY 2013, the DBHDID decided to provide start-up funding to Regional Boards to begin development of Consumer Operated Services Programs (COSP) in various regions. These COSPs would be required to meet fidelity of the SAMHSA Consumer Operated Services toolkit. The DBHDID issued a Request for Application (RFA) process to establish COSPs in four (4) regions during SFY 2013 (Communicare; Lifeskills; Mountain; and Four Rivers). Participation Station in Lexington, Kentucky, and the Personal Involvement Empowering Recovery (PIER) program in Northern Kentucky existed prior to this RFA process. During SFY 2014 and 2015, three (3) additional Regional Boards were awarded start-up funds for COSPs (Seven Counties; NorthKey; and Pathways). All new programs are continuing to work on development and strive towards fidelity. After peer support became a billable service, many regions began working toward making these programs billable as a peer support service.

The DBHDID and the Regional Boards encourage the participation of individuals in recovery family members in planning, evaluating, and service delivery. Priorities for SFY 2016/2017 include:

- Continue to encourage the involvement of individuals in recovery and their family members in the Behavioral Health Block Grant planning process and other DBHDID planning events;
- Continue to design and support statewide programs, trainings, and outcome measures that incorporate recovery principles;
- Continue to require the hiring of peer support specialists across the state;
- Develop more education and support for peer support specialists who are employed, through supervision training and continued training in recovery principles;
- Support the existing COSPs, ensuring fidelity to the SAMHSA model as well as ensuring a recovery oriented service in communities across the state; and
- Continue to support the development of additional peer run services in a manner that is sustainable;

While the DBHDID and the Regional Boards have come a long way in fostering involvement by individuals in recovery and family member in planning, evaluation, and service delivery, many challenges remain, including:

- Not enough access to peer run programming;
- Lack of education and understanding for providers regarding impact and importance of recovery oriented services, including peer support;
- Limited support for individuals providing peer support as a service;
- Few programs that fully incorporate recovery principles; and
- 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 serious mental illness (SMI) 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;
- Crisis Intervention Services;
- 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, thirteen (13) of the fourteen (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).

In January of 2014, a Medicaid State Plan Amendment was approved which included crisis intervention services, mobile crisis services, and residential crisis stabilization programs as Medicaid billable services. Regions have been adjusting to this change and working to develop programming that meets the required standards.

The fourteen (14) 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 twenty-four (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 twelve (12) 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 nine (9) 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 individuals they serve, without disruption. Several regions 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. Substance abuse detoxification programs and substance abuse residential treatment programs were added as newly billable services in the Medicaid State Plan Amendment approved in January of 2014. This has allowed for a better service array for individuals with co-occurring substance use disorders.

The goals for SFY 2016/2017 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 individual in need a warm hand-off to that level of care. Regional boards in three (3) urban areas are 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 emergency room.

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. To date the Jail Triage program provides emergency mental health services to eighty-six (86) county jails in Kentucky.

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.

This following addresses Criterion 4: Targeted Services to Homeless, Rural, and Older Adult Populations for Adults and Children as required by the federal legislation.

1) Outreach to Homeless

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 providing behavioral health services to individuals who are homeless. 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) continue to collaborate on the SSI/SSDI Outreach, Access, and Recovery (SOAR) Initiative, developed a Case Management Manual for homeless service providers and a Homelessness Rights Manual (both available on the KICH website), and promote education and training for discharge planning in public institutions. Efforts are also underway to increase access and availability of housing options for homeless individuals through the promotion of the "Housing First" model.

Most Community Mental Health Centers (CMHCs) offer individualized services designed to alleviate homelessness as well as to provide "mainstream" mental health treatment to persons who are homeless and mentally ill. Of the fourteen CMHCs in Kentucky:

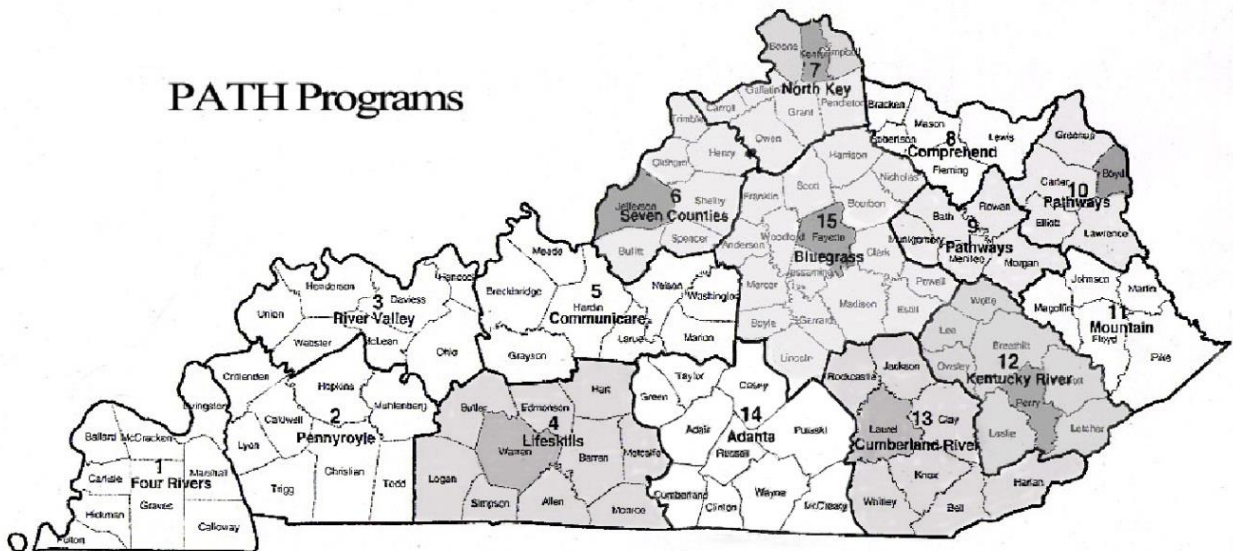
- All regions give a service priority to homeless individuals;
- All regions participate in regional Continuum of Care meetings;
- Thirteen (13) regions do consultation with local shelters;
- Ten (10) regions have staff dedicated to homeless individuals;
- Eight (8) regions regularly visit local homeless shelters;

- Six (6) regions have a walk-in clinic; and
- Four (4) regions do “street outreach.”

KDBHDID received \$469,000 from SAMHSA/CMHS for SFY 2016 for homeless services through the Projects for Assistance in Transitioning from Homelessness (PATH) Grant. The Department continued to contract these homeless services funds with the three (3) urban, two (2) rural and two (2) urban and rural combination CMHC regions.

The seven (7) PATH regions include:

- Bluegrass.org, 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 Comprehensive Community Care, which provides outreach, case management and housing support services in Laurel County.



Note: 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 Boards attempt to provide a statewide system of outreach, community support, and mental health services for persons with serious mental illness who are homeless. The role of the State PATH Contact (SPC) is central to supporting local PATH providers throughout Kentucky. The SPC 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 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 serious 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.

A recent news report states that Kentucky led the nation in the percentage of public school students who were homeless during the 2012-2013 school year. More than 30,000 or nearly 5% of Kentucky’s 685,167 students were classified as homeless. Students are considered homeless if they live on the streets, in a shelter, a hotel/motel, a car or they are sleeping on someone’s couch because they have no residence.

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 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).

The Table attached to this document illustrates the Point In Time Study Results for the most current data available.

2) Rural Area Services

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 for adults and adults with SMI is shown in the charts below.

Regional Boards/CMHCs	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
Total	3,315,996	2,067,359	1,248,637

Region	Rural SMI Pop	Rural SMI Served	Percent Rural SMI Served
1. Four Rivers	2,085	789	38%
2. Pennyroyal	1,799	1,270	71%
3. River Valley	1,392	607	44%
4. Lifeskills	3,024	1,229	41%
5. Communicare	3,185	2,548	80%
6. Seven Counties	803	230	29%
7. NorthKey	1,128	515	46%
8. Comprehend	768	526	68%
9/10. Pathways	2,160	1,451	67%
11. Mountain	3,114	2,968	95%
12. Kentucky River	2,328	2,289	98%
13. Cumberland River	4,709	3,153	67%
14. Adanta	3,670	2,055	56%
15. Bluegrass	2,300	1,070	47%
Total	32,465	20,700	64%
*Based on SFY 2014 data			

Transportation barriers remain one of the greatest concerns among providers, individuals in recovery 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. 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 serious 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.

Most CMHCs deliver or access services via the telehealth network. Eleven out of fourteen regions have telehealth equipment and utilize it for providing some services (e.g., psychiatry services, therapy services, jail triage services, and emergency evaluations for involuntary hospitalization.)

- Kentucky River Community Care, Inc., utilizes telehealth services with individuals in all offices across their region. They also have an agreement with the FCC to have a Kentucky Behavioral Telehealth Network and they participate in the Kentucky Health Information Exchange.
- Bluegrass uses telehealth for psychiatric services in one rural county.
- Lifeskills currently utilizes the telehealth network for psychiatric services in all ten counties they serve. They also use telehealth for discharge planning between Western State Hospital and outpatient offices.
- Four Rivers currently utilizes the telehealth network for psychiatric screening and services and is developing jail triage services via telehealth for SFY 2016.
- Communicare uses telehealth for psychiatry services and therapy services in all eight rural counties in their region.
- NorthKey utilizes telehealth for afterhour emergency room services and mental health evaluations via contract.
- Cumberland River has telehealth available in each outpatient clinic across their region and offers telehealth between sites.
- Adanta provides telehealth psychiatry services to rural counties in their region and provides telehealth psychiatry services via contract as well.

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.;

CMHCs 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.

One strategy widely utilized in the children's mental health arena for addressing 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 regional networks of parent-to-parent or support and advocacy, which provide informal connections and social supports in their own geographic areas. This model is currently being adopted more broadly to reduce isolation and develop natural social supports for children and adults and their families.

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.

Specific challenges presented by older adults with behavioral health issues, as identified in the 2011 Behavioral Risk Factor Surveillance System (BRFSS) survey through the Centers for Disease Control (CDC), include:

- The five (5) year average suicide rates among Kentuckians ages 55-74 and 75 and older are lower than the rate in the 20-54 age group; however, Kentucky's rates for these age groups are higher than the national rates, and increasing;
- Over 17 percent of adults aged 55-63 have substance use issues, but few in this age group receive substance use services;
- In 2011, over 3 percent of Kentucky citizens aged 65 or older were treated for mental health issues although over 13 percent are believed to experience mental health problems that last fifteen (15) days or longer; and
- Older adults who experience frequent mental distress are more likely to report chronic health issues. These individuals experience strokes at twice the rate of those with lower mental distress, and experience coronary disease, heart attack and diabetes/pre-diabetes more than 1.5 times than those with lower mental distress.

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 will not reimburse for all behavioral health providers and not for behavioral health 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 2016/2017 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 continue to support local Mental Health and Aging Coalitions across the state through the mini grant process;
- Target five (5) regions without local Mental Health and Aging Coalitions and assist them in establishing coalitions;
- Work with the Kentucky Association of Gerontology (KAG) to sponsor at least one (1) workshop focusing on mental health and aging at their annual state conference;

- Provide reimbursement for training expenses for coalition members and other related stakeholders to attend training on evidence based practices in the behavioral health field regarding behavioral health; and
- Review state data reports and other relevant information to better understand the behavioral health needs of older adults in Kentucky.

Mental Health Block Grant funds are used to support the following activities through local mental health and aging 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 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;
- Staffing the Elder Abuse Committee;
- Provision of Mental Health First Aid training; 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.

*This following addresses Criterion 5: **Management Systems** for Adults and Children as required by the federal legislation. Narrative Question: Describes financial resources, staffing, and training for mental health services.*

Criterion 5 addresses three critical components of the overall management of the systems of care that serve 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 as is required for the MH portion of the Block Grant but much of it also applies to the SAPT portion or has been added to be more informative about the entire behavioral health system.

Component 1: Financial

Kentucky fully embraced the Affordable Care Act (ACA) during SFY 2014 and developed a state Health Benefit Exchange, where individuals could enroll in various insurance options. Kentucky also opted for Medicaid Expansion and over 400,000

individuals, who were not previously insured or who were underinsured, have enrolled in Medicaid, and an additional 106,000 have enrolled in coverage through a Qualified Health Plan, to date. In addition, a new Medicaid state plan amendment was approved by CMS in January of 2014. Many more behavioral health services became Medicaid reimbursable, most notably substance abuse services, an array of crisis services, and some evidence based practices for adults with SMI. Due to these achievements, the Governor's office elected to reduce traditional funding for behavioral health services, due to the realization that most individuals now had insurance, and most vital behavioral health services were now Medicaid billable. For SFY 2015, savings of \$21 Million were realized in the state budget for behavioral health. In SFY 2016, \$30 Million in savings were included.

Due to these changes, DBHDID evaluated purchasing options, redesigned CMHC contracts and further implemented performance based contracting. In addition, the Cabinet for Health and Family Services continued to contract with five (5) Managed Care Organizations (MCOs) to coordinate behavioral and physical health services for individuals with Medicaid across the state. CMHCs must negotiate services and reimbursement rates, and provide authorization requirements with each separate MCO. Some regions have been more successfully at adjusting to these changes than others.

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

SUBSTANCE ABUSE BLOCK GRANT ALLOCATIONS FOR STATE FISCAL YEAR 2016

Rev. 8.25.15

CONTRACTED TO THE REGIONS FOR SERVICES:

<u>Region</u>	<u>Treatment</u>	<u>Preg & Post-Partum</u>	<u>Prevention</u>	<u>TOTAL</u>
1 Four Rivers	471,211	72,896	153,862	697,969
2 Pennyroyal	528,568	75,305	224,516	828,389
3 River Valley	515,115	79,297	226,693	821,105
4 LifeSkills	721,556	233,883	225,137	1,180,576
5 Communicare	533,379	188,746	252,502	974,627
6 Seven Counties	2,136,172	1,145,316	338,274	3,619,762
7 NorthKey	893,695	630,729	217,048	1,741,472
8 Comprehend	189,196	15,010	111,044	315,250
10 Pathways	786,001	195,123	251,536	1,232,660
11 Mountain Comp	332,745	63,172	163,543	559,460
12 Kentucky River	288,221	90,494	192,645	571,360
13 Cumberland River	538,649	178,790	197,635	915,074
14 Adanta	403,817	117,882	232,652	754,351
15 Bluegrass	1,831,667	445,727	473,170	2,750,564
Totals	10,169,992	3,532,370	3,260,257	\$16,962,619

STATEWIDE PROJECTS:

<u>Region</u>	<u>Program or Service</u>	<u>Amount</u>
4 LifeSkills	Other SA Training/TA Funds	35,000
4 LifeSkills	SA Primary Prevention Training/TA Funds	70,222
4 LifeSkills	SA Treatment Funds	10,000
4 LifeSkills	Kentucky Prevention Network (KPN)	19,950
5 Communicare	Crisis Intervention Training (CIT)	30,000
15 Bluegrass	Statewide Deaf & Hard of Hearing	20,000
15 Bluegrass	Suicide Prevention	15,000
		\$200,172

MISCELLANEOUS FUNDED WITH SAPT BLOCK GRANT:

	<u>Treatment</u>	<u>Preg & Post-Partum</u>	<u>Prevention</u>	<u>TOTAL</u>
REACH of Louisville (Data Collection/Warehousing)	-	-	365,321	365,321
People Advocating Recovery (PAR)-Recovery Oriented Training	96,300	-	-	96,300
Office of Vocational Rehabilitation(OVR)	100,000	-	-	100,000
Oxford House (Case Managers)	180,000	-	-	180,000
KPFC	15,000	-	-	15,000
Kentucky Housing Corp	23,333	-	-	23,333
Louisville Metro Health Dept	500,000	-	-	500,000
Eastern Kentucky University	280,776	-	184,635	465,411
UK - CDAR	614,571	60,000	-	674,571
	1,809,980	60,000	549,956	\$2,419,936

TOTAL CONTRACTED

\$19,582,727

Audit Reserve	664,558			664,558
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TOTAL BLOCK GRANT ALLOCATIONS

\$20,247,285

MENTAL HEALTH BLOCK GRANT ALLOCATIONS FOR FISCAL YEAR 2016						Rev. 7.10.15
CONTRACTED TO THE REGIONS FOR SERVICES:						
				Consumer Operated Programs	SM/SED Deaf & HoH	
Region	Emergency	DIVERTS	Children			TOTAL
Four Rivers	11,936	135,139	80,257	35,000		262,332
Pennyroyal	10,391	169,967	77,492			257,850
River Valley	10,221	186,882	83,988			281,091
LifeSkills	15,697	191,484	91,609	35,000		333,790
Communicare	14,843	163,047	107,963	35,000		320,853
Seven Counties	30,801	441,424	190,488	50,000	38,833	751,546
North Key	12,914	258,649	118,853	50,000		440,416
Comprehend	6,917	35,045	76,963			118,925
Pathways	12,787	212,432	94,444	50,000		369,663
Mountain	12,879	169,467	87,466	35,000		304,812
Kentucky River	9,086	85,096	82,176			176,358
Cumberland River	13,169	243,676	107,350			364,195
Adanta	11,843	135,747	92,674			240,264
Bluegrass	23,908	135,983	152,512		34,482	346,885
TOTAL	197,392	2,564,038	1,444,235	290,000	73,315	\$4,568,980
STATEWIDE PROJECTS:						
Regional Board	Program or Service					Amount
LifeSkills	Children's Training & Technical Assistance					40,000
LifeSkills	Adult MH Training and Technical Assistance					40,000
LifeSkills	Recovery Initiative					20,000
LifeSkills	Peer Support Training & Technical Assistance					20,000
LifeSkills	MH 5% Sed Aside					15,000
LifeSkills	LOCUS					5,000
LifeSkills	Person Centered Recovery Plans					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	Statewide Deaf & Hard of Hearing					34,787
Communicare	CIT Training					70,000
						\$383,787
OTHER:						
	Department of Corrections - Reintegration Specialist					50,000
	Office of Vocational Rehabilitation - Supported Employment Services					250,000
	Eastern Kentucky University					325,868
	Kentucky Housing Corporation - Supported Housing Specialist					13,334
	Kentucky Partnership for Families & Children - Family Driven Youth Guided Training & Support					143,000
	Behavioral Health Planning Council					20,000
	NAMI KY - Recovery Oriented Family Support					142,554
	NAMI of Lexington (Participation Station) - Recovery Oriented Training					150,190
	University of Kentucky - Institute for Pharmaceutical Outcomes & Policy (IPOP)					100,000
	University of Kentucky - Dartmouth Supported Employment					204,097
	Audit Reserve					1,455,790
	State Travel					20,000
						\$2,874,833
TOTAL BLOCK GRANT ALLOCATIONS						\$7,827,600
TOTAL BLOCK GRANT AVAILABLE						\$7,827,600

Component 2: Workforce

KDBHDID contracts annually and directly with each CMHC to provide direct services and each CMHC employs staff who delivers services. Thus, DBHDID involvement in human resource development activities for the CMHCs 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 new Medicaid state plan amendment that was approved in January of 2014 included new staff requirements for various services. Most services billable through Medicaid must now be provided by an independently licensed professional or an individual under supervision working towards licensure. Non-licensed providers who bill Medicaid must now be certified by the DBHDID and must be assigned a billing supervisor. In addition, regions have been developing new services to enrich their available array.

Component 3: Training

DBHDID strives to provide access to on-going training and technical support for all Central Office staff as well as partner agencies and contracted providers statewide. The Department seeks to utilize available technology to provide educational/training and consultation opportunities. One example is the Adobe Connect system of webinar technology. Several DBHDID staff are trained in the AdobeConnect technology and hosting of webinars is now an option for training opportunities. DBHDID provides or sponsors and participates in a variety of training initiatives. This includes many opportunities for central office staff, as well as DBHDID contracted, Medicaid enrolled, and other 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.

During SFY 2015, DBHDID created a Program Integrity Division that included a Program Support Branch. This branch is in the process of streamlining procedures to assist all DBHDID programs in providing training. This Branch is also charged with oversight of the system being developed to credential and track continuing education of non-licensed professionals including targeted case managers (SMI, SED, SUD, BH/PH), community support associates and peer specialists (Adult, Family Youth).

The Department provides scholarships (limited) for individuals in recovery, parents/family members, and CMHC staff to attend training events. Funds are also used to provide Certified Psychiatric Rehabilitation Practitioner (CPRP) examinations from the Psychiatric Rehabilitation Association (PRA) for CMHC staff, as well as to support technical assistance for the development and maintenance of adult and children’s programming (e.g., Targeted Case Management, Crisis Services, Cultural Competency, Therapeutic Foster Care, etc.). 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
Community Support Program (CSP) Directors Technical Assistance Meetings	CSP Directors within CMHCs, Other Contracted Entities	Approximately 35	Quarterly 1 Day
Hearing Voices that are Distressing	Behavioral health providers and administrators and family members	Maximum of 40	As requested 3 hours

Trainings Relevant to Adult Services			
Type of Training	Intended Audience	# of Participants Anticipated	Frequency/ Length of conference
Accessing Affordable Housing in Your Community	CMHC Housing coordinators, housing specialists, case managers for adults with SMI, ACT staff, supervisors and other community partners.	Maximum of 25 for each session	1 2-day training in each hospital catchment area Annually
Olmstead Housing Initiative (OHI) Training	CMHC staff and other community agencies who receive assistance through OHI for housing of adults with SMI	Maximum of 25 for each session	1 day training, repeated across the state
Assertive Community Treatment Team (ACT) Leader Quarterly Technical Assistance Meeting	ACT team leaders	Approximately 25	Quarterly 1 Day
Integrated Dual Diagnosis Treatment (IDDT) Training	ACT team members Other providers	Approximately 40	3 Days Repeated in 3 locations across the state
Supported Employment Training	Supported Employment staff from CMHCs, other contracted entities, DBH staff	Approximately 50	2 Days Annually, Statewide
Advance Recovery Conference	CMHC staff, DBH staff, staff from other state agencies (DAIL, DCBS, etc.)	Approximately 200	1 Day
Crisis Planning Training	CMHC staff, DBH staff, P&A staff, others	Approximately 40	1 Day Repeated 2 x (once in west and once in east)
Developing Readiness for Change	CMHC staff, DBH staff, P&A staff, others	Approximately 40	1 Day Repeated 2 x (once in west and once in east)
Interim Settlement Agreement Technical Assistance Webinars	In-Reach Coordinators, ACT team staff, Regional Transition Coordinators, other staff as appropriate	Unlimited	Monthly 2 hours
Community Transition Team (CTT) Meetings	Directors of 3 state contracted programs for transitional care of adults with SMI	Approximately 15	Quarterly
Adult Crisis Director's Meetings	Directors of adult crisis stabilization units	Approximately 30	Quarterly

Trainings Relevant to Adult Services			
Type of Training	Intended Audience	# of Participants Anticipated	Frequency/ Length of conference
Person Centered Recovery Planning	CMHC staff, DBH staff	Approximately 50	2-Day Training Offered twice, one in east and one in west
Technical Assistance Webinars regarding Person Centered Recovery Planning	CMHC staff	Approximately 30	1 hour calls Offered to each of the 14 CMHCs 2 rounds of TA
Coaching Webinars regarding Person Centered Recovery Planning Training	Regional Boards staff	Approximately 30	1 hour calls Offered to each of the 14 CMHCs 2 rounds of TA

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

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.

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 community partners serving adults with SMI.

Accessing Affordable Housing in Your Community

Education regarding accessing affordable permanent community-based housing for individuals with SMI transitioning from personal care homes and other institutional settings. Includes housing resources, best practice basics, fidelity measurement, recovery oriented principles and supports to improve quality of life.

Olmstead Housing Initiative (OHI) Training

Provided by DBHDID in collaboration with Kentucky Housing Corporation (KHC) to education agencies on processes to secure housing assistance in the form of OHI vouchers which can be used for some flexible housing needs such as furniture, deposits, etc., for individuals with SMI who fit the Olmstead criteria.

Assertive Community Treatment TA Meetings

DBHDID program administrator for ACT meets quarterly with ACT team leaders and consultants. Peer group meetings to discuss fidelity issues, procedural questions, and general education regarding SMI and the evidence based practice.

Integrated Dual Diagnosis Treatment Training

Training regarding IDDT, evidence based practice for individuals with co-occurring mental health and substance use disorders. ACT teams are targeted due to the high incidence of co-occurring disorders of individuals served by ACT.

Interim Settlement Agreement Webinars

Monthly webinars led by DBHDID staff to discuss issues related to the Interim Settlement Agreement for adults with SMI moving out of personal care homes. Technical assistance is given on various topics including data submission, evidence based practices, etc.

Supported Employment Training

DBH Adult Branch hosts an annual, two-day training for staff in Supported Employment programs across the state. Workshops regarding the Individual Placement and Support Model of Supported Employment are provided.

Advance Recovery Conference

DBH, in collaboration with the Kentucky Chapter of Psychiatric Rehabilitation Association (PRA), hosted a one day statewide conference, on March 21, 2014, to introduce the concept of recovery for individuals with SMI. Darby Penney presented information regarding the "Suitcase Exhibit", a presentation developed from research done regarding individuals who had been admitted long term to a psychiatric hospital in New York and whose suitcases, full of their belongings, remained decades after the hospital had closed. In addition, Stephen LeMaster, a speaker from Boston, provided information about Person Centered Recovery Planning. A panel presentation introduced the audience to the Interim Settlement Agreement, which has a purpose of moving individuals with SMI out of personal care homes and into communities of their choice.

Crisis Planning Training

DBH, in collaboration with the Kentucky Chapter of PRA, hosted a one-day training, on June 4, 2014, on Crisis Planning and Wellness Recovery Action Planning (WRAP) with individuals with SMI. Catherine Batscha from the University of Louisville and well as Molly Clouse, an instructor with the Kentucky peer support specialist training, provided a day of training.

Developing Readiness for Change

DBH, in collaboration with the Kentucky Chapter of PRA, hosted a one-day training, on April 23, 2014 and April 30, 2014, on Developing Readiness for Change in individuals with SMI. The target population was individuals working through the Interim Settlement Agreement to assist with moving individuals from personal care homes into communities. Diane Brewer, LPCC, and Susan Turner, an individual in recovery, provided training in eastern Kentucky and training in western Kentucky on this topic, which consisted of assessing readiness in several different areas and assisting individuals in moving through their individual barriers to achieve their own goals.

Adult Crisis Director's Meetings

DBH Program Administrator for adult crisis services hosts a quarterly peer group meeting for directors of adult crisis programs across the state. These meetings give an opportunity to share information, discuss issues and network with peers across the state.

Person Centered Recovery Planning

DBH offered a 2-day training on September 24 & 25, 2014 in Morehead, Kentucky, and a 2-day training on March 18 & 19, 2015 in Hopkinsville, Kentucky, on Person Centered Recovery Planning. Consultants Janis Tondora, PsyD., and Diane Grieder, provided an overview of person centered principles and then hands on experience in providing planning and documenting planning in a person centered way that also met medical necessity criteria. Future trainings are uncertain.

Person Centered Recovery Planning Technical Assistance Webinars

DBH offered each CMHC at least 2 follow TA calls with consultants Janis Tondora and Diane Grieder, who critiqued each region's documentation for adherence to the person centered planning model.

Person Centered Recovery Planning Coaching Webinars

DBH offered each CMHC at least 2 follow up Coaching opportunities with consultants Janis Tondora and Diane Grieder, to discuss implementation strategies and barriers to providing the initiative across their agency.

Trainings Relevant to Children's Services			
Type of Training	Intended Audience	# of Participants Anticipated	Frequency/ Length of conference
Ages and Stages Questionnaire – Social Emotional	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	CMHC partners (LRCs) (Offered Regionally)	Varies depending on location	4 Hours As needed
Behavior Institute, co-sponsor	Educators, administrators, agency service providers, and families	Approximately 1200	Annually; 2.5 days
Child System of Care Summit	Children's Targeted Case Management Providers and their Supervisors, Parents, Central Office Staff, Representatives from Collaborating Agencies	Approximately 500	Annually 2-3 Days
DC:0-3R	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, Child TCM Program Directors	15	Monthly 2 hours
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 other trainings/conferences being offered OR available by request 1-3 Hours
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
School Law	Children's Program Staff from CMHCs & Family Members, Community Partners (Offered Regionally)	Up to 40 per Session	3 Hours, Upon Request

Trainings Relevant to Children's Services			
Type of Training	Intended Audience	# of Participants Anticipated	Frequency/ Length of conference
Seven Challenges	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
Transition Aged Youth Launching Realized Dreams (TAYLRD)	Child and Adult Case Managers	60	As requested 1 Day
Trauma-focused Cognitive Behavioral Therapy Learning Collaborative	Master's Level Clinicians	25	1 Year Learning Collaborative
Trauma Informed System of Care Training	Any Community Providers	50	As requested 3 Hours
Trauma Informed System of Care Training for Trainers	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
Children's Services Directors Meetings (in-person and by conference call)	Children's Services Directors from across the state	Approximately 30	Quarterly
Other Children's Programming Staff from CMHCs as needed	Crisis Directors, TFC Program Dirs., TCM Program Dirs., Early Childhood Program staff, etc.	Varies by Program	No more than quarterly and as requested or deemed beneficial

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

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 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.

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/Fetal Alcohol Spectrum Disorder

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 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.

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.

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.

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.

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

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 12-hour training will provide participants with the basic knowledge and skills to begin facilitating Wraparound with youth and families regardless of the service or treatment setting. This free training is offered to all state agency partners that work with children with SED. The goals of the training are the following: learn to partner with families and bring team members together to best meet the needs of youth and families; gain knowledge of wraparound as a best practice; and increase knowledge of community resources and natural supports for youth and families.

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.

Children’s Programming Director Meetings

DBH Program Administrators hosts peer group meetings to share information, discuss issues and allow CMHC staff to network with peers from across the state. These meetings may be in-person or by conference call and generally are held quarterly or on an as-needed basis.

<i>Trainings Relevant for Both Adult and Children’s Services</i>			
Type of Training	Intended Audience	Number of Participants Anticipated	Frequency/ Length of conference
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
American Sign Language Interpreter Peer Supervision Groups on Mental Health Interpreting	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
Assessing and Managing Suicide Risk: Core Competencies for Mental Health	Behavioral Health Clinicians	Target-30 per Session	As requested One Day
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.
Cognitive Behavior Therapy for Consumers who are Deaf with Language and Learning	Therapists, case managers, rehabilitation counselors for the deaf, and others.	40	As needed.

Trainings Relevant for Both Adult and Children's Services			
Type of Training	Intended Audience	Number of Participants Anticipated	Frequency/ Length of conference
Challenges			
Cognitive Behavior Therapy for Perinatal Depression	Regional Perinatal Depression contacts, Early Childhood Mental Health Specialists	30-50 per Session	3 Times per Year 2 Days
Creating Community Connections: A Behavioral Health Case Management Conference	TCM for adults with SMI, children with SED, individuals with SUD, and individuals with co-occurring complex physical health conditions. Also targets supervisors.	300-400 Maximum	2 Days Semi-Annually or less as funding allows
Crisis Intervention Team Training (CIT)	Law Enforcement Officers	Approximately 180 Total	6 per year 5 Days (40 hours)
Cultural Competency Training of Trainers	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
Deaf and Hard of Hearing Providers' Symposia	DHHS Specialists and other CMHC staff with consumers with hearing loss.	20	Quarterly
Deafness 101	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
Deafness 102	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

Trainings Relevant for Both Adult and Children's Services			
Type of Training	Intended Audience	Number of Participants Anticipated	Frequency/ Length of conference
Emergency Services Training	Behavioral health providers and administrators, community providers and leaders, local interest groups.	Available statewide	As needed
Evidenced Based Care for the Client At-Risk for Suicide	Behavioral health clinicians	Target-80	As requested One Day
Heal the Healer Training and Retreat	Behavioral health clinicians, case managers, supervisors	20-25	2 days Annually
Kentucky Registry of Interpreters for the Deaf (RID)	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 Mental Health Planning and Advisory Council Member Orientation	New and current members.	15	Annually
Kentucky School of Alcohol and Other Drug Studies (Co-Sponsored by KDBHDID)	Behavioral health providers and administrators, consumers and family members	Approximately 800	Annually 4.5 Days
Law Enforcement Response to Individuals with Special Needs	Police Officers, Deputies, School Resource Officers	25	5 Days 40 Hours
Let's Talk Safety for Families: Access to Lethal Means	General Audience	New offering for suicide prevention	As requested 1.5 Hours
Let's Talk Safety: Clinical Issues Associated with Access to Lethal Means	Behavioral Health Clinicians	New offering for suicide prevention	As requested 1.5 Hours

Trainings Relevant for Both Adult and Children's Services			
Type of Training	Intended Audience	Number of Participants Anticipated	Frequency/ Length of conference
Mental Health Interpreting Peer Supervision Groups	A supervision group for clinicians serving clients who are deaf or hard of hearing.	5-15	Monthly
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
Working with the Suicidal Client	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
Come Learn Presentations	DBHDID staff	Unlimited	Quarterly 1 hour
Overview of Early Interventions for First Episode of Psychosis	Regional Board staff, DBH staff, state psychiatric facility staff, other providers of psychiatric services for youth and young adults	Approximately 50	1 Day

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

Creating Community Connections: A Behavioral Health Case Management Conference

For Targeted Case Managers who work with adults with SMI, children with SED, individuals with SUD, and individuals with co-occurring chronic or complex physical health conditions and their supervisors. Has traditionally been two (2) days.

Crisis Intervention Team

In collaboration with the National Alliance on Mental Illness (NAMI), 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.

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.

Heal the Healer Training and Retreat

This 2-day, annual training/retreat is an opportunity for "helping professionals" to learn self-care theory and practice applicable to both professionals and their clients.

KDBHDID Orientation

The Department provides an orientation to all new staff. The training enhances staffs' knowledge of the mission and vision of the agency, programs and services administered by the Department, and staff who lead those initiatives.

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. We will be initiating an interpreting mentoring program in FY2011 to take it to the next level

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").

Come Learn Presentations

Quarterly "brown bag" presentations by various agency staff regarding topics that are of interest and important for DBHDID staff to understand.

Overview of Early Interventions for First Episode of Psychosis

On November 25, 2014, the DBHDID offered a one day training to introduce state partners to the concepts of evidence based treatment for first episode of psychosis. The DBHDID Medical Director led the conversation with a presentation about psychosis and treatment methods. A panel discussion, including individuals in recovery from psychosis and family members, discussed strengths and needs of the system regarding treatment for individuals experiencing their first episode of psychosis.

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 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, as well as American Indian/Alaskan Native populations in the states.

Requested Revision:

Assess the strengths and needs of the primary prevention services system to address individuals in need of primary substance abuse prevention services. Please differentiate between the child and adult primary prevention systems.

Response:

Strengths:

Kentucky has a well-developed prevention system, 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 eighteen 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 three years of being hired. (Kentucky has one of the highest percentages of ICPS exam pass rates of any state in the United States.)

Though the number of Drug Free Community grantees has decreased slightly since our last SAPT Block Grant Plan (from 32 to 26), Kentucky still has the highest number of Drug Free Community Grantees per capita than any other state in the United State. 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 to local coalitions who apply for DFC funding.

The Kentucky Prevention System has made a concerted effort to integrate both the Strategic Prevention Framework and SAMHSA's Strategic Initiative # 1 into its prevention system. The administrative

regulations which govern the Regional Prevention Centers (908 KAR 1:400) were revised to include specific reference to the Strategic Prevention Framework.

Department Responsibilities. The department shall:

- (1) (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

With CSAP's help, Kentucky obtained training and technical assistance from J.B Associates on the Strategic Prevention Framework in 2012. The training was offered in two different parts of the state and was attended by all Regional Prevention Center Directors, RPC staff, prevention coalitions and KY-ASAP Local Board members. The training was the Kentucky Prevention Branch's response to a service gap that emerged during a workforce development survey conducted during our SPE Grant. The survey revealed that only 23% of the RPC staff felt they had sufficient skills training their communities on the SPF and further that only about 40% of the counties in their regions were implementing the SPF effectively. As new prevention specialists enter the workforce we must ensure that they are trained in the SPF so that our prevention system operates with the same vision, mission and principles.

With regards to SAMHSA's Strategic Initiative # 1, the Prevention Branch has successfully intersected with the Substance Abuse Treatment and Mental Health Branches, as well as KY's suicide prevention initiatives to offer support for planning efforts and opportunities for collaborative work. An example of this intersection is the Prevention Branch now serving on the Prescription Medication Policy Academy Planning team. The expansion of the KIDS NOW PLUS Program (an early intervention program that targets pregnant women who are at risk for ATOD use during their pregnancy) is one outcome resulting from this collaboration/integration effort. KIDS NOW PLUS is now offered in 13 of the 14 Regional Prevention Centers in the state, an increase in involvement of five additional regions.

Kentucky has also made significant strides in educating its prevention workforce about co-occurring disorders and trauma informed care. This has been done largely through the three annual, ongoing prevention work force components: Kentucky School of Alcohol and Other Drug Studies, Kentucky Prevention Network and Kentucky Prevention Academy. Prevention staff works with conference planners to ensure that the training content includes quality training on the Strategic Prevention Framework, suicide prevention, co-occurring disorders, trauma informed care and reducing stigma associated with medically assisted treatment for pregnant women. In fact, the Prevention Branch recently collaborated with the Treatment Branch to organize and host a one day conference, "Improving Outcomes Among Drug Addicted Pregnant Women and Parenting Women." All of the RPC Directors as well as some staff attended this one day workshop. Among the topics addressed were prevention's role in reducing stigma associated with pregnant women who seek medically assisted treatment. Many of

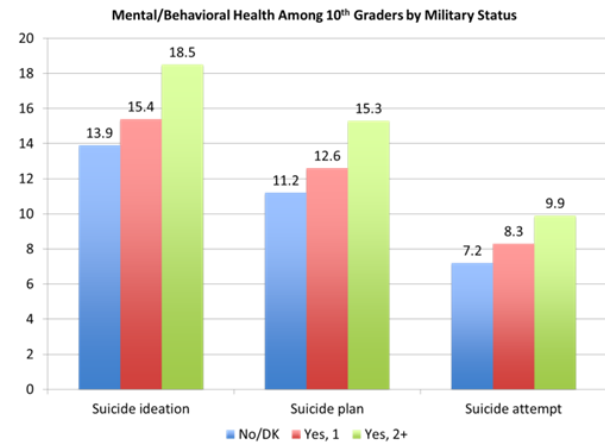
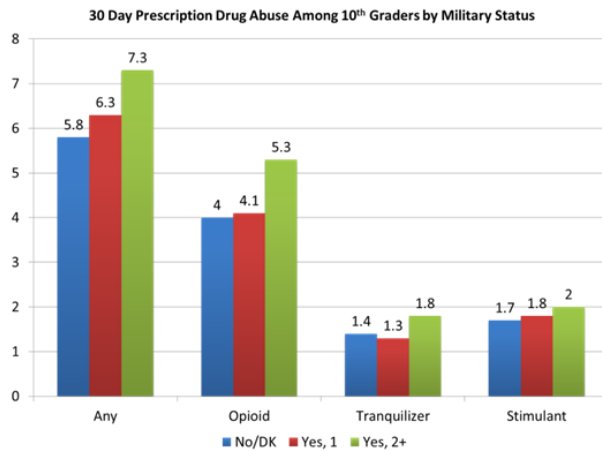
our RPCs have hosted Mental Health First Aid trainings. Some RPC staff are certified Mental Health First Aid Trainers.

The RPCs are also involved in efforts to reduce stigma associated with Naloxone Administration and needle exchange. Senate Bill 192, which passed in the last legislative session, allows first responders and family members to administer Naloxone and gives doctors the authority to prescribe it to family members of persons who have a history of opioid dependency. The legislation provides significant funding for treatment of heroin addiction and also provides money for prevention coalitions to educate community members on the benefits of Naloxone administration. The Kentucky Office of Drug Control Policy recently issued an RFP to KY-ASAP Local Boards, Regional Prevention Centers and Prevention Coalitions to do work in this area.

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. The Kentucky School of Alcohol and Other Drug Studies, our annual substance abuse prevention and treatment conference has greatly expanded the scope of its prevention offerings to include such topics as "Prevention's Role in Kentucky's Heroin Epidemic" and "Trends in Emergency Treatment of Acute Overdoses, How EMS Can Work to Prevent Poor Outcomes." Having such work force training venues available makes it possible for the Prevention Branch to address training gaps in the prevention workforce as new priorities emerge.

The Prevention Enhancement Site System created during Kentucky's first State Incentive Grant continues to provide high quality training on specialized areas such as Tobacco Environmental Strategies, Alcohol Environmental Strategies, how to build capacity with the faith-based community, Fetal Alcohol Spectral Disorder and Marijuana. This year, a Suicide Prevention site was established through a Zero Suicide grant. The site is housed within the Adanta Regional Prevention Center. The Site coordinator formerly managed the RPCs in the State Office and has a very close working relationship with all of the RPC Directors and thorough knowledge of Kentucky's state prevention network.

The Kentucky Incentives for Prevention (KIP) Survey continues to provide timely, county-level data on substance abuse consumption, consequences, risk/protective factors and behavioral health for ages 12-18. The 2014 survey was updated to include questions about suicide ideation, suicide attempts, depression and number of family members serving in the military. These new data sets provided us with a wealth of information that has driven our state planning efforts. (See graphs below) The data suggests that having one or more family in the military puts a child at risk for a number of substance abuse and behavioral health problems. As result, we have designated service members, veterans and families (SMVF) as a prevention priority for both PFS 2015 and Block Grant planning.



The Kentucky Synar Program has very strong partnerships and continues to provide quality merchant education training through its Tobacco Retail Underage Sales Training (TRUST). This year, the training content was revised to include high quality audiovisual film clips of purchase scenarios, as well as information on electronic nicotine devices and other alternative tobacco products. Thus far, roughly 2000 clerks and managers have received training through the TRUST program. Three states have asked permission to use material from the TRUST program to develop their own merchant education programs.

The Prevention Branch has developed a new prevention data reporting system. The system was developed to respond to the new needs of our prevention system and to address the suggested enhancements made by the CSAP Site visit teams in past site visit reviews. The new system will be able to better link evidence based programs, the six CSAP strategies and state strategies. Additionally, it will connect the plans created by RPCs to the work completed or carried out and entered into the system. It will also give us a more accurate picture of how much Block Grant funding is spent on each of the six strategies. This new system improves prevention efforts on two fronts.

First, the new system will be able to capture, through automatic reporting features, plans around substances and behaviors KY's prevention system is targeting, CSAP strategies planned to address the substances and behaviors, high risk populations being focused upon, and partners who the RPCs have planned to engage to advance the work. An additional feature that is being built into the system is planned outcome measures so that our prevention system initiates an evaluation and sustainability assessment of their work at the beginning, in the planning phases. These automated features were not available in our previous data system.

A second improvement feature of the prevention data system is its ability to connect the planning component to the activities or services reported component, a feature not available with our previous system. This means that the work of our prevention system will be seen in output form, be aligned with the activity associated with a particular substance or behavior and the strategy proposed. Connecting

plans with strategies and services has been a challenge for the system, and this feature will assist with closing this gap.

Still in the development phase, an additional improvement is helping the prevention system to understand and identify outcome measures associated with their strategies and service delivery. Being able to understand the short-term outcomes of service delivery has been a challenge. It is anticipated that this will be a continuous quality improvement effort for the prevention system, having data drive the approach to improving the quality of services, processes, and activities.

Weaknesses

Significant gaps exist in Kentucky's capacity to provide prevention services to the Service Members, Veterans and Families (SMVF) population. At a recent planning meeting, RPC Directors were asked: On a scale from 1-10, one being not ready, and 10 being very ready to work with the military, where would you place your RPC in terms of its readiness to work SMVF individuals in your community in a culturally appropriate manner? What would your RPC need to move along the continuum of readiness?

Six Regions rated their readiness level at 1. Six regions rated their readiness level at 2. One region rated their readiness at 3 and one region rated their readiness at 4. Clearly, our network of prevention specialists will have to do much work to get their communities ready to work with this population. Another question that was asked was: "What would your RPC need in order to move forward along the continuum of readiness?" The most common responses were:

- 1 More knowledge about evidence based prevention strategies for the SMVF population
- 2 Effective ways to create linkages with the SMVF population and identify prevention champions
- 3 Crafting culturally appropriate prevention messages for the SMVF population
- 4 Lessons learned from other states who have worked with the SMVF population

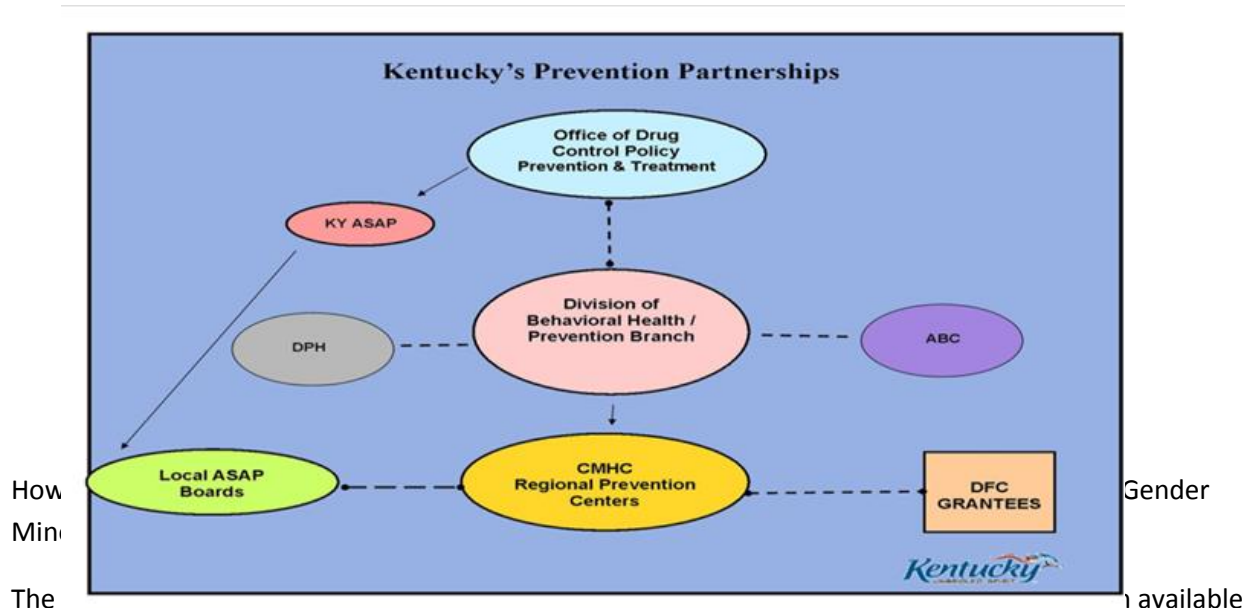
The training needs listed above reflect capacity building gaps that we, at the state and regional levels, will have to fill before our communities can draft effective strategic plans to deliver services to the SMVF population. We are already in the process of incorporating these needs into our Prevention Branch Workforce Development Plan.

Reaching the LGBTQ community continues to be a challenge due to a scarcity of data and difficulty in developing a mechanism to administer prevention services to this at risk population. In order to obtain better data on this population, Prevention Branch staff and Evaluators discussed adding a sexual orientation question to the 2014 KIP Survey. All parties agreed that the data gained would be valuable for planning purposes, but also felt that the question might cause concern among parents in some school districts which could result in decreased participation in the survey. To date, we have not had sufficient needs and resource assessment data to begin planning efforts. The LGBTQ Work Group began this process four years ago has not been active recently. Efforts to revive the LGBTQ work group have not been successful.

Delivering prevention services to the adult population continues to be a challenge. Most of this effort currently consists of universal indirect strategies – PSAs, social norms messaging and media campaigns that target adults providing alcohol to youth. Some of our RPCs have made some headway in offering direct services to adults by partnering with local EAP programs, or by providing our Monitor, Educate, Dispose or Secure (MEDS) Program to curb prescription drug diversion. On the whole, the adult population remains difficult to serve due to lack of county level consumption data, lack of knowledge of adult risk and protective factors and lack of knowledge about universal adult evidence-based programs.

Organization of the Kentucky Prevention System and its regional and local entities

The chart below depicts the key players in Kentucky’s Prevention System. The Division of Behavioral Health’s Prevention Branch works closely with the Kentucky Office of Drug Control policy, the Department for Public Health and the Department for Alcoholic Beverage Control. The solid lines indicate funding streams, while the dotted lines reflect collaborative agreements. The Office of Drug Control oversees the Kentucky Agency for Substance Abuse Policy which oversees a state-wide network of 118 substance abuse prevention and treatment local planning and coordination boards which are funded by Master Settlement Dollars. The Director of KY-ODCP also serves on our SEOW/Evidence-Based Workgroup. The Department for Public Health and the Department for Alcoholic Beverage Control are members of our Synar Program and our SEOW/Evidence-Based Work Group. The Prevention Branch Administers the RPCs, which are housed in the Community Mental Health Centers. The RPCs are our “boots on the ground” and provide technical assistance and training on the Strategic Prevention Framework and other prevention needs to KY-ASAP Local Boards, DFC Grantees and other prevention coalitions.



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data in the needs assessment section of their county work plan. Once these needs have been determined, the RPCs 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, Kentucky Prevention Academy and the Kentucky Prevention Network. Kentucky has no federally recognized tribes. This gap makes it difficult to reach the Native American population. The most recent census data lists the Native American Population in Kentucky at 0.3%.

2016-17 Revision Request for additional information

- How is KY addressing the needs of diverse racial, ethnic and sexual gender minorities?
- 'KY's assessment identified gaps for the MHS for special populations such as Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ)& racial minorities such as African Americans & Hispanics but KY did not make these populations as one of KY priorities. Please address.
- Please address how these systems address the needs of diverse racial, ethnic and gender minorities in KY

The items below are provided to highlight how the Department and providers (CMHCs) address the specific needs of diverse racial, ethnic and sexual gender minorities, as well as other health disparity groups (e.g., the homeless, socially isolated, living in extreme poverty, substandard housing, trauma, etc.). The department allows the individual CMHCs to set priorities in their own region but offers guidance and support to assist with awareness and best practice/policy protocols.

All staff within the 14 CMHCs are required to participate in cultural competency training during their agency's initial orientation. The training emphasizes sensitivity to racial, ethnic, religious, gender identity and sexual orientation differences. CMHCs conduct person-centered assessments and as such inquire about the ethnic and cultural identity of those they serve. CMHCs also provide various on-line and live training opportunities throughout the year to staff.

Each of the 14 CMHCs, as required by contract, has a designated staff person to serve as the agency's point person for SMVF who provide consultation to all staff and oversee related programming. They have received special training (initial 40 hour training required) and are continually providing outreach to community partners. Several CMHCs have agreements/contracts with Veterans Affairs to provide office space for VA clinicians in rural areas or other partnerships to assist with outreach and service provision to SMVF. One CMHC worked with the VA to start a veterans' residential treatment programs and developed a curriculum to address trauma issues specific to veterans. The Department sponsors two events annually to train and coach providers serving SMVF population. See elsewhere in this section (Criterion 5) the discussion about Operation Headed Home and Operation Immersion. The CMHCs keep abreast of VA clinics and resources available for SMVF and often make referrals and provide warm hand offs where applicable.

The Department and the CMHCs offer a variety of trainings and other learning/sharing opportunities for all staff regarding best practices for providing care that is trauma-informed. Specialty training for clinical staff is regularly provided on specifics for doing therapy with LGBTQI clients. In one region of the state with a higher percentage of Hispanic/Latino population, they employ two clinical staff (one in children's and one in adult services) that are fluent in Spanish. These providers offer individual, group and family therapy as well as psychological testing to this population. The region also employs one full time Assessment Specialist that is fluent in Spanish to complete an initial assessment and conduct emergency assessments that may walk in. The after hour, on-call team also uses these staff to provide services in Spanish for emergency response services.

Another CMHC employs several staff that are fluent in their home languages; one is from India and one is from Africa.

The CMHCs also employ staff that identify as part of the LGBT community and are able to provide clinical services as requested by a consumer. There has recently been training conducted to increase knowledge and assist with policy setting for ensuring the needs of transgender individuals are met within the crisis services arena.

For CMHCs with Therapeutic Foster Care programs, training is provided to all foster parents specific to diversity / ethnic issues and issues specific to the LGBT population and opportunities are provided for the children in foster care to be exposed to a variety of different ethnic and cultural experiences.

Providers of Crisis Stabilization Units note that they routinely make accommodations for individuals with cultural or religious preferences (i.e., holiday celebrations, respecting who may touch a Muslim client's copy of the Koran, providing separate (private) accommodations for LGBT clients when requested, meals are chosen for individuals that meet their religious specifications, etc.)

Also, language barriers are addressed by the use of interpreters across the state and the managed care companies may also assist with this.

One CMHC reports that they have partnered with the KY Refugee Office and have invited staff in to do trainings on cultural sensitivity. As part of a person centered assessment we inquire about cultural issues.

Learning about the culture of poverty is important for providers in Kentucky and there are numerous opportunities provided throughout the state on a regular basis. This is repeatedly a requested/needed training topic.

Addressing the needs of individuals who are deaf or hard of hearing is also important in Kentucky. The Department hosted the first Deaf or Hard of Hearing track at the (children's) *System of Care* conference this year. Topics included working with the Department for Community Based Services (DCBS-child welfare), Early Interventions for Children with Hearing Loss, and Resource Mapping for Individuals Who Are Deaf or Hard of Hearing. As a result, child-serving agencies and those serving individuals who are Deaf or Hard of Hearing had an opportunity to cross train and build relationships. As a result of the System of Care Conference, DCBS has designated a point person to address concerns with accessibility and quality of care when Deaf-member families are involved in cases.

The first Mental Health First Aid Training in American Sign Language (ASL) was held in Kentucky for over thirty (30) individuals. Partners included the Eastern Kentucky University (EKU) American Sign Language Interpreter Education Program, Vocational Rehabilitation, and Kentucky Association of the Deaf.

Two (2) Deaf instructors were trained to provide Driving Under the Influence (DUI) education in American Sign Language. Three (3) additional ASL interpreters completed the Mental Health Interpreter Training (MHIT). There are now at least two (2) MHIT trained interpreters in each state hospital catchment area.

The Department reviews the results of the MSHIP and YSS-F annually and while recognizing that the scores on the "Highly Culturally Sensitive Staff" is not all-telling, the current year scores do not indicate concern (score for YSS-F was 96% reporting positively)

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet services needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the populations relevant to each block grant within the state's behavioral health system, especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet these unmet service needs and gaps.

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](#) (NSDUH), the [Treatment Episode Data Set](#) (TEDS), the [National Facilities Surveys on Drug Abuse and Mental Health Services](#), the annual [State and National Behavioral Health Barometers](#), and the [Uniform Reporting System](#) (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should 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, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance abuse prevention, 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.

[SAMHSA's Behavioral Health Barometer](#) is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the [National Survey of Substance Abuse Treatment Services](#) (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the [Behavioral Health Barometers](#). States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the [Healthy People Initiative](#)¹⁸ HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

¹⁸ <http://www.healthypeople.gov/2020/default.aspx>

Footnotes:

II. Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system

Identify the unmet service needs and critical gaps within the current system. This step should identify the unmet service needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the populations relevant to each block grant within the state's behavioral health system, especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet these unmet needs and gaps. 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 (NSDUH), the Treatment Episode Data Set (TEDS), the National Facilities Survey on Drug Abuse and Mental Health Services, the annual State and National Behavioral Health Barometers, and the Uniform Reporting System (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should 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, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance abuse prevention, 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 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:

- 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 Medicaid Expansion in Kentucky, with over 500,000 new individuals covered by Medicaid
- Opening the network of Medicaid billable behavioral health providers to those other than CMHCs
- Implementation of new services as outlined in new Medicaid state plan amendment approved by CMS in January 2014 (especially substance abuse services, crisis services and evidence based practices for adults with SMI and children with SED)
- Development of new regulations, in collaboration with other state agencies (Medicaid, Child Welfare, State Guardianship, etc.) in order to adequately outline new available services and supports and new eligible service providers
- Evaluation of state behavioral health authority's purchasing options and subsequent progress toward redesign of CMHC contracts and implementing performance based contracting
- Implementation of the ACA and the Governor's Office decision to reduce behavioral health funding in the biennium (SFY 2015 and SFY 2016), due to anticipated savings with more individuals and more services being covered by Medicaid and third party payers (DBHDID state funding was reduced by \$21 Million in SFY 2015; \$30 Million in SFY 2016)

- Entering into an Interim Settlement Agreement (ISA) with Kentucky Protection and Advocacy, as of August 2013, and agreeing to move at least 600 individuals with SMI out of personal care homes and into permanent supportive housing in communities of their choice within a 3-year period
- Rebalancing of DBHDID facility funds into community funding for Direct Intervention Very Early Response Treatment System (DIVERTS) services to support individuals identified through ISA. (\$6 - \$7 Million for a three year period)
- Securing Settlement Funds from pharmaceutical companies through the Kentucky Attorney General's Office, of which many were designated for use in programming to address substance use disorders among adolescents and adults, including pregnant women
- Coordinating behavioral health and physical health care by five contracted Managed Care Organizations (MCOs)
- Legislative Actions (including unfunded mandates)
- Returning Service Members, Veterans and their Families with Behavioral Health Needs
- Increasing Behavioral Health Workforce Shortages and credentialing issues
- Increased concern about the state's underfunded Pension System and Increased Retirement Contribution by CMHCs

Division of Behavioral Health – Unmet Service Needs

Mental Health

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.

During SFY 2014 & SFY 2015, Colette Croze, MSW, a private consultant specializing in public resource management, provided technical assistance to DBHDID regarding the substance use continuum of care in Kentucky. This assisted DBHDID with preparation for ACA implementation, including Medicaid expansion, workforce readiness/expansion, Health Benefits Exchange, creating a substance abuse benefit package through Medicaid, and other topics. Results from this technical assistance included a more clearly define Plan and Budget process with DBH contractors, an evaluation of purchasing options regarding substance abuse services, and an evaluation of contracts with Managed Care Organizations.

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 45% of adults with SMI in Kentucky receive services from the Regional Boards, and about 9.5% of adults with SMI served by the Regional Boards received targeted case management services. It was also noted that about 47% of children with SED received services from the Regional Boards and about 16% of the children with SED served by the Regional Boards received targeted case management services.

In May 2013, Deloitte issued a report entitled, "The Commonwealth of Kentucky Health Care Workforce Capacity Report". This study assessed current access to all health care in Kentucky, considering that 640,000 were estimated to be uninsured at the time of the study. This report determined that large gaps appear in the health care workforce, especially in rural and underserved areas across the state. It noted that over 80% of Kentucky counties had a major gap in behavioral health providers, including psychiatrists/psychologists. As a result of this study, CHFS opened the available network of Medicaid providers for behavioral health services and created regulations outlining processes for providers, other than CMHCs, to become Medicaid billable organizations.

The Center for Mental Health Services (CMHS) conducted a mental health block grant monitoring visit June 17-19, 2014. The monitoring team met with DBHDID Commissioner and other Department leadership, financial administrators, as well as Department staff in children and adult programming. The team attended a Behavioral Health Planning and Advisory Council meeting and interviewed a group of individuals in recovery and family members from across the state. Some recommendations following this visit included:

- DBHDID should include individuals in recovery when meeting with Managed Care Organizations and DMS should consider providing incentives to MCOs to promote positive outcomes;
- DBHDID should implement a formal cultural competency program and assign a program coordinator;
- DBHDID should enhance the use of geographic information systems to assist in advocacy and regional planning efforts;
- The Cabinet and DBHDID should carefully track and analyze outcome data regarding programs and services to improve return on investment;
- DBHDID should provide training about behavioral health issues and resources to inmates who staff reentry councils and reentry hotlines;
- DBHDID should consider expanding school based mental health services;
- The Behavioral Health Planning and Advisory Council should plan a retreat with activities designed to focus Council efforts and highlight areas for collaboration. In addition the Council could receive SAMHSA technical assistance regarding orientation to Department data collection and mandated responsibilities of their use;
- DBHDID should increase involvement of individuals in recovery in the development of regulations; and
- DBHDID should expand the use of telehealth for individuals in rural areas, and work with multiple state agencies to improve transportation issues.

At the Finance and Data Committee meeting of the Behavioral Health Planning and Advisory Council (BHPAC) in April of 2014, Council members suggested priorities for block grant funding allocations. The Council listed Trauma and Justice and Recovery Support as top strategic priorities. Supported employment, peer support, adolescent recovery groups, and quality, safe child care for parents in treatment at consumer run programs were listed as top service priorities. The Council recommended the following priority populations:

- Individuals with substance use disorders
- Individuals who are homeless
- Mental health support groups in schools
- Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ)

At the Finance and Data Committee meeting of the BHPAC in April of 2015, Council members again suggested some priorities for block grant funding. Council members suggested funding of programs such as Youth Drop-In Centers, Oxford House (an evidence based practice for individuals with substance use disorders) projects involving both supported employment and case management services, Homeless Prevention Projects, and emergency preparedness funding.

During SFY 2015, Kentucky System Transformation Advocating Recovery Supports (KYSTARS) conducted a needs assessment regarding consumer run programs across the state. This assessment gathered information regarding four (4) primary areas:

- Safety
- Group Process/Wellness
- Recovery Philosophy

- Leadership

A KYSTARS review team interviewed leadership and participants of each consumer run program funded by DBH at that time. (e.g. five (5) programs). KYSTARS found that all programs would benefit from additional training in various program areas. All programs could benefit from safety training, four (4) of the programs could benefit from wellness education, three (3) programs could benefit from training on recovery philosophy, and four (4) programs could benefit from leadership training. KYSTARS used these findings to design beneficial workshops at their annual conference for peers and providers in May of 2015. KYSTARS will continue to work with these programs, and others, through contract with DBH.

During SFY 2015, the Kentucky chapter of the National Alliance on Mental Illness (NAMI KY) conducted a statewide needs assessment regarding the mission of NAMI and unmet needs of individuals in recovery and their family members. Some findings included:

- Underrepresented community groups needing outreach (African American groups; Hispanic groups; private hospitals, therapists, doctors; Immigrant refugees; young siblings of persons with SMI; children in general)
- More programming implementation needed (provide training for each signature NAMI program every year; expand training opportunities for rural affiliates; more supported employment assistance; fundraising; continue assistance to end seclusion and restraint)
- Additional supports needed (peer to peer; ending the silence; parents and teachers as allies; NAMI BASICS; provider education; services for young people; NAMI support group in every county; more opportunities for individuals in recovery to provide training)

Prevalence Data for Adults with SMI

This section addresses Criterion 2 as required in federal block grant legislation.

Kentucky's earliest estimates of the prevalence of severe 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 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 originally published on May 20, 1993.

Early planning in Kentucky for adults with severe 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 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.

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, and a rate of 2.6 percent for adults with severe and persistent mental illness (SMI).

Variable	Criteria
Age	Age 18 or older
Diagnosis	Major Mental Illness <ul style="list-style-type: none"> • Schizophrenia Spectrum and Other Psychotic Disorders • Bipolar and Related Disorders • Depressive Disorders • Trauma and Stressor Related Disorders
Disability	Clear evidence of functional impairment in two or more of the following domains: <ul style="list-style-type: none"> • 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. • 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. • 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. • Physical Functioning: Person's general physical health, nutrition, strength, abilities/disabilities and illnesses/injuries. • 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.
Duration	One or more of these conditions of duration: <ul style="list-style-type: none"> • Clinically significant symptoms of mental illness have persisted in the individual for a continuous period of at least two- (2) years. • The individual has been hospitalized for mental illness more than once in the last two- (2) years. • 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

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 2014.

Regional Boards	Adult Census 2010	Estimated Prevalence (2.6% of the Adult Census)	Kentucky Adults with SMI Served in SFY 2014	Penetration Rate - SMI Served
Four Rivers	161,545	4,200	2,325	55%
Pennyroyal	158,100	4,111	3,565	87%
RiverValley	161,977	4,211	2,130	50%

LifeSkills	217,231	5,648	1,967	35%
Communicare	200,640	5,217	3,850	74%
Seven Counties	730,843	19,002	7,630	40%
NorthKey	326,235	8,482	2,866	34%
Comprehend	42,757	1,112	704	63%
Pathways	170,601	4,436	2,882	65%
Mountain	119,756	3,114	3,089	99%
Kentucky River	89,550	2,328	2,250	97%
Cumberland River	181,110	4,709	3,220	68%
Adanta	160,202	4,165	2,239	54%
Bluegrass	595,449	15,482	4,270	28%
TOTAL	3,315,996	86,216	42,987	50%

Note: The data for SFY 2015 is not certified until October 15th thus SFY 2014 data is used.

Data Sources Used

- Kentucky MIS Client/Event Data Set
- Kentucky State Data Center/US Census Bureau 2010
- 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 210.005 <http://www.lrc.ky.gov/Statutes/statute.aspx?id=40795>

**Prevalence Rate for Children with SED
Criterion 2**

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.)

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 2013 –59,723 or 6% (of Kentucky's child population)

Kentucky MH Children Served SFY 2014 –57,476 or 6% (of Kentucky's child population)

Kentucky SED Children Served SFY 2013 –29,242 or 57% (of the 5% SED population)

Kentucky SED Children Served SFY 2014 –29,389 or 57% (of the 5% SED population)

Regional Boards	Child Census 2010	Estimated Prevalence (5% of the Child Census)	Kentucky Children with SED Served in SFY 2013	Penetration Rate of Children with SED Served in SFY 2013	Kentucky Children with SED Served in SFY 2014	Penetration Rate of Children with SED Served in SFY 2014
Four Rivers	44,367	2,218	1,461	66%	984	44%
Pennyroyal	51,686	2,584	613	24%	601	23%
RiverValley	51,495	2,575	873	34%	1,094	42%
LifeSkills	66,964	3,348	1,172	35%	1,270	38%
Communicare	68,477	3,424	3,500	102%	3,021	88%
Seven Counties	228,248	11,412	6,575	58%	6,862	60%
NorthKey	112,412	5,621	2,317	41%	2,383	42%
Comprehend	13,721	686	570	83%	606	88%
Pathways	48,935	2,447	1,624	66%	2,003	82%
Mountain	34,337	1,717	1,212	71%	1,480	86%
Kentucky River	25,212	1,261	1,268	101%	1,080	86%
Cumberland River	55,508	2,775	3,120	112%	3,088	111%
Adanta	47,054	2,353	1,794	76%	1,844	78%
Bluegrass	174,955	8,748	3,143	36%	3,073	35%
TOTAL	1,023,371	51,169	29,242	57%	29,389	57%

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](#)

Co-occurring Disorders

Prevalence Data

In SFY 2014, 7,637 individuals over the age of 18, diagnosed with co-occurring mental health and substance use disorders were served by the Regional Boards.

In January 2014, a new Medicaid state plan amendment for Kentucky was approved by CMS. In this new billable service package, substance use disorder services were added, as well as several evidence based practices, including peer support and ACT.

Until then, individuals in Kentucky who were diagnosed with substance use disorders were required to provide payment through other insurance, self-pay, or by providers who were funded through grants. Many individuals did not receive treatment, or were not given adequate treatment, and many were not diagnosed appropriately due to fear of not being reimbursed if substance use was even mentioned in a medical record. Beginning in SFY 2015, Kentucky's data should improve and identification and services for individuals with co-occurring disorders should increase as well.

Between SFY 2009 and SFY 2015, a team of integration specialists was developed by DBHDID to use DDCAT and DDMHT tools and to visit regional programming and assess co-occurring capabilities. All programs were offered the opportunity to use the data from their DDCAT/DDMHT 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 considered co-occurring capable. The DBHDID provided technical assistance during this time period, regarding change projects as well as DDCAT/DDMHT fidelity assessments. A Transformation Transfer Initiative (TTI) grant, as well as securing a national consultant (Heather Gotham, co-creator of the tools), were instrumental in supporting regions in working towards co-occurring capability in their programming for adults. The DBHDID continues to provide technical assistance or help with fidelity assessments as requested.

The DBHDID has been working since SFY 2014 to implement Assertive Community Treatment as a service across the state for individuals with SMI. However, in working with ACT teams it became apparent that a large number of the individuals being served also had co-occurring substance use disorders. ACT teams have been ill prepared to provide good treatment to these individuals. In SFY 2015, the Department contracted with Case Western Reserve University to provide a series of training in Integrated Dual Diagnosis Treatment (IDDT), an evidence based practice that has been renamed Integrated Treatment for Co-Occurring Disorders by SAMHSA. Case Western provided three

(3) separate training events in various parts of the state. Each training event consisted of three (3) days of training. All staff members of Assertive Community Treatment (ACT) teams across the state were trained in IDDT. At present, seventeen (17) ACT teams were trained in this model. When SFY 2015 data is analyzed, Kentucky should be able to more accurately assess the level of comorbidity of diagnoses for individuals receiving ACT as well as other services.

Unmet Needs and Critical Service Gaps

As a result of these statewide assessments, it became clear that programs did not include many peer led mutual support groups. Mutual support and mutual aid groups are identified as one of the ten guiding principles of recovery from SAMHSA. The DBHDID leveraged funds from the TTI grant and later from the block grant, for purposes of hiring an individual in recovery from co-occurring disorders to consult with DBHDID staff, regional staff and peers, and develop co-occurring mutual support groups in many regions across the state. Specifically, this individual in recovery assisted with development of Double Trouble in Recovery (DTR) mutual support groups across the state. DTR is a twelve-step self-help group that is facilitated by individuals in recovery from both mental health and substance use disorders. DTR is considered a best practice. At present, there are at least nine (9) regions that provide DTR as a support for individuals and more groups are continuing to develop. DBHDID continues to offer technical assistance and materials to assist with the development of this support across the state.

Kentucky's behavioral health service system continues to have workforce development needs for those serving individuals with co-occurring mental health and substance use disorders. The statewide system that has traditionally served adults with SMI needs much more in the way of training, implementation techniques, and technical assistance/coaching to make quality integrated services a reality for all individuals in Kentucky. In addition, the statewide system that has traditionally served adults with substance use disorders need much more in the way of training, and technical assistance/coaching on treating mental health issues as well.

Kentucky's ACT teams need to fully implement integrated principles of co-occurring disorder treatment into their services. This is very important due to the vulnerability of the population being served by ACT teams. The individuals being served by ACT have very intense treatment needs and many require integrated treatment in order to be successful.

There is also a gap regarding intensive outpatient treatment for individuals with co-occurring disorders in Kentucky. There are several intensive outpatient treatment programs offered for individuals with substance use disorders across the state. In the new 2014 service package offered through Medicaid, integrated treatment programs for individuals with mental health disorders was added as a billable service. In response, a few of those programs have developed across the state as well. However, it is unclear how either of these programs serves individuals who have co-occurring disorders. Either program, whether through the substance use disorder providers, or through the mental health providers, should be able to serve individuals with co-occurring disorders and ensure quality outcomes.

Kentucky has been training peer support specialists since 2006. However, initially, peers were only trained who were in recovery from mental health or co-occurring disorders. During the last few years, the DBHDID has been training peers in recovery from substance use disorders as well. When the new Medicaid state plan amendment was approved by CMS in January 2014, peer support was included as a billable service. The DBHDID changed the language in its peer support regulation to support training individuals in recovery from mental health, substance use or co-occurring disorders to become peer support specialists. Peer support for all populations is now a billable Medicaid service. More work needs to be done in this area to ensure adequate numbers of peer support specialists to work with all populations and to ensure adequate support and supervision.

Priorities for SFY 2016/2017:

- To monitor the status of providing integrated care through co-occurring capable programs in the regions across the state;
- Continue to provide more cross training opportunities through Kentucky School and other training events, and more training on co-occurring topics in general;

- Continue to require the use of evidence based treatment practices, including Integrated Dual Diagnosis Treatment (IDDT);
- Provide technical assistance to ACT teams regarding IDDT through the use of fidelity assessments, consultations and continued training, until IDDT is implemented with fidelity through all ACT services;
- Increase the number of peer specialists in recovery from co-occurring disorders hired by providers and improve supervision and support for peer specialists who are employed; and
- Continue to support and facilitate new peer led mutual support groups.

Data Sources Used:

- DBHDID SFY 2015/2016 Plan and Budget Documents
- Institute of Pharmaceutical Outcomes and Policy (IPOP) Data
- DBHDID/CMHC SFY 2016 contracts
- <http://media.samhsa.gov/co-occurring/news-and-features/integrated-treatment.aspx> (Toolkit for Integrated Treatment for Co-Occurring Disorders)
- <http://ahsr.dartmouth.edu/html/ddcat.html> (DDCAT/DDMHT information)
- <http://www.hazelden.org/web/go/dtr> (Double Trouble in Recovery)
- <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=13> Double Trouble in Recovery)
- <http://www.samhsa.gov/recovery>
- <http://www.niatx.net/Home/Home.aspx?CategorySelected=HOME>

Outreach to Service Members, Veterans and their Families in Kentucky:

Prevalence Data, Unmet Needs and Critical Service Gaps:

The Division of Behavioral Health is striving to meet the behavioral health needs of the Service Members, Veterans and their Families (SMVF) in Kentucky. The Substance Abuse and Mental Health Services Administration (SAMHSA) through its Service Members, Veterans, and their Families (SMVF) Training and Technical Assistance Center has held Policy Academies to help states and territories strengthen the behavioral health service systems supporting the SMVF population. Since 2012, Kentucky has been selected to participate and highlight their efforts at multiple SMVF Policy Academies including: Behavioral Health, Suicide Prevention, and most recently, Substance Use Disorders. Kentucky is very fortunate to have a strong representation at the table of Military leaders, Veterans Administration Hospital, state-wide service organizations, higher education representatives, and the backing of Military leadership.

Kentucky has a strong military presence with approximately 64,000 current personnel, predominately Army (35,713), Reserve and National Guard (18,538), with two large army military bases located within our borders – Ft. Campbell and Ft. Knox. More than 36,000 personnel are presently considered active duty. More than two-thirds of those military connected individuals live within our communities and access community resources for behavioral health needs. Approximately 334,000 military Veterans reside in Kentucky. There were an estimated 30,000 children and youth (ages 0 to 18) from Guard, Reserve and active duty families residing in Kentucky. Military families and Veterans in Kentucky are recognized as underserved populations as it pertains to physical and behavioral health needs.

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.

Some 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 New Dawn, Operation Enduring Freedom and Operation Iraqi Freedom with undiagnosed traumatic brain injury (TBI), Post-Traumatic Stress Disorder (PTSD), and other behavioral health disorders. There are not currently enough behavioral health providers or enough services to address these specific needs in Kentucky. Awareness and service capacity is building, but the services are often fragmented and not specifically designed for this population.

In 2013, DBH inserted language into the Community Mental Health Center contract that required each CMHC to identify at least one individual to act as a liaison to the SMVF population within their region. These individuals are known as Military Behavioral Health Coordinators (MBHC) and function as a point of contact, help the client to navigate the system and identify additional resources/benefits. The coordinators have attended Operation Immersion and Operation Headed Home events in order to gain perspective and insight into the needs of SMVF.

Operation Headed Home Conferences

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.

Since 2010, DBH has hosted four (4) Operation Headed Home conferences and trained more than one thousand (1,000+) individuals for FREE. 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 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 back to work and school, polytrauma, polypharmacy, substance abuse prevention and treatment, and hearing loss and tinnitus from blast injuries. Normal attendance for this event is over 300 individuals.

Upcoming conferences will strive to strengthen the community-based resources for returning Service members, Veterans and their Families. We will focus on reintegration of the Service member/Veteran back into the community. This will be accomplished by the development of region wide support systems. Participants will also be educated in the areas of 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 is designed to remove barriers and ease soldier apprehension and increase access to treatment. The Kentucky Division of Behavioral Health and the Kentucky National Guard have teamed up to present a comprehensive four (4) day training in military culture and issues unique to Service members, Veterans and their families. This training immerses behavioral health providers and professionals into aspects of military culture and the deployment experience. Attendees sleep in barracks, participate in early morning physical training, chores and inspection, learn about military culture/structure, experience the Field Leadership Reaction Course, experience combat simulators unique to the military, experience combat missions, enjoy MREs (Meal, Ready-to-Eat), and network with military personnel and resource providers. In addition, workshops are provided on TBI, PTSD, Combat Stress, Suicide Prevention, Substance Abuse Prevention and Treatment, Military Sexual Assault and Prevention Program, Trauma Informed Care and current best practices to treat military clients and their families.

Kentucky has held five (5) Operation Immersion events since inception in 2012 at the Wendell H. Ford Regional Training Center. This site is one of the premier Kentucky National Guard training venues. Two hundred and seventeen (217) behavioral health professionals/providers have attended this hands-on event for FREE to learn about military culture and focus on how to help the SMVF population in Kentucky.

- Kentucky has approximately 4.4 million residents with a Veteran population of 330,599.
- As of September 2014 there were a total number of 24,493 women Veterans in Kentucky and that number is down 5,917 from the 30,410 reported from the September 2012 data. Unfortunately women are not aggressive in seeking services as many do not consider themselves a Veteran. However, as more awareness is raised, such as the Governor's recent proclamation of 2015 as the "Year of the Women Veterans", more women are beginning to register at conferences and events and for their benefits.
- During SFY 2014, the Community Mental Health Centers (CMHCs) in Kentucky reported treating 769 active duty Service members. This is a .99 % increase from the CMHCs SFY 2012 data.
- During SFY 2014, the CMHCs in Kentucky reported treating 2,301 Veterans. This is a 1.06 % increase from the CMHCs SFY 2012 data.

Veteran and Active Duty Counts by Region										
Region	FY2012					FY2014				
	Active Duty		Veterans		All Clients	Active Duty		Veterans		All Clients
	Count	Percent	Count	Percent		Count	Percent	Count	Percent	
01 - Four Rivers	50	0.54%	183	1.99%	9,192	33	0.26%	245	1.95%	12,559
02 - Pennyroyal	98	0.70%	313	2.24%	13,949	108	0.84%	403	3.14%	12,844
03 - River Valley	54	0.54%	50	0.50%	9,978	35	0.36%	34	0.35%	9,667
04 - Lifeskills	42	0.31%	60	0.45%	13,447	43	0.33%	63	0.49%	12,931
05 - Communicare	15	0.13%	139	1.17%	11,891	85	0.56%	237	1.58%	15,047
06 - Seven Counties	65	0.15%	290	0.69%	42,035	74	0.17%	240	0.56%	42,930
07 - NorthKey	40	0.38%	126	1.20%	10,470	29	0.22%	125	0.96%	13,026
08 - Comprehend	50	0.93%	82	1.52%	5,399	39	0.75%	86	1.65%	5,211
10 - Pathways	63	0.36%	288	1.65%	17,469	47	0.28%	265	1.58%	16,756
11 - Mountain	71	0.65%	63	0.58%	10,899	54	0.46%	90	0.77%	11,729
12 - Kentucky River	104	0.78%	76	0.57%	13,369	109	0.68%	104	0.64%	16,128
13 - Cumberland River	4	0.02%	7	0.04%	18,631	6	0.03%	9	0.04%	22,210
14 - Adanta	36	0.31%	166	1.43%	11,612	37	0.33%	147	1.31%	11,188
15 - Bluegrass	74	0.30%	312	1.26%	24,765	70	0.30%	253	1.09%	23,211
State Totals*	766	0.36%	2,155	1.01%	213,106	769	0.34%	2,301	1.02%	225,437
*State Totals may include duplicates when clients were seen in multiple regions.										
Report Date: July 13, 2015										

Areas of Focus

- Provide effective behavioral health services
- Increase help-seeking behavior
- Reduce access to potentially lethal means
- Strengthen leadership, structure, and sustainability
- Develop opportunities to discuss current and future plans/partnerships for the expansion of the state-wide SMVF initiative.

Kentucky will continue the multiple policy academy teams that began as a result of SAMHSAs SMVF TA Center. Currently, these teams are separate and will be combined during a site visit from the SMVF TA Center in the Fall of

2015. As each team progresses toward their goals, they have identified that all of the unmet needs are related. One of the overarching goals of the combined groups will be to develop and implement a comprehensive statewide strategic plan serving behavioral health needs of the SMVF population.

Goals and Priorities for FY 2016/2017:

Priority 1. Provide Effective Behavioral Health Services

Goal:

- 1. Encourage help-seeking behavior by increasing access in utilization of available services by SMVFs.**
- 2. Continue to train, educate and develop the behavioral health workforce as it relates to the SMVF population in Kentucky.**

Kentucky Military Provider Designation:

- Utilizing already developed and/or endorsed programs and trainings, DBHDID is developing a Military Behavioral Health Provider Designation. This designation offers providers an opportunity to receive coordinated training efforts to increase knowledge and provide more adequate care to Kentucky's SMVF population. This designation targets both clinical and non-clinical providers working in behavioral health. Prior to receiving the designation, providers will participate in Operation Immersion, complete web-based educational sessions, receive two (2) day in-depth training in suicide prevention and intervention (non-clinical), or assessment, management, and treatment (clinical). Following designation, providers will be required to maintain designation through continued education opportunities, some of which will be provided through the regular Operation Headed Home event. Designated providers will then be considered preferred providers for those in the SMVF population seeking behavioral health services.

Peer Support Phase

- The Division of Behavioral Health has identified twenty (20) Veterans in recovery from a behavioral health disorder that desire to become a Certified Peer Support Specialist with the intent to establish a Veteran/Military Peer Support Network. The Peer Support Specialists will receive certification after successful completion of a week-long training course and passing a written and oral exam. The Peer Support Specialists may have the opportunity to provide peer support at the 14 Community Mental Health Centers (CMHC) across Kentucky, as well as other through other behavioral health provider organizations.

Priority 2. Increase Help-Seeking Behavior

Goal 1:

Provide TA to CMHCs and Managed Care Organizations regarding TRICARE, the military insurance benefit, and encourage agencies to accept and work with TRICARE for the SMVF population in Kentucky

Goal 2:

Create and distribute marketing information linking SMVF population to services in their area, as well as statewide services

Goal 3:

Increase help-seeking behavior by raising awareness of available resources and encouraging utilization of services by SMVF

Develop Provider Directory/Database for SMVF population

- Determine the mechanism to house the resource directory of available SMVF services

- Investigate the cost of creating and maintaining a database/resource directory
- Collaborate with other state agencies that currently have similar programming (i.e.- a statewide 211 telephone information program), or add to current Kentucky DBH Provider Directory

Review Resources and Capacity to Create Branding and Marketing Materials

- Utilize/rework current available materials for distribution
- Work with the Kentucky Broadcasting Association and Kentucky Press Association for distribution of materials and assistance
- Request TA from SMVF TA Center regarding evaluation and marketing

The DBHDID and the Kentucky National Guard have partnered to include a screening, brief intervention, referral and treatment (SBIRT) process into the Guard's annual periodic health assessment conducted among all 7,000 National Guard members every fiscal year. An initial proof of concept was conducted in May 2014 and refinements to the process are awaiting further approval.

Priority 3. Reduce Access to Lethal Means

Goal:

Reduce access to potential lethal means through education, safety control devices and information dissemination

Engage multiple entities including the Regional Prevention Centers, VA Medical Hospitals and the Kentucky Department of Veterans Affairs as part of the education/outreach to reduce access to lethal means.

- Work with community organizations to increase Naloxone education and promote the use of Naloxone kits in community in order to reduce the number of deaths associated with prescription opioid and heroin overdose
- Distribution of gun locks at Veteran Events acquired from the VA Medical Centers
- Provide safety plan handouts at events
- Promote medication take back days with SMVF emphasis
- Distribution of medication lock boxes with the National Crisis Hotline numbers on lock boxes
- Brief intervention and referral should be available at all events; ensure that MBHCs have a clinical person available to help with the warm hand off
- All materials and events should follow the safe messaging guidelines and Framework for Successful Messaging

Priority 4. Strengthen Leadership, Structure and Sustainability

Goal: A comprehensive SMVF needs assessment will be conducted as part of the Zero Suicide Initiative.

Capture Data to Support Decision Making

- Effective July 17, 2014, Gov. Beshear assigned the military behavioral health initiative to DBHDID, with continued input from KDVA, KDMA, KCMA and AOC at the discretion of the Cabinet for Health and Family Services.
- Improvement in SMVF Data:
 - DBHDID's Information System Coordinator is working to update and clarify language for providers funded by DBHDID in order to identify the SMVF population seeking services. Better identification will

- provide the Department with an improved understanding of the services needed and provided through the CMHC.
- Providers will be encouraged to utilize the updated language to identify SMVF individuals and address their needs, especially for Veterans with less-than-honorable discharge.

Data Sources Used:

- http://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml U.S. Census Bureau| American FactFinder
- http://www.va.gov/vetdata/Veteran_Population.asp 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/Report.asp> U.S. Department of Veterans Affairs, The National Center for Veterans Analysis and Statistics (NCVAS)
- DBHDID Client Event Data Set
- <http://www.samhsa.gov/veterans-military-families> SAMHSA's Veterans and Military Families
- <http://store.samhsa.gov/shin/content//PEP14-LEADCHANGE2/PEP14-LEADCHANGE2.pdf> The federal Strategic Initiatives- used to list Military specifically as a strategic goal- new plan- woven into several- although not mentioned as often as we used to see: e.g.,
- <http://www.samhsa.gov/veterans-military-families/samhsas-efforts> SAMHSA's Efforts to Support Veterans and Military Families
- <http://www.samhsa.gov/veterans-military-families/critical-issues> Critical Issues Facing Veterans and Military Families
- <http://www.samhsa.gov/veterans-military-families/at-risk-populations> At-Risk Populations among Veterans and Military Families
- <http://www.samhsa.gov/veterans-military-families/reintegration-into-civilian-life> Reintegration into Civilian Life
- <http://www.samhsa.gov/veterans-military-families/grants> Grants Related to Veterans and Military Families
- <http://www.samhsa.gov/veterans-military-families/publications-resources> Publications and Resources on Veterans and Military Families

Substance Abuse Prevention

The KY-SEOW, originally constructed by the Kentucky DBHDID, is housed and managed by REACH of Louisville. Since the creation in 2010 the SEOW works to support the implementation of a public health approach to substance abuse prevention as originally outlined by the Strategic Prevention Framework-State Incentive Grant (SPF-SIG). The SEOW utilizes state and community-level data to inform planning, implementation, and evaluation activities directed toward the prevention of substance abuse and the promotion of positive mental health. The SEOW systematically evaluates 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 functions 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.

The SEOW consists of a Chair and Co-Chair from the BHDID Division of Behavioral Health. Project staff and technical support will be provided by a contract with REACH of Louisville, Inc. SEOW members are responsible for attending scheduled SEOW meetings, providing relevant data pertaining to substance use and mental health, guiding the analysis and interpretation of state and community data, and providing guidance for the development of state and community profiles.

Current SEOW members are:

Steve Cambron	Div. Behavioral Health
Dr. Richard Clayton	University of Kentucky
Ron Crouch	State Workforce Cabinet
Bob Illback	REACH of Louisville
Van Ingram	Off. Drug Control Policy
Teresa Mcgeeny	REACH of Louisville
Mike Razor	Alcoholic Bev. Control
Dr. Vestena Robbins	Div. Behavioral Health
Dr. Ramona Stone	University of Kentucky
Jan Ulrich	Div. Behavioral Health

Area of Focus:

Reduce Underage Youth Access to Cigarettes, and E-Cigarettes

Prevalence Data/Unmet Needs and Service Gaps:

According to the most recent (2013) Youth Risk Behavioral Survey, 23.6% of the respondents under the age of 18 reported that they had bought cigarettes in a convenience store during the 30 days prior to the survey. The Kentucky Synar Survey reveals that the percentage of retail outlets that sold cigarettes to underage youth increased from 5.4% in SFY 2014 to 7.8% in SFY 2015. Kentucky ranks 6th highest in the U.S. for youth smoking rate (17.9%). A review of the Regional Prevention Center Work plan shows that out of 120 counties served only 39 has a youth tobacco access component. Over the past few years tobacco prevention in Kentucky has lost ground to Methamphetamine and Prescription drug abuse. We need to revitalize our efforts to implement environmental strategies that target the retail environment.

The 2014 Kentucky Incentives for Prevention (KIP) survey reveals that 6th and 8th graders use e-cigarettes more often than regular cigarettes. 1.6% of 6th graders reported smoking cigarettes in the last 30 days compared to 3% for e-cigarettes. 8.2% of 8th graders reported smoking cigarettes compared to 9% for e-cigarettes. 10th and 12th graders smoke cigarettes at slightly higher rates than e-cigarettes. 16.3% compared to 16% for 10th graders and 22.5% compared to 17% for 12th graders. This is the first year we have collected data on e-cigarettes and youth use is likely to increase as e-cigarettes become more and more popular. A review of Regional Prevention Center work plans reveals that out of the 120 counties served by the Regional Prevention Center network only two are implementing prevention strategies that address E-cigarettes. Considering the data, this is a significant gap in services. Much more needs to be done to prevent increased use of e-cigarettes among underage youth in Kentucky.

Goal for SFY 2016/2017:

- A reduction in the number of Kentucky youth under the age of 18 who report that it is “sort of easy” or “very easy” to get cigarettes as measured by the Kentucky Incentives for Prevention Survey
- A reduction in the number of Kentucky youth under the age of 18 who report that they have bought cigarettes at a retail store in the last 30 days as measured by the Youth Risk Behavior Survey. (YRBS)

Objective #1

- Upgrade the audio visual quality and content of the online Tobacco Retail Underage Sales Training (TRUST) with higher quality video clips, more interactive learning features and information on E-cigarettes and other alternative tobacco products.

Strategy:

- Solicit feedback from the Tobacco Retail Advisory Council, the Tobacco Prevention and Cessation and the Prevention Branch of the Division of Behavioral Health, and the Tobacco Prevention Enhancement Site as to the needed enhancements.

Goal for SFY 2016/2017:

- Purchase requisition reflecting the agreed upon enhancements to the TRUST training
- Posting of the new online module Department for Alcoholic Beverage Control website within the first quarter of FFY 2016.

Target Population

- Tobacco Retailers

Objective # 2

- Increase the number of tobacco retail clerks who complete TRUST by 50%.

Strategy

- Market TRUST through a variety of ways: Postcards, articles in trade Journals

Goal for SFY 2016/2017

- Increase number of certificates generated by the TRUST online training system.

Objective #3

- Develop TRUST Window Cling which reminds customers that anyone who looks under twenty seven years of age will be asked for an ID if they attempt to purchase cigarettes.

Strategy

- Develop window cling with input from the Tobacco Retail Advisory Council, the Tobacco Prevention Enhancement Site, the Prevention Branch of the Division of Behavioral Health and prevention specialists across the state.

Goal for SFY 2016/2017

- Increase number of TRUST Window clings distributed.

Target Population:

- Tobacco retail clerks

Objective # 4

- Draft an action plan for a Kentucky Tobacco Retail Licensing Law

Goal for SFY 2016/2017

- A draft plan approved by the Kentucky Synar Program.
- References to the licensing law action plan as reflected in Synar Program Meeting Minutes

Target Population:

- Prevention Specialists, state level stakeholders, legislators.

Objective #5

- Build Capacity with Tobacco Retailers

Strategy

- Offer trainings to Prevention Specialists and coalitions on how to build effective working relationships with tobacco retailers in their regions.

Goal for SFY 2016/2017

- Increase number of trainings given

Target Population:

- Prevention Specialists, Tobacco Prevention Enhancement Site

Objective # 6

- Develop a data report on E-cigarette consumption based on KIP 2014 data and Tobacco Prevention Enhancement Site data. The data report would shed light on the following areas:
 - How does e-cig consumption in urban areas compare with that in rural?
 - What does e-cig usage look with regard to race, gender and age?
 - How many youth who report using e-cigs also smoke regular cigs?
 - Areas/counties of the state that have higher levels of e-cig consumption compared to state and national averages.

Strategy

- Convene and engage the State Epidemiology Outcomes Workgroup (SEOW) to create a data report on E-cigarette consumption

Goals for SFY 2016/2017

- SEOW meetings minutes reflecting discussion and work around E-cigarette data report
- Data Report
- Presentations to Regional Prevention Center staff based on the data report

Target Population

- Kentucky Prevention Professionals
- RPC staff
- State Stakeholders (Alcoholic Beverage Control (ABC), DPH, DBH, Kentucky Office for Drug Control Policy (KY-ODCP)
- Center for Substance Abuse Prevention

Objective #7

- Increase awareness of the harmful health consequences of E-cigarettes

Strategy

- Draft Press releases, articles, editorials that reflect the most recent and credible research on E-cigarettes, provide training/presentations on E-cigarettes to prevention specialists and coalition members. Collaborate with the Tobacco Prevention Enhancement site to coordinate E-cigarette messaging on the state & Local Levels.
- Consult with the KY-SEOW for other data sources on E-cigarettes

Goal for SFY 2016/2017

- Increase number of press releases, articles, presentations
- An increase in strategies addressing E-cigarettes in RPC Work Plans.

Target Population

- Kentucky Prevention Professionals
- RPC staff
- State Stakeholders
- The general public

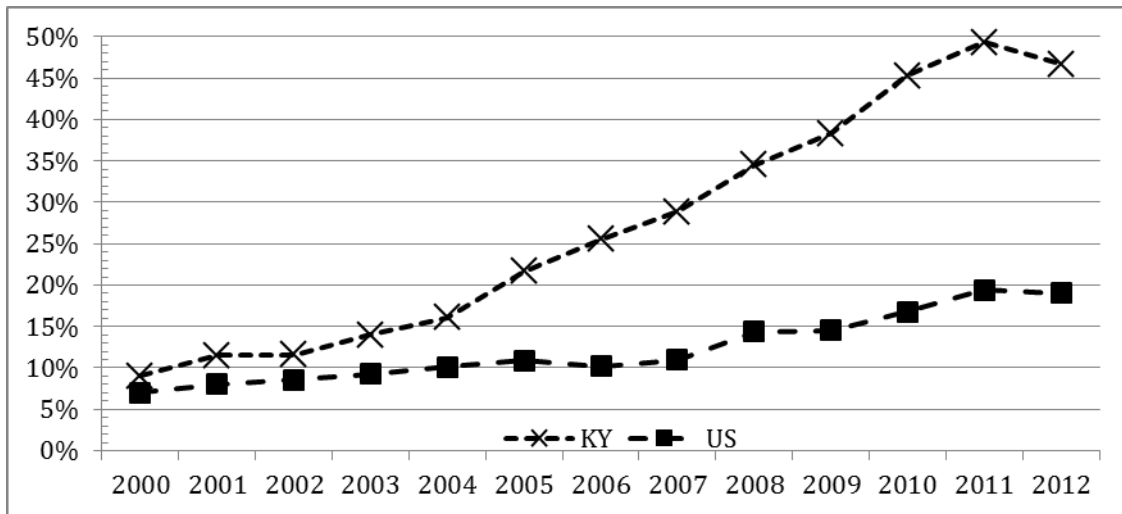
Area of Focus:

Reduce prescription drug misuse and abuse among 12 to 18 year olds.

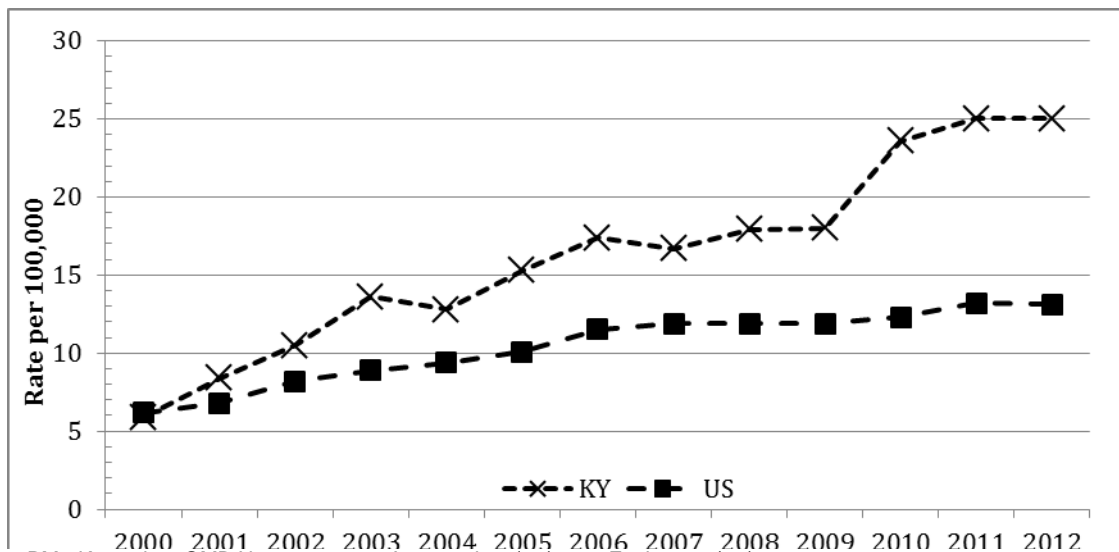
Prevalence Data/Unmet Needs and Service Gaps:

Kentucky has been significantly impacted by Prescription Drug (PD) use and its consequences over the past 15 years. According to admission data from the Treatment Episode Dataset (See graph below), the percentage of incident admissions reporting any prescription drug significantly increased from 9% in 2000 to an alarming 46.7% in 2012. This is in stark contrast to the US that has witnessed a much more gradual increase from 7% to 19%. Similarly, large disparities in prescription drug overdose mortality were also found between Kentucky and the US during this time (Figure 2). Although KY's rate was similar to the US in 2000 (6 per 100,000), the rates began to noticeably diverge after 2002. By 2003, KY's rate was approximately 14 per 100,000 compared to 9 per 100,000 nationally. KY's rate then drastically increased to 25 per 100,000 in 2012, while the national rate slowly increased to 13 per 100,000.

Trends in Incident Prescription Drug Admissions (TEDS-A 2000-2012)



Trends in Prescription Drug Overdose Mortality (CDC WONDER 2000-2012)



Data are now emerging regarding the behavioral health needs of this segment of the military community, such as through the Screening, Brief Intervention, and Referral to Treatment (SBIRT) practice. SBIRT is a tool to identify those potentially at high risk for or experiencing substance abuse, suicide ideations and/or behavioral health concerns. For example, recent screening of the National Guard population revealed that since October 2012, 458 Kentucky National Guard (KYNG) soldiers tested positive during unit urinalysis drug screenings. Since 9/30/11, KYNG has recorded 10 suicide attempts and 46 suicidal ideations. Four completed suicides have been confirmed since 2008 within the KYNG. In Kentucky, there are an estimated 30,000 children and youth (ages 0 to 18) from families of Guard, Reserve, and Active Duty military members. For the first time in 2014, the Kentucky Incentives for Prevention (KIP) survey included a question on family military status: Is anyone in your family currently serving on active duty or retired/separated from the Armed Forces, the Reserves, or the National Guard? A remarkable 41.9% overall responded exactly one or more than one, with the Communicare (47.9%) and Pennyroyal (44.8%) region communities having the highest concentration.

With regard to the relationship between military family membership, prescription drug use, and behavioral health, several alarming findings emerge. According to the KY-SEOW needs assessment that was conducted for the Partnership for Success 2015 application, 10th graders with exactly one or greater than one military family member consistently had higher 30-day rates of PD use. Those with one or more consistently had the highest rates and this pattern also emerged for behavioral health. Comparing this group to the No/Don't Know students, the percentage point differences ranged from 2.7% to 5% across each behavioral health indicator.

Factors	Family member on active duty or veteran		
	No/Don't Know n (%)	Yes, exactly one n (%)	Yes, 1+ n (%)
30-Day PD Use			
Any prescription	522 (3.3)	184 (3.7)	263 (3.9)
Opioids	619 (4.0)	200 (4.1)	359 (5.3)
Tranquilizers	216 (1.4)	62 (1.3)	119 (1.8)
Stimulants	261 (1.7)	91 (1.8)	138 (2.0)
Mental/Behavior			
SPD ¹	2,663 (17.0)	883 (17.8)	1,382 (20.4)
Self-harm	2,732 (18.8)	921 (20.0)	1,506 (23.8)
Suicide ideation	2,190 (13.9)	769 (15.4)	1,261 (18.5)
Suicide plan	1,764 (11.2)	624 (12.6)	1,038 (15.3)
Suicide attempt	1,136 (7.2)	412 (8.3)	677 (9.9)

Strategies

- Implementation of media campaigns to raise awareness about the risks of prescription drug and heroin abuse and about the proper method of prescription drug disposal
- Implementation of the Parents' Pledge Campaign,
- Use of the Wellness Initiative for Senior Education (WISE) curriculum with seniors to protect against inappropriate youth access
- Implementation of the Monitor, Educate, Dispose or Secure (MEDS) campaign,
- Distribution and use of prescription lock boxes.
- Collaborate with the Military Behavioral Health Program Administrator and other experts to identify specific factors that need to be addressed in order to deliver prevention services to the military population.
- Identify types of prevention services needed to suit the needs of the military population.
- Consult with the KY-SEOW and Advisory Council for effective ways to deliver appropriate prescription prevention strategies to the military population.

Goal for SFY 2016/2017

- A statewide reduction in past 30 day use of prescription drug without a doctor's prescription as measured by the 2016 Kentucky Incentives for Prevention Survey.
- Number of people served by prescription drug abuse prevention programs
- Number of prescription drug lock boxes distributed
- Number of PSAs, brochures and other awareness material distributed

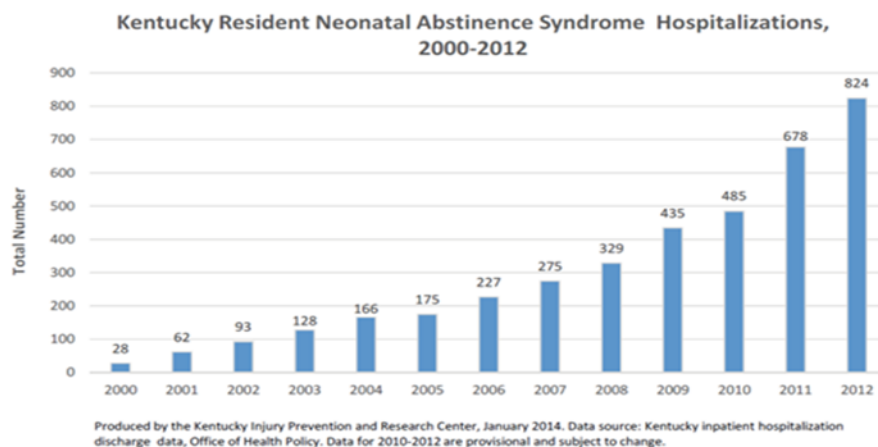
Area of Focus:

Reduce Alcohol Tobacco and Other Drug Use Among Pregnant Women

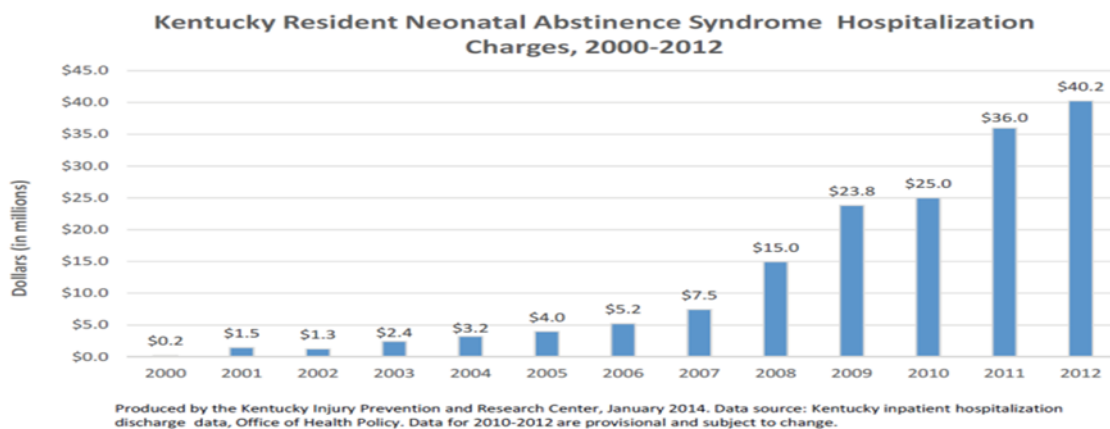
Prevalence Data/Unmet Needs and Service Gaps:

In Kentucky, 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. Pregnant women who are dependent on prescription substances face tremendous stigma from their family, social networks, and society. This stigma causes fears within the community and with medical providers, creating a barrier for pregnant women to receive adequate and appropriate treatment for their substance use/misuse; especially when it comes to treating substance use in pregnant women with Medication Assisted Treatment. The DBH Prevention Branch plans to partner with the Substance Abuse Treatment Branch and other key stakeholders to develop and implement strategies to reduce stigma on the community level, specifically with reference to the benefits of Medically Assisted Treatment (MAT).

From 2000 to 2012, there has been a drastic increase in the number of Kentucky infants that have been hospitalized with Neonatal Abstinence Syndrome (NAS). In 2000, there were 28 NAS babies hospitalized in the state, by 2012, 824 babies were reported hospitalized with NAS. (See table below)



As this rise in diagnoses occurred, the cost to treat children with NAS significantly increased from \$235,423 in 2000 to \$40,200,000 (+/-) in 2012. Substance exposed infants and children have also been shown to have significantly higher rates of early mental health and behavioral problems, as well as higher rates of adverse birth outcomes, and required increased health care utilization after discharge. (See table below)



Public schools do not currently provide prevention education related to substance use during pregnancy. Given the magnitude of the problem this is a glaring service gap. By delivering prevention education to pregnant women through the RPC network we hope to reduce the number of substance exposed infants and improve birth outcomes in Kentucky.

Goal for SFY 2016/2017

- Expand substance abuse prevention services for pregnant women to thirteen (13) Regional Prevention Centers.
- Increase knowledge of the effects of substance use during pregnancy, Neonatal Abstinence Syndrome and substance exposed infants
- Increase number of pregnant women served
- Increase number of referrals for pregnant women who need substance use disorder treatment.
- Increase number of information graphics distributed.

Strategies:

- Provide community education on risks associated with substance use and pregnancy
- Outreach to develop referral sources
- Create collaborative relationships with community partners to enhance and improve services to pregnant women at risk for drug and alcohol abuse
- Provide direct prevention/education services to pregnant women at risk for substance abuse during pregnancy
- Collaborate with KY-SEOW to develop a Neonatal Abstinence Syndrome Info Graphic

Area of Focus:

Prevent suicides and attempted suicides among populations at high risk, especially military families, LGBTQ youth, and American Indians and Alaska Natives.

Prevalence Data/Unmet Needs and Service Gaps:

Kentucky’s rate of suicide for youth and young adults age 10-24 has risen substantially since 2010 (5.17 per 100,000 in 2010 to 9.45 per 100,000 in 2012; National Violent Death Reporting System (NVDRS), 2005-2012) when compared to other states. And, the rate for youth and young adults has risen over time more dramatically than the

general population during this time (rate increase of 4.28 for youth and young adults and 2.24 for all ages; NVDRS, 2005-2012). Certain risk factors increase the odds of suicide among Kentucky middle and high school students. Those who experience dating violence are between 6 and 7 times more likely to attempt suicide, those who experience sexual assault at school are 6.5 times more likely, and students who experience bullying (including cyberbullying) are between 4.5 and 6 times more likely to attempt suicide compared to students who do not experience these risk factors (KIP, 2014). Students who have one or more family members or people close to them who have served in the military are significantly more likely to attempt suicide than students who do not have a family member or someone close to them that has served in the military (7.2% versus 6.3%; KIP, 2014). Thirty-three percent (33%) of Kentucky high school students that reported sexual activity with the same sex (or with both sexes) attempted suicide, compared to 8.2% of students who reported sexual activity with only those of the opposite sex (YRBS, 2013).

Objective:

- Fuller integration of suicide prevention in substance abuse prevention activities

Strategies

- Develop and implement Prevention Specialist Workforce Survey around suicide
- Increase support for regional suicide prevention gatekeeper trainings, such as Question, Persuade and Refer (QPR) and Mental Health First Aid
- Engage Regional Prevention Center staff to conduct annual surveys with Middle and High schools in their regions around suicide prevention and planning needs, and follow up assistance with these needs, including emergency planning
- Engage Regional Prevention Center staff to assist with suicide prevention community readiness, needs assessment and resource scans

Goals for SFY 2016/2017

- Increase number of suicide related trainings sponsored by the Regional Prevention Centers
- Increase number of RPC work plans that contain suicide prevention strategies and related activities
- Increase number of Prevention Specialists that participate in the Work Force Survey around suicide
- Increase number of suicide-related need assessments and resource scans

Data Sources Used:

Youth Risk Behavioral Survey (YRBS) 2013
Kentucky Synar Survey
Kentucky Incentives for Prevention Survey
Regional Prevention Center Work Plans
Tobacco Retail Underage Sale Training (TRUST)
Treatment Episode Data Set (TEDS) Data
Center for Disease Control (CDC) Wonder 2000-2012
Kentucky Office of Health Policy
Kentucky Injury Prevention and Research Center, January 2014
National Violent Death Reporting System (NVDRS)
State Epidemiology Outcomes Workgroup (SEOW)

Substance Abuse Treatment

Women who are pregnant and have a mental health and/or substance use disorder

Kentucky has embraced the Affordable Care Act, expanding Medicaid coverage to a larger population and developing a successful Health Benefits Exchange. However, most critical to this population is the ACA parity

requirement that ensures substance abuse and mental health services are covered. Prior to this, Medicaid SUD services were only available to pregnant and post-partum (up to 60 days) women, including case management and prevention services.

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. The CMHCs now have a set protocol for asking about pregnancy at first contact with new female clients, including adolescents. Therefore the consistency of immediate admission has increased.

Kentucky has six (6) substance abuse programs designed specifically for pregnant women that receive public funding.

1. **KIDS NOW Plus (KN+)** Substance Abuse and Pregnancy Program provides Universal, Selective, and Indicated 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 Contingency Management program. KN+ services have recently expanded and are now providing prevention and case management services in thirteen (13) of fourteen (14) regions.
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.
5. **Chrysalis House** is a comprehensive agency located in Lexington, KY with three residential facilities, a (40) forty-unit apartment complex, eighteen (18) scattered-site apartments, an 18,000 square foot, multi-purpose community center, and two playgrounds. This agency specializes in treating pregnant and parenting women who can keep their newborns and toddlers on-site with them while in residential treatment.
6. **Freedom House** provides a holistic and comprehensive program that is designed to treat the women's chemical dependency in a residential treatment program for alcohol and/or drug dependent pregnant women and women with young children.

Currently, Kentucky's statewide prevention and treatment infrastructure is growing due to the recent expansion of Medicaid to the larger population and the inclusion of Substance Use Disorder (SUD) services. Across the state there are approximately fifteen (15) residential treatment programs and thirty six (36) intensive outpatient programs available (including private providers) that serve pregnant women. Four (4) of the residential programs that accept pregnant women, allow the woman's dependent children to live on-site with her during treatment.

In Lexington, KY, Polk Dalton Clinic (part of UK Healthcare) provides evidence based comprehensive care for opioid dependent pregnant population in a structured clinic workflow that will include prenatal care, substance abuse counseling, and neonatology consultation. It is anticipated that birth outcomes for the women and children involved

in this program will improve. Additionally, there is a goal of decreasing length of stay and admissions to Neonatal Intensive Care Unit (NICU) for any babies who experience Neonatal Abstinence Syndrome (NAS). Through an increasing skillset for successful long-term recovery and sobriety, it is hoped that there will be a seamless transition of postpartum patients to community partners.

The state of Kentucky currently has twenty (20) Narcotic Treatment Programs/Opioid Treatment Programs that accept pregnant women, along with approximately 430 Buprenorphine DATA 2000 waived Physicians. The Methadone/Opiate Rehab and Education (M.O.R.E.) Center located in Louisville, Kentucky receives SAPT grant monies to assist in the treatment for this priority population along with the Bluegrass Narcotics Treatment program in Lexington, Kentucky. All of these programs consider pregnant women a priority population.

Kentucky has several initiatives to address prescription drug use such as: Partnership for Success II grant (PFS II), Kentucky All Schedule Prescription Electronic Reporting (KASPER) system, development of House Bill 1(HB1), Medicaid expansion, Regional Prevention Centers (RPCs), KY Health Now, and the development and implementation of the Kentucky Agency for Substance Abuse Policy (KASAP). KY has strived to move forward with prevention and treatment measures to help improve quality of life for our residents and to develop drug-free communities.

Multiple trainings for health care providers have been hosted around the state providing hundreds of health care professionals with specific training and information on this topic. These have included state and regional meetings sponsored by a wide variety of agencies and organizations including; the Kentucky Perinatal Association, Norton Healthcare, the University of Louisville, the University of Kentucky Division of Neonatology, and the Kentucky Chapter of ACOG. In addition, the Governor's Office of Drug Control Policy has recruited physicians with obstetric, neonatal, and addiction medicine expertise for trainings providing continuing medical education to physicians at no charge.

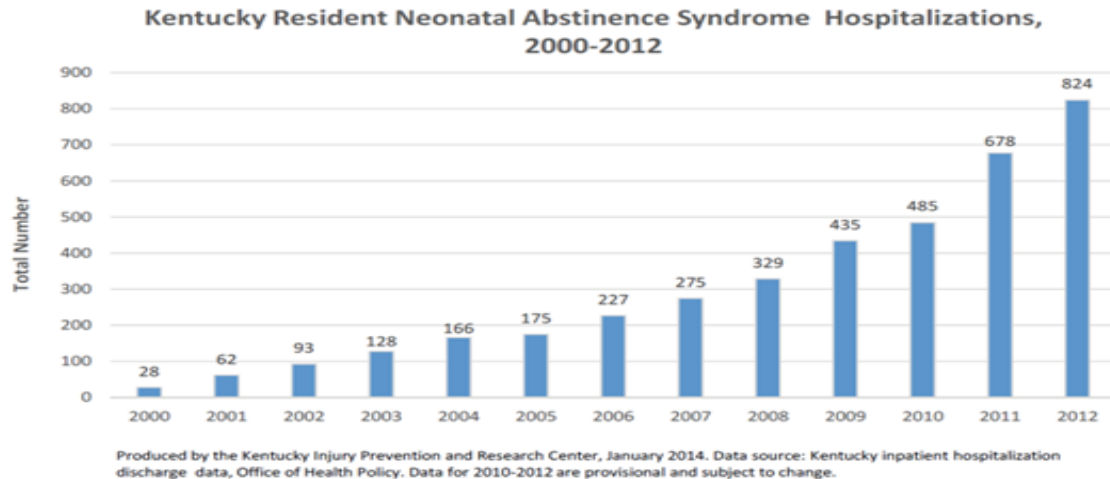
The Kentucky Chapter of the American Academy of Pediatrics, representing some 400 pediatricians across the state, recently completed strategic planning, and selected positive parenting as one of the top three strategic goals for the organization in the next five (5) years. They have also been advocates for increasing access to children's behavioral health services including infant mental health. Most recently, they have included in trainings on toxic stress and adverse childhood experiences, which are a significant factor in the outcomes of these substance-exposed infants.

Kentucky is working with many agencies and departments to collect data annually that is related to substance-exposed births and/or substance usage during pregnancy. There are many Kentucky data sources that include but not limited to the State Epidemiology Outcomes Workgroup (SEOW), Child Welfare data, and Vital Statistics data to assist in identifying and collecting data in this area. The Kentucky All Schedule Prescription Electronic Reporting (KASPER) system can provide statistics on the number of controlled substances dispensed to women of child bearing age; further identifying the population that needs to be monitored for potential substance exposure during pregnancy or NAS.

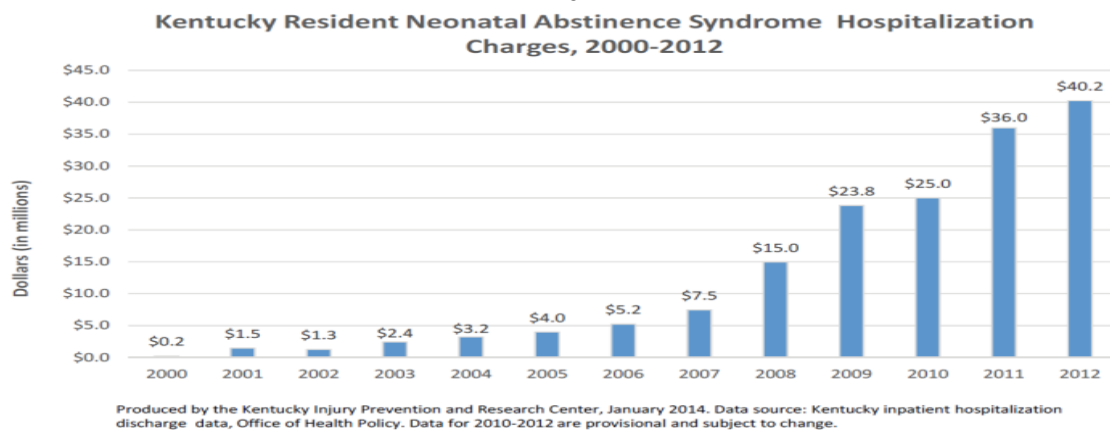
Unmet Needs and Prevalence Data:

- Substance abuse is an increasing problem for women. More than 4 million women in the U.S. use drugs and 3.7 million women have taken prescription drugs non-medically during the past year. Pregnant women that use and/or abuse substances, face tremendous stigma from their family, social networks, and society. This stigma impacts the treatment that they need and require, due to the potential risks of harm to the fetus.
- According to the 2013 National Survey on Drug Use and Health, 5.4% of pregnant women aged 15-44 reported to using illegal drugs and 9.4% reported using alcohol during their pregnancy.

- Pregnant women, who chronically abuse prescription medications, also have a greater-than-normal risk for medical complications. The most frequent resulting in the highest percentage of complications are various infections in the pregnant mother and her fetus.
- Due to being primarily a rural state there is a disconnect between service providers that has resulted in a poorly developed treatment provider community. It is this disconnect that makes it difficult to exchange data, resulting in an underestimation of need for services and/or treatment, resulting in a lack of readily available resources in many regions across the state. In developing policies that have the potential of positively affecting women of child-bearing age that abuse prescription drugs, Kentucky will be taking specific actions to improve and enhance services.
- With the expansion of services and coverage, there is a need for a larger provider pool and that is in the process of being developed.
- Residential substance abuse treatment is minimally available to pregnant women partially due the federal Medicaid Institute for Mental Disease (IMD) restrictions requiring facilities to have a maximum of sixteen (16) beds. Specific support services are also limited due to the specific needs of pregnant women. Although effective screening of pregnant women for substance abuse by medical providers is limited in Kentucky, the state in collaboration with other agencies and through KIDS NOW Plus, has developed an implementation plan for SBIRT with pregnant women and continues to advocate its use.
- Kentucky has a state law in place allowing health care providers to screen mothers for substances of abuse [KRS 214.160], however, there is no agreed-upon standard for screening mothers or babies. As a result many babies are not being diagnosed and/or treated, leading to increased chances of complications and increased potential for neglect and abuse once the child leaves the hospital. Hospitals who have instituted a policy to screen all newborn infants have found rates as high as 30% positives (for substance exposure) in some areas of the state. HIPAA restrictions also make it difficult for the physician treating infants to gain access to the mother's medical record and may limit the ability of that physician to identify risk factors for Substance Exposed Infants (SEI) and/or NAS and screen infants appropriately.
- 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. These fears continue to rise due to recent legislation change in a neighboring state making substance abuse/misuse during pregnancy a criminal offense.
- Pregnant women that are dependent on prescription substances face tremendous stigma from their family, social networks, and society. This stigma causes fears within the community and with medical providers, creating a barrier for pregnant women to receive adequate and appropriate treatment for their substance use/misuse. This is true especially when it comes to treating substance use in pregnant women with Medication Assisted Treatment. DBHDID hopes to educate and inform a broad array of treatment providers and community members surrounding the benefits of MAT with this population in particular and the broader opiate dependent population in general.
- Public schools do not currently provide prevention education related to substance use during pregnancy. However, Prevention Specialists with KIDS NOW Plus in various regions have begun providing substance abuse prevention outreach in their local high schools.
- From 2000 to 2012, there has been a drastic increase in the number of Kentucky infants that have been hospitalized with Neonatal Abstinence Syndrome (NAS). In 2000, there were twenty eight (28) NAS babies hospitalized in the state, by 2012, 824 babies were reported hospitalized with NAS.



- As this rise in diagnoses occurred, the cost to treat children with NAS significantly increased from \$235,423 in 2000 to \$40,200,000 (+/-) in 2012. Substance exposed infants and children have also been shown to have significantly higher rates of early mental health and behavioral problems, as well as higher rates of adverse birth outcomes, and required increased health care utilization after discharge.



- Another factor to consider in surveying our expectant mother population is having a closer look at addressing the needs of women living in Appalachia. Excluding marijuana, rural Appalachian Kentucky has one of the highest occurrences of illicit drug use for person's 12 and older.

Priorities for SFY 2016/2017:

- Continue to monitor and support the CMHCs compliance with screening for pregnancy on the first contact.
- Provide continued funding for services supporting pregnant women including; residential services, life skills, parenting, supported housing, employment assistance and recognizing specified needs.
- Expand treatment capacity for pregnant women and strengthen the use of Evidence Based Practices in women's treatment.
- Continue collaboration with the Department for Public Health, toward addressing the issue of smoking during pregnancy.
- In collaboration with the Kentucky Chapters of the American College of Obstetrics and Gynecology, and the American Medical Association, a statewide initiative is needed to expand universal screening and provide brief intervention and referral to treatment services as a routine part of pre-natal care through promoting 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. This initiative would increase the identification of substance use/abuse during pregnancy and allow for earlier intervention, thus minimizing the adverse affects on the baby.

- 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.
- Improve KIDS NOW Plus services that are currently provided, by focusing on the use of Evidence Based Practices and Evidence Informed Practices, by monitoring for service outcomes, and through expanding substance abuse prevention services to women of child bearing age, both prior to and during pregnancy. Focusing additional educational/prevention services on women prior to pregnancy allows for the opportunity to educate them regarding the risks and complications associated with drug abuse and provide them with the information and resources they need to make better lifestyle choices before they become pregnant.
- Continue to collaborate with state partners and agencies that are focused on bettering the lives of pregnant women who are using substances.
- Move towards a system of care to address the concerns surrounding substance use prior to pregnancy through post-delivery and beyond. Allowing intervention during all stages of pre- and post- pregnancy, resulting in service provision that is interrelated and interconnected.

Data Sources Used:

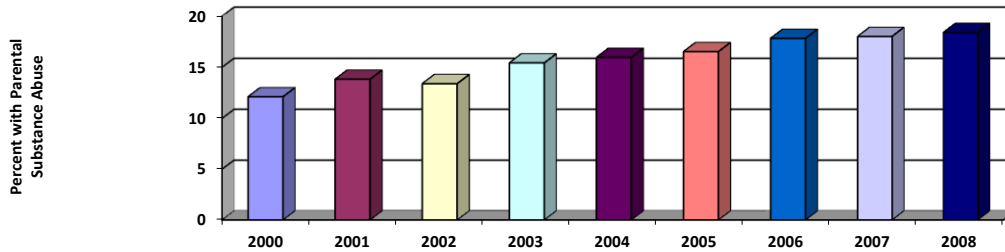
- Substance Abuse and Mental Health Services Administration, *2011 Opioid Treatment Program Survey: Data on Substance Abuse Treatment Facilities with OTPs*. BHSIS Series S-65, HHS Publication No. (SMA) 14-4807. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.
- Substance Abuse and Mental Health Services Administration, *Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings*, NSDUH Series H-46, HHS Publication No. (SMA) 13-4795. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.
- Halfon N, Mendonca A, and Berkowitz G, *Health status of children in foster care. The experience of the Center for the Vulnerable Child*. Arch Pediatr Adolesc Med, 1995. (149(4): 386-92.
- Office of Drug Control Policy, Annual Report
- CDAR: Center for Drug and Alcohol Research, Kids Now Plus Annual Report for 2014
- Substance Abuse and Mental Health Services Administration, *Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings*, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

Parents with Substance Abuse and/or Mental Health Disorders with Dependent Children

Prevalence Data:

In Kentucky, substance abuse is having an increasingly negative effect on child and family well-being with reports of the profound effects of diverted prescriptions, pain medications and now heroin. We know that among young children coming into out of home care (OOHC) in Kentucky; more than 80% of families have risks to child safety due to substance abuse. For children ages 3 years and younger, nearly 90% of these children had parental substance abuse as a risk factor. These substance abusing families are likely to have an average of four additional safety and risk factors including poverty, domestic violence, criminal history, and multiple adult partners in the home. The children have an average of six prior referrals before entering OOHC compared to four referrals for children where parental substance abuse is not a risk factor. The multiple recurring referrals reflect a tendency toward ambiguous responses to assessment and intervention for substance abusing families because of limited treatment resources for the families.

The percent of children entering out of home care (OOHC) as infants increased from 12% in 2002 to more than 18% in 2009. Figure 1 shows the increase among infants identified as having parental substance abuse (alcohol or drugs) as a condition for entry to OOHC.



Between 2008-2013, Kentucky has continued to see an increase in reports of substance exposed infants, by looking at all children in our statewide data system ages 0-2 weeks, with a report for abuse/neglect with parental substance abuse as a risk factor. According to this data, during the calendar year 2008, The Department for Community Based Services (DCBS) received 748 reports statewide of newborns citing substance abuse as a risk factor. Of those reports, 536 were substantiated for abuse or neglect. In 2010, DCBS received 1142 reports of newborns citing substance abuse as a risk factor. Of those reports, 685 were substantiated. In 2013, DCBS received 1495 reports, substantiating 818.

It is believed, with the rise of opiate addiction in our state, we are seeing more awareness and reporting of substance exposed infants and in particular the opiate exposed infants who are experiencing NAS. Front line DCBS staff struggle with how to best work with this population of families, considering the sharp increase of opiate use in Kentucky, mainly the use of pain medication and most recently heroin.

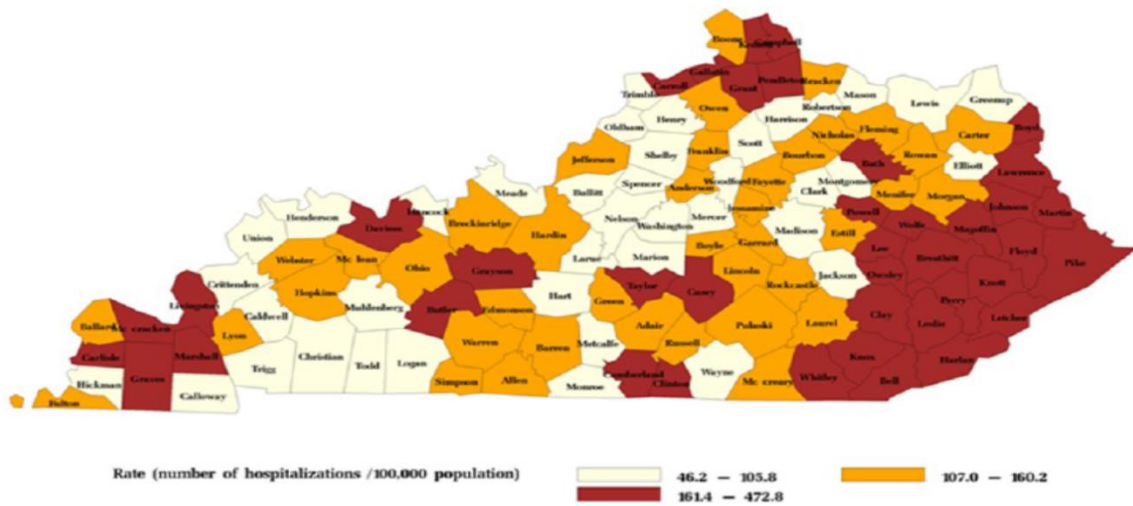
Heroin use has increased across the US among men and women, most age groups, and all income levels. Some of the greatest increases occurred in demographic groups with historically low rates of heroin use: women, the privately insured, and people with higher incomes. Addiction to prescription painkillers is the strongest risk factor for heroin addiction (CDC Vital Signs).

- 45% of people who used heroin were also addicted to prescription opioid painkillers (CDC Vital Signs)
- Kentucky has the fourth highest rate of painkiller prescribing in the US at 128 opioid painkiller prescriptions for every 100 people (CDC National Prescription Audit 2012)

Opioids drive continued increase in drug overdose deaths: *Drug overdose deaths increase for 11th consecutive year (CDC press release)*

- Heroin overdose deaths in Kentucky increased by 207% from 2011 to 2012
- Kentucky's rates of drug overdose deaths more than doubled from 1999 to 2010
- Kentucky ranks 2nd in the nation at 24.6 drug overdose deaths per 100,000 (2011-13 three year average)
- Since 2008, more Kentuckians have died from drug overdoses than motor vehicle accidents

Annual Rate of Drug Overdose Hospitalizations, 2009-2013



KIPRC, 2015

In March 2015, The Heroin Bill (SB 35) was signed. The key elements of this bill include;

- Enhanced Penalties for high level traffickers.
- Good Samaritan Clause for calling for assistance.
- Some funds for treatment services in specific settings.
- Naloxone rescue for First Responders.
- Local option for Harm Reduction through Needle Exchange program.

The Needle Exchange program implements a harm reduction program in local health departments. Individuals may exchange used hypodermic syringes or needles for free, sterile hypodermic syringes and needles to be provided by the local health departments. DBHDID participated with DPH to develop protocol for the Needle Exchange Program. The goal of the program is to;

- Reduce the spread of blood-borne infections, HIV and Hepatitis C.
- Provide support to drug users and links to services such as drug treatment and medical care.
- Acknowledge that IV drug use threaten public health and takes the necessary steps to address the problem.

By utilizing funds provided by a recent Kentucky Pharmaceutical Settlement, DBHDID has contracted with hospitals located in KY's three most-populated areas to increase the availability of and use of Narcan kits (Naloxone) to effectively disrupt deaths due to opioid misuse.

Naloxone is useful both in acute opioid overdose and in reducing respiratory or mental depression due to opioids. It is included as a part of emergency overdose response kits distributed to heroin and other opioid drug users, and this has been shown to reduce rates of deaths due to overdose.

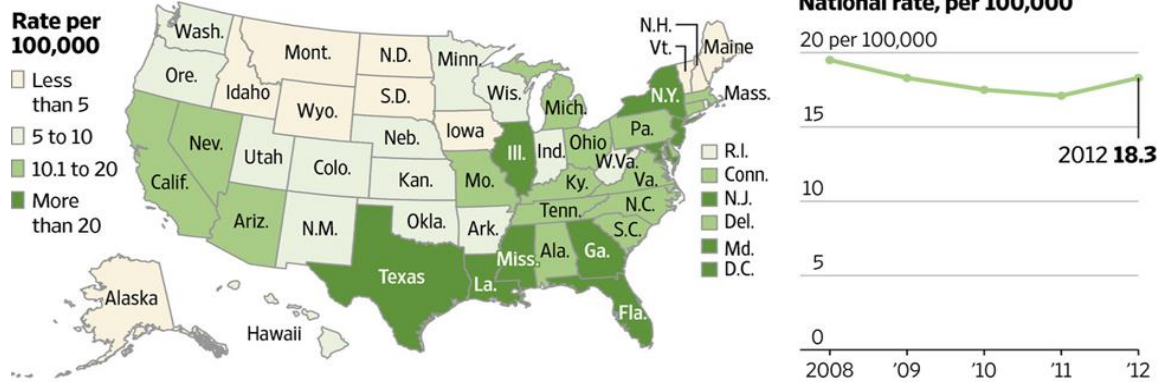
In 2003 the number of new HIV cases without AIDS in KY was 109. In 2013 it was 268. Center for Disease Control (CDC) ranks KY #1 in the rising rate of Hepatitis C. In Kentucky, the number of people discharged from hospitals with a dual diagnosis of hepatitis and dependence on opioids increased from 39 in 2000 to more than 1,500 in 2012

- Hepatitis C (HCV)
 - Over 70% of persons who inject drugs long term may be infected with approximately 73% of young adults (≤ 30) with hepatitis C report injection drug use as their principal risk factor Kentucky rates of acute hepatitis C increased by 357% from 2007-2011 In 2013, Kentucky had the nation's highest rate of acute hepatitis C (5.1 per 100,000).

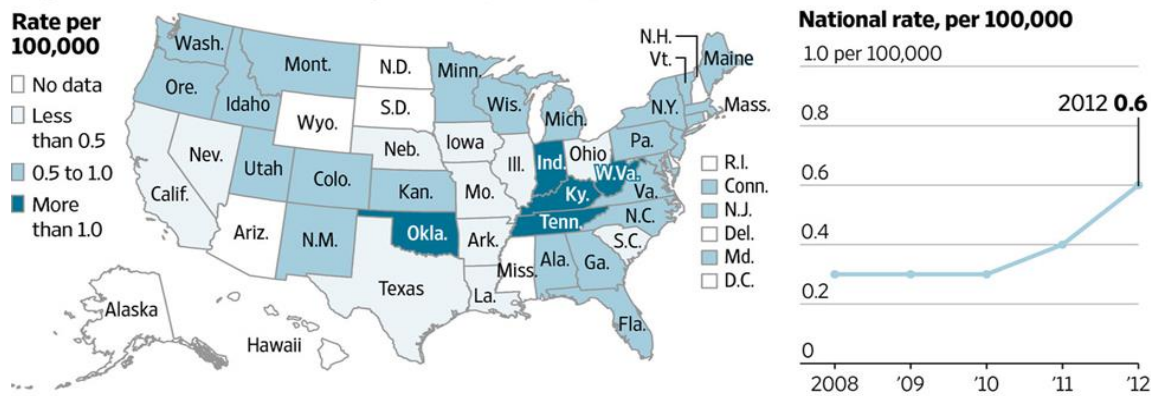
Growing Problem

HIV and hepatitis C infections have risen recently. With hepatitis C, many acute infections go unreported and usually progress to chronic hepatitis C, a long-term illness affecting an estimated 2.7 million Americans.

New diagnoses of HIV, 2012 (47,746 nationwide)



Reported cases of acute hepatitis C, 2012 (1,778 nationwide)



Note: Data for 2012 are most recent available.

Source: Centers for Disease Control and Prevention

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DBHDID participated in the SAMHSA Policy Academy on prescription drug abuse and was subsequently awarded In Depth Technical Assistance (IDTA) provided by the National Center on Substance Abuse and Child Welfare (NCSACW) to work on developing a System of Care for Women of Child-Bearing age and Pregnant Women who are using substances. The core team involved in the project includes; DCBS, Family Drug Courts, Public Health, Office of Drug Control Policy, Medicaid, Office of Inspector General and Community Partners including CMHCs, Narcotic Treatment Programs, Veterans of America Freedom House, Chrysalis House and The Polk Dalton Clinic.

Multiple trainings for providers have been hosted around the state providing specific training and information on how to recognize, assist, treat and refer opioid-dependent pregnant women. These have included state and regional meetings sponsored by a wide variety of agencies and organizations including; the Kentucky Perinatal Association, Norton Healthcare, the University of Louisville, the University of Kentucky, Division of Neonatology, and the Kentucky Chapter of ACOG. In addition, the Governor's Office of Drug Control Policy has recruited physicians with obstetric, neonatal, and addiction medicine expertise for trainings providing continuing medical education to physicians at no charge.

Kentucky has embraced the Affordable Care Act, expanding Medicaid coverage to a larger population and developing a successful Health Benefits Exchange. Kentucky's statewide prevention and treatment infrastructure is growing due to that expansion and the inclusion of SUD services. Medicaid services for SUD have historically been only available to pregnant and post-partum women, including case management and prevention services. However, now the fathers, husbands, boyfriends, and significant others are being provided access to substance abuse treatment services. Not only allowing for the mother to receive SUD treatment services, but the whole family is now

able to receive services to treat and heal the whole family. DBHDID does not require the CMHCs to prioritize parents with dependent children, but they are strongly encouraged and many CMHCs report that they prioritize parents from the child welfare system.

In 2015, the Kentucky Legislature passed the Governor signed a law establishing a Licensed Clinical Alcohol and Drug Abuse Counselor (LCADC) which is a major step toward improving the quality of services provided to individuals in need of SUD services.

Unmet needs and Service Gaps:

- 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:
 - 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.
 - 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.
 - 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.
- As the result of the rise in Substance Exposed Infants (SEI) and NAS there is a need for standardized protocols to address the needs of the infants and families. Standards would include; screening and assessment, referrals to DCBS and/or treatment services, aftercare services, and follow up services once the child is discharged home.
- Currently within the treatment and recovery community, there is resistance from the Abstinence Based Only Philosophy toward the use of Medication- Assisted Treatment (MAT).
- More training and supervision toward workforce development in EBP is needed to ensure the provision of appropriate treatment particularly to the opiate addicted clients.
- Integration with primary care providers to identify and refer individuals at risk, including pregnant women.

Goals for SFY 2016/2017

- Develop workgroups to identify standards of care that reflect best practices for treatment and working with pregnant and parenting women who are dealing with Substance Use Disorders. Establish a continuum of treatment that matches the intensity and level of individual substance use needs.
- Require Universal Screening by medical providers using SBIRT Principles
- Identify Barriers to Universal Screening
- Support Community-Based collaborative efforts by providing funding for community-based facilitators and a state liaison
- Establish local/regional comprehensive multi-disciplinary teams to implement statewide standards of care.
- Develop a continuum of treatment programs. Expand home visiting programs
- Enhance childcare and transportation services to increase accessibility

- Create a “no wrong door” web-based resource for providers across systems
- Work with insurance carriers to establish a continuum of reimbursable services for this population across funding streams
- Expand Medicaid coverage for postpartum women for up to one year
- Create a workgroup to develop materials and identify opportunities for outreach and education for professionals, individuals, families and agencies.
- Provide education about substance exposed infants and maternal substance abuse for maternal healthcare providers through residency programs, continuing medical education, graduate medical education and continuing education units
- Include injury prevention education and strategies as part of SA treatment and NAS discharge to prevent injuries and fatalities to infants (shaken infant, sleeping babies, abuse)
- Develop a workgroup to identify best practices and educational resources for clinicians in pain management during pregnancy; screening, counseling, referral, treatment for substance abuse; patient education
- Help provider associations collaborate with other experts on inter-disciplinary educational opportunities on best practices and community resources, including drug mortality data.

Data Sources Used:

- DCBS TWIST (The Worker’s Information System),
- TEDS (Treatment Episode Data Set)
- NOMS (National Outcome Measures) data set.
- Halfon N, Mendonca A, and Berkowitz G, *Health status of children in foster care. The experience of the Center for the Vulnerable Child.* Arch Pediatr Adolesc Med, 1995. (149(4): 386-92.
- HCV (CDC Health Advisory http://emergency.cdc.gov/han/han00377.asp#_ENREF_18)
- http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6417a2.htm?s_cid=mm6417a2_w
- http://www.cdc.gov/nchhstp/stateprofiles/pdf/Kentucky_profile.pdf
- <http://www.cdc.gov/hepatitis/statistics/2013surveillance/index.htm>
- <http://healthyamericans.org/reports/injuryprevention15/release.php?stateid=KY>
- <http://www.cdc.gov/hepatitis/statistics/2013surveillance/index.htm>

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 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 from SFY 2014 to SFY 2015. Of the 19,079 individuals treated for substance abuse in the Community Mental Health Centers (CMHCs) during SFY 2014, 4,335, or 23%, reported having used IV drugs.

Approximately 10,766 individuals who sought substance abuse treatment services at Kentucky Opiate Treatment Programs (OTP) between SFY 2013 and SFY 2014 reported having an injection drug use history. This number was obtained by an informal data poll from the DBH Program Administrator for OTP.

Overall, there were a total of 74,462 individuals over the course of about four (4) years who sought addiction treatment in Kentucky and had a history of injection drug use. This represents a significant increase. However, this

data only includes individuals who were treated within CMHC treatment programs. At present, there is no way of systematically gleaning data from other private substance abuse programs including, Kentucky Recovery Centers, private suboxone clinics, Alcohol and Drug Entities, across the state.

Addiction to prescription painkillers is the strongest risk factor for heroin addiction (CDC Vital Signs)

- 45% of people who used heroin were also addicted to a prescription opioid painkiller
- Kentucky has the fourth highest rate of painkiller prescribing in the US at 128 opioid painkiller prescriptions for every 100 people (CNC National Prescription Audit 2012)

Opioids drive continued increase in drug overdose deaths: *Drug overdose deaths increase for 11th consecutive year (CDC press release).*

- Heroin overdose deaths in Kentucky increased by 207% from 2011 to 2012
- Kentucky's rates of drug overdose deaths more than doubled from 1999 to 2010
- Kentucky ranks 2nd in the nation at 24.6 drugs overdose deaths per 100,000 (2011-2013 average)
- Since 2008, more Kentuckians have died from drug overdoses than motor vehicle accidents

Hepatitis C (HCV)

- Over 70% of persons who inject drugs long term may be infected with HCV (CDC Health Advisory)
- Approximately 73% of young adults with hepatitis C report injection drug use as their principal risk factor
- Kentucky rates of acute hepatitis C increased by 357% from 2007-2011
- In 2013, Kentucky had the nation's highest rate of acute hepatitis C (5.1 per 100,000)

Kentucky currently has twenty (20) licensed OTPs, two (2) publically funded and eighteen (18) 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.

Kentucky has relatively low rates of HIV AIDS, but a much higher rate of Hepatitis C, as self- reported by each individual.

Unmet Needs and Critical Service Gaps:

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) MAT is seldom presented as a treatment option to patients; 2) the majority of CHMC programs are abstinence-based and do not accept individuals utilizing MAT. Over the past few 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 served by the CMHC using IV drugs normally are detoxed in a social setting, without any pharmacological assistance.
3. Most individuals with substance abuse traditionally served through public funds are indigent, and private OTPs have been out of reach. Also, traditionally the two publically funded programs are in the main urban areas, and have such an extensive waiting list that there was normally over a year waiting list. However, because of Medicaid Expansion in Kentucky and because of a new Medicaid state plan amendment that included substance use disorder treatment, including opiate treatment, waiting lists are now only ten (10)

days to two (2) weeks. Also, because of Kentucky opening the network of behavioral health providers to include Medicaid approved private providers, accessibility has improved. Because the state is mostly poor, rural, and mountainous, accessibility needs to continue to improve. Since 2011, four (4) full OTPs and five (5) medication stations have been added to address capacity issues. Access and service capacity remains a major issue in Kentucky.

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.
5. DBHDID has traditionally collected data from the CMHC client/event data set. However, the majority of programming serving individuals with opioid addiction are private programs or else licensed as Alcohol and Drug Entities through the Office of the Inspector General (OIG). The DBHDID does not have good data collection methods for programming, other than for those served through CMHCs.
6. Individuals with opioid addiction do not typically go to CMHCs for services due to stigma and lack of necessary programming for their specific treatment.
7. Although Medication Assisted Treatment is now a Medicaid billable service in Kentucky, progress has been slow regarding establishing reimbursement rates for the various components of Medication Assisted Treatment, so provision of this service has been hampered. In addition, organizations are having difficulty with procedures related to becoming a Medicaid billable entity in order to be able to provide this service.

Priorities for SFY 2016/2017

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.
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.
4. KY SA Prevention and Treatment education needs to include information on the danger of IV drug use and needle sharing.

5. Data needs to be collected from providers of opioid treatment, other than just CMHC data. In addition, data regarding prevalence of IV drug use, 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, Administrative Offices of the Courts, and others.
6. DBH needs to work with Medicaid to clearly identify the process for organizations to become Medicaid billable agencies (e.g. Behavioral Health Service Organizations) and develop methods of providing that information to private organizations across the state.

Data Sources Used:

- 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.
- CDC Vital Signs
- CDC National Prescription Audit 2012
- NQF Standard of Care regarding Withdrawal Management
- <http://healthyamericans.org/reports/injuryprevention15/release.php?stateid=KY>
- http://emergency.cdc.gov/han/han00377.asp#_ENREF_18
- http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6417a2.htm?s_cid=mm6417a2_w
- http://www.cdc.gov/nchhstp/stateprofiles/pdf/Kentucky_profile.pdf
- <http://www.cdc.gov/hepatitis/statistics/2013surveillance/index.htm>
- Informal Data Survey of OTPs

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 81 cases of TB were reported for 2013, which is a rate of 1.8 per 100,000. 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 Used:

- 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 as of 12/31/2013, the number of new HIV disease cases diagnosed among Kentuckians in 2013 was 372. This translates to a rate of 8.4 per 100,000. This is comparatively lower than the US estimated rate of 15.3 per 100,000 for 2012. The reports for 2012 identify 366 HIV disease cases that have been diagnosed among Kentuckians. Cumulatively, 84 pediatric cases of HIV disease have been diagnosed in Kentucky since 1982, with less than five (5) new cases diagnosed annually for the most recent years.

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 Used:

- Department for Public Health

Adolescents with Substance Use Disorders and/or Mental Health Disorders

Prevalence Data/Unmet Needs and Service Gaps:

Previously barriers in Kentucky to improve adolescent substance abuse services included a lack of state funds, a lack of service options, and a lack of community awareness about the problem. However, much of that has changed.

As of January 2014, the new Medicaid state plan included reimbursement for substance abuse services that would allow for youth to obtain substance abuse treatment services without having to go through Early and Periodic Screening Diagnostic and Treatment (EPSDT) funding thus making it much easier for youth and their families to obtain services. At the same time as the Medicaid state plan changed there was also the opening of the Medicaid behavioral health provider network that made available a wider variety of geographically accessible treatment options.

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).

With a recent pharmaceutical settlement fund a small portion of money was earmarked for school based behavioral health screening. A demonstration project and implantation plan has allowed for forty-four (44) schools and 107 trained screeners to implement the Global Assessment of Individual Needs-Short Screening (GAIN SS) as a screening instrument with plans to move statewide over the course of the next two years. There have been clinical staff trained in assessment methods/tools in most every CMHC and several private providers in the state. Kentucky continues to provide training and coaching on the use of the Global Assessment of Individual Needs (GAIN) family of screening and assessment tools.

Previously the need to enhance treatment options for adolescents with juvenile justice involvement was especially pronounced. Kentucky, like many states historically, has responded to certain behaviors by detaining youth, including those who commit status offenses, an approach shown to be ineffective and highly expensive (Nelson, 2008). In fact, Kentucky had been one of the states with the highest rate in the nation, that detained youth charged with a status offense. (Kentucky Youth Advocates (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. 2014 legislation substantially overhauled Kentucky's Juvenile Justice System with the creation of a Senate Bill. This bill amended or created new obligations for the Administrative Office of the Courts (AOC), the Department of Juvenile Justice (DJJ) and other organizations that pushed the state to recognize and expand training and usage of evidence based screening, assessment, and treatment as community based as possible for youth experiencing substance use and behavioral health issues thus possibly preventing and/or reducing the likelihood of deep end involvement or recidivism in to the justice system. Thus, the need for accessible and effective treatment is paramount throughout the system.

With the benefit of the SAMHSA State Adolescent Treatment Enhancement and Dissemination grant and the Attorney General's pharmaceutical settlement, dollars were earmarked for the training and expansion of evidence based practices and treatment services. Clinical staff across the state have been trained with fidelity measures in place for Adolescent Community Reinforcement Approach (A-CRA), GAIN, Seven Challenges, Functional Family therapy and Cognitive Behavioral Therapy as well as trainings to build competency in adolescent treatment providers with regards to group skills, gender specific treatment, brain development and motivational interviewing. Services were also expanded outside of the CMHCs and Intensive Outpatient Programs (IOP) and residential treatment programs were started. A fairly comprehensive array of services for youth with substance use disorders is now available to varying degrees across Kentucky. Services for adolescents are provided by CMHCs, private providers, and Psychiatric Residential Treatment Facilities that have become licensed as Alcohol and Drug Entities and by Medicaid as Behavioral Health Services Organizations.

Kentucky has made strides in promoting evidence based practices and has implemented now many evidence based practices across the state in various treatment milieus with both public and private providers. . Additionally, statewide trainings to treatment providers and other youth-serving staff have been offered through partnerships with the Kentucky Adolescent Treatment Consortium, the System of Care Academy funded in part by a System of Care Grant and by securing a portion of the Kentucky School for alcohol and drug studies to offer an adolescent specific track, including evidence based treatment models.

Some Kentucky specific data reveals:

- Approximately 26% of Kentucky high school students are current smokers compared to 18.2% nationally (YRBS, 2009).
- 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).

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 years old), with approximately 15.4% reporting use compared to 11.9% nationally (National Survey on Drug Use and Health (NSDUH), 2008-2009).

Further, heroin has now become the drug of choice for many individuals across the nation and Kentucky. The larger metropolitan areas of Lexington, Louisville and Northern Kentucky have been especially hard hit by this epidemic. A growing number of youth and young adults previously abusing expensive prescription drugs are now using heroin, which is cheaper and easier to buy. This is taking a deadly toll on Kentucky's transition-age youth. Heroin overdose deaths increased 650% between 2011 and 2012, from twenty-two (22) cases in 2011 to 143 in 2012. In 2011, the percentage of heroin overdose deaths was 3.22%. In 2012, it had jumped to almost 20% of all overdose deaths.

Results of the 2010-11 NSDUH reveals further distressing statistics for Kentucky's youth and young adults. As noted in Table 1, the dramatic increase in the use of drugs, alcohol and tobacco between those who are 12-17 years old and 18-25 years old is startling, furthering illustrating the need for intervention at earlier ages and the urgent need for treatment and recovery supports for transitional age youth.

ITEM	12 – 17 Years	18 – 25 Years
Past Month Illicit Drug Use	29	82
Past Year Marijuana Use	41	109
Past Year Non-Medical Pain Reliever Use	22	50
Past Month Alcohol Use	43	235
Past Month Binge Alcohol Use	26	174
Alcohol Dependence or Abuse	12	52
Needing But Not Receiving Treatment For Alcohol Use	12	48
Past Month Tobacco Product Use	50	232
Past Month Cigarette Use	39	195
Had at least one major depressive episode in the	30	36

past year		
Serious thoughts of suicide in the past year	Not reported	30

As noted previously, the KYT initiative proposes to include military personnel of transition age and military-connected youth as special populations of focus. The recognition of the needs of this special population have become ever-more apparent in the results of the most recent Kentucky Incentives for Prevention (KIP) survey (2014), a school-administered survey that assesses the extent of alcohol, drug, and tobacco use among 11 to 18 year olds throughout Kentucky. Table 2 depicts the prevalence of prescription drug use and mental health correlates among 10th graders from military-connected families. For any prescription drug use as well as the three main prescription drug classes, 10th graders from military-connected families consistently had higher 30-day rates of prescription drug use. Military-connected youth also had higher rates of mental distress as indicated by self-harm, suicidal ideation, suicide plans, and suicide attempts.

Table 2. Prevalence of Prescription Drug Use and Mental Health Correlates among 10th Graders from Military-Connected Families (KIP, 2014)			
Family Member on Active Duty or Veteran			
	No/DK N (%)	Yes N (%)	Yes More than 1 N (%)
30-Day Prescription Drug Use			
Any prescription	522 (3.3)	184 (3.7)	263 (3.9)
Opioids	619 (4.0)	200 (4.1)	359 (5.3)
Tranquilizers	216 (1.4)	62 (1.3)	119 (1.8)
Stimulants	261 (1.7)	91 (1.8)	138 (2.0)
Mental Health			
Symptoms Psychological Distress	2,663 (17.0)	883 (17.8)	1,382 (20.4)
Self-harm	2,732 (18.8)	921 (20.0)	1,506 (23.8)
Suicide ideation	2,190 (13.9)	769 (15.4)	1,261 (18.5)
Suicide plan	1,764 (11.2)	624 (12.6)	1,038 (15.3)
Suicide attempt	1,136 (7.2)	412 (8.3)	677 (9.9)

Goals for SFY 2016/2017:

- Encourage the statewide use (especially the CMHCs) of an evidence based screening and assessment tool for initial screening/assessment process (i.e. GAIN Family of instruments). All CMHCs should conduct standard screening and assessment for trauma and substance use for all youth who enter the door.
- Continue to implement school based screening for behavioral health needs in middle and high schools using the GAIN SS.
- Continue to work with AOC, DJJ, CMHCs, and communities across the state to implement system change and engage behavioral health providers and the community to work together to help adolescents who may have substance use disorders/co-occurring mental health and substance use disorders, and their families, in accessing less restrictive community services versus more restrictive placements such as out of home or detention services
- Continue to support infrastructure in using evidence based treatment and assessment by offering an adolescent track at the annual Kentucky School for Alcohol and Drug Studies. CMHC Plan and Budget documents will be reviewed to identify needed topics for adolescent treatment providers.

- 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.
- Support each CMHC in developing at least one (1) Intensive Outpatient Program for adolescents with substance use and/or co-occurring disorders and the ability to provide this level of treatment with confidence.
- Provide support and coaching for the development of co-occurring capable programming in at least six (6) sites in the state by utilizing the Dual Diagnosis Capability in Youth Treatment (DDCYT) tool to assess current co-occurring capability and evaluate strengths and weaknesses and provide feedback to programs. This would include training DDCYT assessors within the CMHC system.
- Use intake and follow-up data from providers to strengthen clinical workforce regarding adolescent behavioral health treatment, and to assist providers and policymakers in better understanding characteristics/needs of adolescents entering treatment.
- Restructure funding to support more treatment and aftercare of adolescents in need of behavioral health services.
- Strengthen the use of data in guiding treatment efforts and in comparing outcomes for adolescents with those of adults.
- Continue to assist with the ongoing work of the Kentucky Adolescent Substance Abuse Consortium (KASAC).
- Continue to work with Substance Abuse Treatment – Education and Dissemination (SAT-ED) cooperative agreement to provide financial mapping of behavioral health services for adolescents and their families, to identify service gaps and offer ideas to expand the continuum of services and supports.
- Continue to collaborate with KASAC regarding state standards for endorsement of treatment providers for adolescents with behavioral health disorders and their family.

Data Sources Used:

- Centers for Disease Control and Prevention (CDC). (2010). *Behavioral Risk Factor Surveillance System Survey Data*. (BRFSS) Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.
- Centers for Disease Control and Prevention (CDC). *Youth Risk Behavior Surveillance*. Available at <http://www.cdc.gov/HealthyYouth/yrbs/index.htm>
- Nelson, D. (2008). *A Road Map for Juvenile Justice Reform. 2008 National KIDS COUNT Data Book*. Annie E. Casey Foundation. Available at http://www.aecf.org~/media/Pubs/Initiatives/KIDS%20COUNT/123/2008KIDSCOUNTEssayARoadmapforJuvenileJusticeReform/KC08Essay_Road_Map.pdf. Accessed July 2012.
- REACH of Louisville, Inc. (2010). *Kentucky Incentives for Prevention (KIP) Survey: Statewide Trends Related to Substance Abuse, School Safety, & Gambling (2003-2010)*: Louisville, KY: REACH of Louisville, Inc.
- Substance Abuse and Mental Health Services Administration. National Survey on Drug Use and Health (NSDUH). Available at <https://nsduhweb.rti.org/>
- Kentucky Youth Advocates <http://kyyouth.org>

Step 2: Identify the unmet service needs and critical gaps within the current system.

Goal for SFY 2016/2017: Reduce the incidence of underage drinking.

Objective: Decrease in the number of 10th graders who report drinking alcohol in the past 30 days.

Strategies: Implement Environmental Strategies such as Social Host Ordinances, Responsible Beverage Server Training. Educate communities on the benefits of these strategies; work with law enforcement to ensure that they are enforced. Increase early screening and assessment of adolescents in school settings; assess availability of treatment services for adolescents with substance abuse disorders.

□Target Population: 8th 9th and 10th graders, adults, alcohol retailers, and the community at large.

Step 2: Add additional information on how you know there is an underage drinking problem. Use the area of focus model as you did for other prevention priorities in this step.

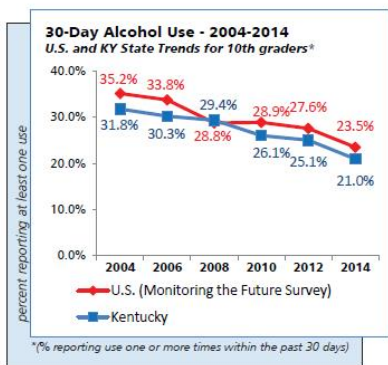
Historically, Kentucky’s past 30 day underage youth drinking rates have been lower than the national average (Monitoring the Future) for all grades. This trend is consistent with the 2014 Kentucky Incentives for Prevention (KIP) data. However, when the KIP past 30 day drunkenness and past two week binge drinking rates are compared to national averages a troubling picture emerges. For past 30 day drunkenness the Kentucky rates are higher than the national average across all grade levels. For past two week binge drinking, the Kentucky rates are very close to the national rates, with 8th grade rates slightly higher than the national average. This data suggests that while, as a whole less Kentucky youth drink as compared to the national average, those who do drink alcohol consume at higher rates than the national average. The SEOW generated a regional report to identify areas of high magnitude. These regions will be a priority for our UAD efforts. (See tables below.) This is a source of concern as drunkenness and binge drinking are indicators most closely associated with consequences (traumatic brain injury, DUI-related injuries, fighting, and unplanned sex. Etc.) By increasing early screening and assessment of adolescents in school settings we hope to be able provide intervention services to those youth in need before negative consequences occur. We also know from our KIP data that the two most popular locations where youth report consuming alcohol are friend’s homes (13.2%) and parties (12.3%). When asked where youth who drank in the past 30 days obtained their alcohol 14.6% of students surveyed reported that they got their alcohol from friends. Sadly, the second most popular source of alcohol was parents (4.5%), followed by older brother and sister (3.8%) Convenience stores and other retail outlets were the least likely place for youth to get alcohol (1.8%). The data clearly indicates that we need to do more to reduce underage youth social access to alcohol. Social Host Ordinances, educating parents and communities on the legal consequences of providing alcohol to underage youth as well as changing the social norms around alcohol as a rite of passage are strategies that will be implemented to address this problem

Past 30 Day Drunkenness

Monitoring the Future		KIP
8 th	2.7%	6.5%
10 th	11.2%	16.5%
12th	23.5%	25.1%

Past 30 day Binge Drinking

Monitoring the Future		KIP
8 th	4.1%	4.8%
10 th	12.6%	12%
12th	19.4%	18.7%

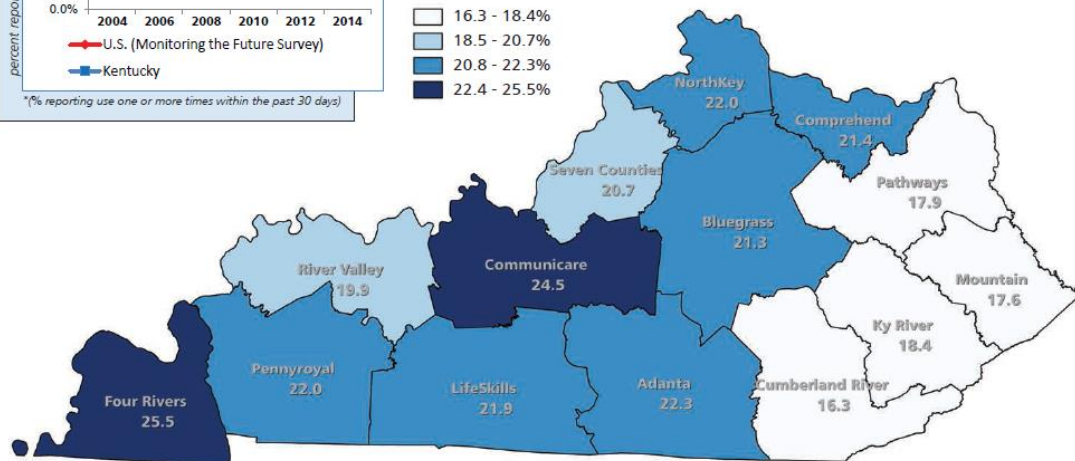


Grade 10 - Alcohol (more than just a few sips) 30-Day Use, 2014

(% responding that they had used the substance one or more times within the past 30 days)

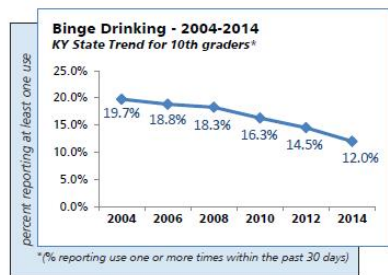
PERCENTAGE OF 10TH GRADERS, 2014

Min: 16.3% (CUMBERLAND RIVER); Max: 25.5% (FOUR RIVERS)



NON-PARTICIPATING DISTRICTS BY REGION: LIFESKILLS (Bowling Green Independent, Glasgow Independent, Warren County), SEVEN COUNTIES (Anchorage Independent, Jefferson County), NORTHKEY (Fort Thomas Independent, Gallatin County, Southgate Independent, Kenton County), PATHWAYS (Raceland-Worthington Independent), MOUNTAIN (Paintsville Independent), CUMBERLAND RIVER (East Bernstadt Independent), BLUEGRASS (Berea Independent, Jessamine County.)

Data are classified using Natural Breaks. Natural Breaks minimize each class's average deviation from the class mean, while maximizing each class's deviation from the means of the other groups.



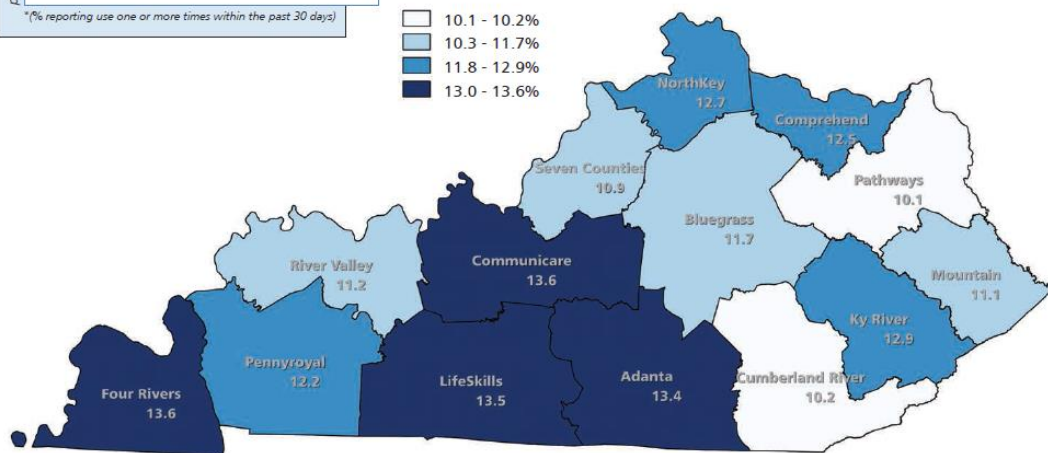
Grade 10 - Binge Drinking, 2014

(5 or more drinks in a row in the past two weeks)

(% responding that they had 5 or more drinks in a row one or more times within the past two weeks)

PERCENTAGE OF 10TH GRADERS, 2014

Min: 10.1% (PATHWAYS); Max: 13.6% (COMMUNICARE/FOUR RIVERS)



NON-PARTICIPATING DISTRICTS BY REGION: LIFESKILLS (Bowling Green Independent, Glasgow Independent, Warren County), SEVEN COUNTIES (Anchorage Independent, Jefferson County), NORTHKEY (Fort Thomas Independent, Gallatin County, Southgate Independent, Kenton County), PATHWAYS (Raceland-Worthington Independent), MOUNTAIN (Paintsville Independent), CUMBERLAND RIVER (East Bernstadt Independent), BLUEGRASS (Berea Independent, Jessamine County.)

Data are classified using Natural Breaks. Natural Breaks minimize each class's average deviation from the class mean, while maximizing each class's deviation from the means of the other groups.

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's [NBHQF](#). The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at <http://www.samhsa.gov/data/quality-metrics/block-grant-measures>. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?
4. If not, what changes will the state need to make to be able to collect and report on these measures?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Quality and Data Collection Readiness

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's [NBHQF](#). The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Form (NQF) wherever possible. SAMHSA is also working to align these measures and with other efforts with HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

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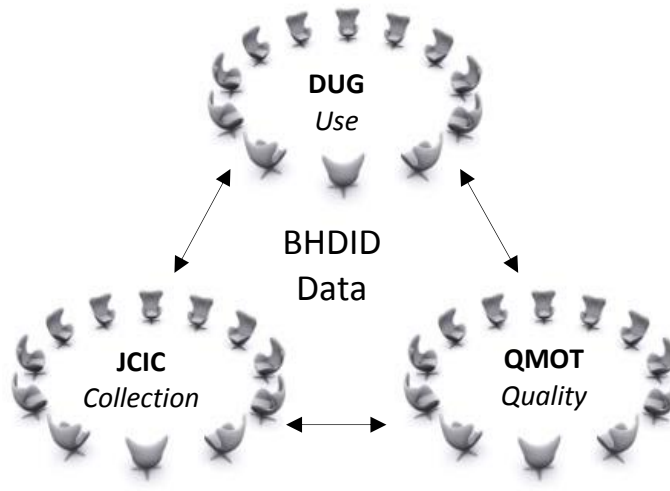
The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g. Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understand modifications to data collection systems may be necessary to achieve these goals and will work with states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

DBHDID recognizes the need for quality data collection and its use in planning, development and outcomes. The key structure for DBHDID data collection, quality and use involves three standing DBHDID committees, that are devoted solely to data and data related issues.



These three (3) standing data committees are supported by DBHDID Commissioner Office leadership, the Division Directors, and representation from branch staff. These committees are:

- Data Users Group (DUG) – meets monthly. Provides recommendations and directions for the collection, analysis, architectural design and structure, use of data and information relevant to desired outcomes management across the Department. The DUG team evaluates data and related issues that support the provision of quality services and areas for improvement are explored.
- Quality Management Outcomes Team (QMOT) – meets quarterly. Recommendations from the QMOT team provide direction for the collection of information relevant to desired outcomes, methods of measurement, and design of processes for continuous outcomes management across the Department. Outcomes are evaluated that support the provision of quality services and areas for improvement are explored.
- Joint Committee for Information Continuity (JCIC) – meets every other month. This committee makes recommendations concerning information management to the Department. The JCIC team facilitates the development of data related contract items and provides direction and assistance in the continued development of an information system to manage a public behavioral health system.

1. Briefly describe the state’s data collection and reporting system and what level of data can be reported currently (e.g., at the client, program, provider, and/or other levels).

The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (BHDID) collects data from its providers serving individuals in the community and in state-owned and state-operated facilities. For purpose of project-based analysis, the community-based data and facility data are relational via common data elements.

Community-Based Data

The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (BHDID) collects data monthly from Community Mental Health Center providers. This data supports the BHDID’s efforts to monitor client-level demographic and diagnostic statistics, service utilization, and provider & human staffing used to provide direct care behavioral health services (including services for Mental Health, Substance Abuse, and Developmental & Intellectual Disabilities). The BHDID uses this data as source for federal Block Grant reports, National Outcome Measures (NOMS), Treatment Episode Data Set (TEDS), Client Level Data reporting (CLD), Uniform Data Reporting

System (URS) and a variety of other uses. Specific to the CLD, Kentucky has successfully reported CLD using the original CLD methodology since the inception year.

Facility Data

The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (BHDID) daily collects data on its state-owned and state-operated facilities which for behavioral health include 3 state psychiatric hospitals and 1 state psychiatric unit within a medical facility. The data collected includes client level admission and discharge information and includes demographics, diagnostic, and living arrangement (housing) status at admission and discharge. The BHDID uses this data as source for federal National Outcome Measures (NOMS), Client Level Data reporting (CLD), Uniform Data Reporting System (URS) and a variety of other uses such as SMHA Profiles and surveys.

2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (BHDID) operates its community-based and facility data system within the Department. The BHDID is one Department within the Cabinet for Health and Families Services which also houses the Department for Medicaid Services, the Department for Community Based Services (DCBS is Kentucky's child welfare department), and the department for Public Health. Each Department within the Cabinet houses its own data system(s). For purpose of project-based analysis, the various department data sets can be made relational via common data elements. For example, Medicaid claims data can be cross referenced with behavioral health markers to collect behavioral health data regarding individuals served by providers other than only DBHDID contracted providers.

3. Is the state currently able to collect and report on the draft measures at the individual client level (that is, by client served, but not with client-identifying information)?

Yes, for most measures. Our state tends to have difficulty collecting school attendance data since such data rests at the local level. Also, there have been difficulties establishing continuing memorandum of agreements with justice serving agencies, so data regarding justice involvement is inconsistent.

4. If not, what changes will the state need to make to be able to collect and report on these measures?

The state must further clarify the draft measures, and work with leadership to more consistently manage data collection regarding justice involvement.

Please indicate areas of technical assistance needed related to this section.

The state would benefit from technical assistance that reviews details of each measure and clearly explains SAMHSA's established expectations, including a timeline. It would be helpful to learn more about any expected changes in structure or organization of SAMHSA data contractors to whom states directly send data. It would be beneficial to provide webinars designed to keep states updated on any possible changes to data contractors and perhaps to include feedback from state experiences, prior to making changes. The state would benefit from further guidance about expectation for data collection, either one on one or through group webinars, conference calls, or in-person meetings.

Quality and Data Readiness

Kentucky's Prevention Data System (PDS)

At this time, the Prevention and Health Promotion Branch is in the final stages of developing its new Prevention Data System (PDS), with enhancements to understand the connections between evidence based programs, the six CSAP strategies and state strategies. It will also be capable of connecting plans of the RPCs to the work completed or carried out and entered into the system. This new system improves prevention efforts on two fronts.

- First, the new system will be able to capture, through automatic reporting features, plans around substances and behaviors KY's prevention system is working on, CSAP strategies planned to address the substances and behaviors, high risk populations that RPCs are targeting, and partners planned to engage to advance the work. An additional feature that is being built into the system is planned outcome measures so that our prevention system initiates evaluation and sustainability of their work at the beginning, in the planning phases. These automated features were not available in our previous data system.

- A second improvement feature of the prevention data system is the planning component will 'speak' to the activities or services reported component, a feature not available with our previous system. This means that the work of our prevention system will be seen in output form and will also be able to be aligned with what was planned for a particular substance or behavior and the strategy proposed to complete the activity. Connecting plans-to-strategies-to-services has been a challenge for the system; this feature will assist with closing this gap.

Still in the development phase, an additional improvement is helping the prevention system to understand and identify outcome measures associated with their strategies and service delivery. Being able to understand the short-term outcomes of service delivery has been a challenge. It is anticipated that this will be a continuous quality improvement effort for the prevention system, as data will drive the approach to improving the quality of services, processes, and activities.

- The PDS will collect information related to:

- Strategies and prevention services implemented by the RPCs (i.e., attempts to involve schools, businesses, government agencies and individuals through the strategy lens of information dissemination, education, alternative activities, community based processes, environmental, and problem identification and referral);
- Demographic composition of the population served, including number served, age, gender, race, ethnicity, and whether part of high risk population; and,
- Intervention strategies or types for the population served.
- The PDS will provide feedback on engagement processes, used with trend data on substance use and abuse, to understand efforts needed to affect change.

- The PDS will inform the Branch and RPCs on frequency and participation in processes, informing the strength and commitment of coalitions and groups, in tandem with types of efforts led by the coalitions and groups, informing on the effectiveness of the group.

How the Prevention Data System is Used and by Whom:

- Information entered into this web-based platform will be done by RPC staff in each of our 14 Regional Prevention Centers, chronicling their efforts in communities to reduce substance use and abuse.
- The PDS is maintained by Prevention and Health Promotion Branch staff, with reports developed in conjunction with RPC Directors and other special projects of the Branch, and generated and distributed monthly by Prevention and Health Promotion Branch staff.
- Reports generated by the PDS will provide RPC Directors the ability to evaluate level of effort put forth in each county, with information used for planning future activities; as well, for state staff to track progress towards attaining Work Plan objectives.
- Data will be extracted annually and otherwise, reporting to CSAP on types and numbers of strategies and participants/demographics, as well as the spread of work across the commonwealth.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1
 Priority Area: Adults with Serious Mental Illness (SMI)
 Priority Type: MHS
 Population(s): SMI

Goal of the priority area:

Increase access to evidence based practices for Adults with SMI

Objective:

Increase the total number of Adults with SMI who receive Peer Support (PS) services and Assertive Community Treatment (ACT) and by 5% from SFY 2015 to SFY 2017.

Strategies to attain the objective:

CMHCs are required by contract to employ Peer Support Specialists to serve Adults with SMI and to develop ACT teams. Peer Specialists are also required as designated members of ACT teams.
 Each of the 14 CMHCs is required by contract to have at least one fully staffed ACT team.
 Provide training and technical assistance to ensure that CMHCs understand how to provide and bill for ACT services.
 Provide training and Technical Assistance and fidelity monitoring to ensure most effective implementation of ACT services.
 Continue to provide awareness activities and training regarding Recovery Principles and the importance of including Peers in the service delivery array.
 Provide training for how to most effectively supervise the work of Peer Specialists.

Annual Performance Indicators to measure goal success

Indicator #: 1
 Indicator: Peer Services for Adults with SMI who meet criteria for the service
 Baseline Measurement: Total number of Adults with SMI who received Peer Services, from the 14 CMHCs, in SFY 2015.
 First-year target/outcome measurement: Increase by 2.5% the total number of Adults with SMI who receive Peer Services, from the 14 CMHCs, from SFY 2015 to SFY 2016.
 Second-year target/outcome measurement: Increase by 2.5% the total number of Adults with SMI who receive Peer Services, from the 14 CMHCs, from SFY 2016 to SFY 2017.

Data Source:

MIS data set used by the Department and the 14 CMHCs

Description of Data:

Data report to show the total number of unduplicated Adults with SMI served by the 14 CMHCs, who receive the identified service of Peer Support, in SFY (July 1-June 30).

Data issues/caveats that affect outcome measures::

Department will also keep track of the number of Peer Specialists employed by the CMHCs to use for comparative analysis.

Indicator #: 2
 Indicator: Assertive Community Treatment (ACT) services for Adults with SMI who meet criteria for the service
 Baseline Measurement: Total number of Adults with SMI who receive ACT services from the 14 CMHCs in SFY 2015
 First-year target/outcome measurement: Increase by 2.5% the total number of Adults with SMI who receive ACT services from the 14

CMHCs from SFY 2015 to SFY 2016.

Second-year target/outcome measurement: Increase by 2.5% the total number of Adults with SMI who receive ACT services from the 14 CMHCs from SFY2016 to SFY 2017.

Data Source:

MIS data set used by the Department and the 14 CMHCs

Description of Data:

Data report to show the total number of unduplicated Adults with SMI, served by the 14 CMHCs, who received the identified service of ACT in the SFY (July 1-June 30)

Data issues/caveats that affect outcome measures::

Department will also track the number of ACT teams in operation through the CMHCs to use for comparative analysis

Priority #: 2
Priority Area: Children and Youth with Severe Emotional Disabilities (SED)
Priority Type: MHS
Population(s): SED

Goal of the priority area:

Increase access to evidence based practices for Children/Youth with SED

Objective:

Track the total number of children/youth who receive High Fidelity Wraparound (HFW) from the 14 CMHCs and track the total number of certified Youth Peer Specialists from SFY 2015 to SFY 2017

Strategies to attain the objective:

Recruit and train high fidelity wraparound facilitators and their supervisors
Recruit and train youth peer specialists
Ensure there is a formalized process in place to train, certify and track SED Targeted Case Managers and HFW facilitators
Ensure there is a formalized process in place to train, certify and track Youth Peer Specialists

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Increase in the total number of DBHDID Certified HFW facilitators/supervisors to serve children/youth with SED from SFY 2015 to SFY 2017
Baseline Measurement: Total number of DBHDID Certified HFW facilitators/supervisors in SFY 2015 =0
First-year target/outcome measurement: At least 50 unduplicated HFW facilitators/supervisors shall be trained and certified in SFY 2016
Second-year target/outcome measurement: At least 50 additional, unduplicated, HFW facilitators/supervisors shall be trained and certified in SFY 2017

Data Source:

DBHDID Certification Data Base

Description of Data:

Provider entities must obtain approval of training curricula or receive training through DBHDID. DBHDID is in the process of creating an on-line data base in SFY 2016 to track the training and certification of non-licensed service providers (TCM, PS, Community Support Associates)

Data issues/caveats that affect outcome measures::

All new tracking system

Indicator #: 2

Indicator: Increase in the total number of DBHDID Certified Youth Peer Specialists to serve children/youth with SED from SFY 2015 to SFY 2017

Baseline Measurement: Total number of DBHDID Certified Youth Peer Specialists in SFY 2015 =8

First-year target/outcome measurement: At least 10 Youth Peer Specialists shall be trained and certified in SFY 2016

Second-year target/outcome measurement: At least 10 additional Youth Peer Specialists shall be trained and certified in SFY 2017

Data Source:

DBHDID Certification Data Base

Description of Data:

DBHDID Certification Data Base
 Provider entities must obtain approval of training curricula or receive training through DBHDID. DBHDID is in the process of creating an on-line data base in SFY 2016 to track the training and certification of non-licensed service providers (TCM, PS, Community Support Associates)

Data issues/caveats that affect outcome measures::

All new tracking system

Priority #: 3

Priority Area: Primary Prevention Substance Abuse

Priority Type: SAP

Population(s): PP

Goal of the priority area:

Reduce the incidence of Underage Drinking

Objective:

Decrease in the number of 10th graders who report drinking alcohol in the past 30 days

Strategies to attain the objective:

Educate parents about "host parties" and the negative physiological effects of alcohol consumption by adolescents. Work to establish Social Host Ordinances. Implement Strategies such as " I Won't be the One" to reduce underage use social access to alcohol. Improve early prevention screening and assessment of adolescents in school settings

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Numer of 10th graders who report drinking alcohol in the past 30 days

Baseline Measurement: 2014 Survey results indicate 21% of 10th graders that answered at least once they have had an alcoholic beverage in the past 30 days

First-year target/outcome measurement: N/A Survey is only conducted every two years

Second-year target/outcome measurement: Decrease by 2% the number of 10th graders that answered at least once they have had an alcoholic beverage in the past 30 days

Data Source:

Kentucky Incentives for Prevention (KIP) Survey 2016

Description of Data:

The KIP survey provides information about student self-reported use of substances (e.g., within the last 30 days, last year), student perceptions about substance use (e.g., level of risk, peer and parent disapproval), and perceived accessibility of substances in the community. The 2014 survey includes the addition of several new questions related to heroin use, bullying, dating violence, and suicidal ideation. Once the survey data are gathered and analyzed, each participating school district receives a report outlining district-specific results, and depicting comparisons to the region, state and (when available) the rest of country.

The KIP survey is Kentucky's largest source of data related to student use of alcohol, tobacco, and other drugs (ATOD), as well as a number of factors related to potential substance abuse. In 2014, over 124,000 students representing 159 school districts (of the state's 173) completed the survey, and the information gathered provided an invaluable substance abuse prevention tool for those communities. Districts utilize their KIP results extensively for grant-writing purposes, prevention activities, and various other needs related to program planning.

Data issues/caveats that affect outcome measures::

Results of KIP survey conducted in 2016 are available in 2017

Priority #: 4
Priority Area: Pregnant Women/Women with Dependent Children (Adolescents and Adults) with Substance Use Disorders
Priority Type: SAT
Population(s): PWWDC

Goal of the priority area:

Increase access to treatment for Pregnant/Post Partum and Women with Dependent Children who have Substance Use Disorders (SUDs)

Objective:

Increase the total number of Pregnant/Post Partum women and Women with Dependent Children with SUDs who receive Case Management Services

Strategies to attain the objective:

Outreach to referral sources for women with SUDs (e.g., primary care, pediatricians, OB/GYNs, emergency rooms, law enforcement, etc.)

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Increase by 10% the total number of unduplicated PWWDC who receive Case Management services from the 14 CMHCs from SFY 2015 to SFY 2017
Baseline Measurement: The total number of unduplicated PWWDC who received Case Management services from the 14 CMHCs in SFY 2015
First-year target/outcome measurement: Increase by 5% the total number of unduplicated PWWDC who received Case Management services from the 14 CMHCs from SFY 2015 to SFY 2016
Second-year target/outcome measurement: Increase by 5% the total number of unduplicated PWWDC who received Case Management services from the 14 CMHCs from SFY 2016 to SFY 2017

Data Source:

MIS data set used by the Department and the 14 CMHCs and additional Data Analysis provided by the Center for Drug and Alcohol Research

Description of Data:

Data reports show the unduplicated number of PWWDC served who meet the demographics for PWWDC and received case management services from the CMHCs in each SFY

Data issues/caveats that affect outcome measures::

Priority #: 5
Priority Area: Intravenous Drug Users

Priority Type: SAT

Population(s): IVDUs

Goal of the priority area:

Distribute additional Narcan Rescue Kits in effort to reduce deaths of IV Drug Users.

Objective:

Provide Naloxone Rescue kits, to specified hospitals and others across the state, for distribution to every treated and discharged overdose victim

Strategies to attain the objective:

Distribute NARCAN Kits to additional hospitals in other areas of the state and to first responders and others as funding allows
Educate IV Drug Users, their families and the general public about the availability and effectiveness of Naloxone in the event of an overdose.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Total number of Narcan (Naloxone) kits distributed to hospitals or elsewhere in the SFY
Baseline Measurement: Two thousand kits were distributed to three hospitals (UK,U of L and St. Elizabeth) in SFY 2015
First-year target/outcome measurement: At least 100 additional kits will be distributed in SFY 2016
Second-year target/outcome measurement: At least 100 additional kits will be distributed in SFY 2017

Data Source:

The Substance Abuse Treatment Advisory Committee (SATAC) who is charged with tracking distribution

Description of Data:

DBHDID has access to the number of kits distributed through the KYKIDS Recovery project

Data issues/caveats that affect outcome measures::

Priority #: 6

Priority Area: Individuals who receive SUD services and have or are risk for TB

Priority Type: SAT

Population(s): TB

Goal of the priority area:

Improve data collection of individuals with or at risk of TB who receive services for SUDs

Objective:

Improve screening for diagnosis of Tuberculosis (TB) among individuals receiving services, from the 14 CMHCs, for SUDs.

Strategies to attain the objective:

Continue partnering with the KY Department for Public Health and the CMHCs to improve data collection definitions and screening protocol.
Ensure that CMHCs are systematically screening for Tb among individuals receiving services for SUDs.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Total number of individuals receiving services from the 14 CMHCs for SUDs who are screened for TB or are referred for a TB screen.
Baseline Measurement: Total number of individuals screened for TB by CMHCs in SFY 2015, who received services for SUDs.

First-year target/outcome measurement: Ensure at least 60% of the total number of individuals, who received services for SUDs, are screened for TB, by CMHCs in SFY 2016.

Second-year target/outcome measurement: Ensure at least 70% of the total number of individuals, who received services for SUDs, are screened for TB, by CMHCs in SFY 2017,

Data Source:

MIS data set used by the Department and the 14 CMHCs

Description of Data:

Client demographic field for TB

Data issues/caveats that affect outcome measures::

Data sharing with Public Health will also be used for comparative analysis.

Priority #: 7

Priority Area: Individuals in Recovery from Substance Use Disorders

Priority Type: SAT

Population(s): Other (Rural, Military Families, Homeless, Underserved Racial and Ethnic Minorities, Adult Men and Women in Recovery from SUDs)

Goal of the priority area:

Increase the number of Oxford Houses in Kentucky

Objective:

Open at least 2 additional Oxford Houses in KY by the end of SFY 2017

Strategies to attain the objective:

Contract with Oxford House to employ Case Managers and with the KY Housing Corporation to secure revolving funds to support financing of the housing units.
DBHDID staff members will work with national partners to ensure successful operation of the houses.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Open at least two new Oxford Houses in Kentucky between SFY 2015 and SFY 2017.

Baseline Measurement: There were four Oxford Houses in KY at the end of SFY 2015.

First-year target/outcome measurement: Increase the total number of Oxford Houses in KY to 5 by the end of SFY 2016.

Second-year target/outcome measurement: Increase the total number of Oxford Houses in KY to 6 by the end of SFY 2017.

Data Source:

DBHDID tracking of Oxford Houses and occupancy rates

Description of Data:

DBHDID will monitor and ensure tracking of the opening and successful operation of Oxford Houses in KY.

Data issues/caveats that affect outcome measures::

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	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	\$32,077,746		\$0	\$1,705,800	\$9,678,000	\$0	\$0
a. Pregnant Women and Women with Dependent Children*	\$7,000,000		\$0	\$0	\$3,600,000	\$0	\$0
b. All Other	\$25,077,746		\$0	\$1,705,800	\$6,078,000	\$0	\$0
2. Substance Abuse Primary Prevention	\$8,559,000		\$0	\$1,470,000	\$6,600,000	\$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. Evidenced Based Practices for First Episode Psychosis (10% of the state's total MHBG award)							
10. Administration (Excluding Program and Provider Level)	\$120,000		\$0	\$0	\$2,250,000	\$0	\$0
11. Total	\$40,756,746	\$0	\$0	\$3,175,800	\$18,528,000	\$0	\$0

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

State Pregnant and Women with Dependent Children funding includes agency receipts received from the state Department of Early Childhood Development.

Other Federal Prevention funding includes funds received from SAMHSA to provide Partnerships for Success 2015.

Other Federal Treatment funding includes a small carry-forward from SAMHSA for Adolescent Treatment, and the SA portion of the Cooperative Agreement to Benefit Homeless Individuals - States.

KENTUCKY PLANS TO CONTINUE TO ALLOCATE AT LEAST 21% OF THE TOTAL BLOCK GRANT AWARD ($\$20,247,277 \times 2 \text{ YEARS} \times 21\% = \$8,503,860$) IN ORDER TO ASSURE THAT WE MEET REQUIRED SET-ASIDES.

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	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			\$46,600,000	\$24,400,000	\$180,000,000	\$5,400,000	\$0
6. Other 24 Hour Care		\$0	\$19,200,000	\$600,000	\$29,995,600	\$3,400,000	\$0
7. Ambulatory/Community Non-24 Hour Care		\$10,909,000	\$2,410,600	\$6,551,700	\$74,550,000	\$0	\$0
8. Mental Health Primary Prevention**		\$50,000	\$0	\$0	\$700,000	\$0	\$0
9. Evidenced Based Practices for First Episode Psychosis (10% of the state's total MHBG award)		\$132,579	\$0	\$68,000	\$80,000	\$0	\$0
10. Administration (Excluding Program and Provider Level)		\$884,800	\$236,000	\$876,300	\$18,862,000	\$0	\$0
11. Total	\$0	\$11,976,379	\$68,446,600	\$32,496,000	\$304,187,600	\$8,800,000	\$0

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

Planning Tables

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	SABG Expenditures	MHBG Expenditures
Healthcare Home/Physical Health	\$	\$30,000
General and specialized outpatient medical services;		
Acute Primary Care;		
General Health Screens, Tests and Immunizations;		
Comprehensive Care Management;		
Care coordination and Health Promotion;		
Comprehensive Transitional Care;		
Individual and Family Support;		
Referral to Community Services;		
Prevention Including Promotion	\$84,289	\$

Screening, Brief Intervention and Referral to Treatment ;		
Brief Motivational Interviews;		
Screening and Brief Intervention for Tobacco Cessation;		
Parent Training;		
Facilitated Referrals;		
Relapse Prevention/Wellness Recovery Support;		
Warm Line;		
Substance Abuse Primary Prevention	\$8,667,600	\$50,000
Classroom and/or small group sessions (Education);		
Media campaigns (Information Dissemination);		
Systematic Planning/Coalition and Community Team Building(Community Based Process);		
Parenting and family management (Education);		
Education programs for youth groups (Education);		
Community Service Activities (Alternatives);		
Student Assistance Programs (Problem Identification and Referral);		

Employee Assistance programs (Problem Identification and Referral);		
Community Team Building (Community Based Process);		
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental);		
Engagement Services	\$2,400,898	\$3,000,000
Assessment;		
Specialized Evaluations (Psychological and Neurological);		
Service Planning (including crisis planning);		
Consumer/Family Education;		
Outreach;		
Outpatient Services	\$12,436,167	\$1,200,000
Individual evidenced based therapies;		
Group Therapy;		
Family Therapy ;		
Multi-family Therapy;		

Consultation to Caregivers;		
Medication Services	\$2,448,974	\$50,000
Medication Management;		
Pharmacotherapy (including MAT);		
Laboratory services;		
Community Support (Rehabilitative)	\$1,073,159	\$4,200,000
Parent/Caregiver Support;		
Skill Building (social, daily living, cognitive);		
Case Management;		
Behavior Management;		
Supported Employment;		
Permanent Supported Housing;		
Recovery Housing;		
Therapeutic Mentoring;		
Traditional Healing Services;		

Recovery Supports	\$381,611	\$1,000,000
Peer Support;		
Recovery Support Coaching;		
Recovery Support Center Services;		
Supports for Self-directed Care;		
Other Supports (Habilitative)	\$54,956	\$85,000
Personal Care;		
Homemaker;		
Respite;		
Supported Education;		
Transportation;		
Assisted Living Services;		
Recreational Services;		
Trained Behavioral Health Interpreters;		

Interactive Communication Technology Devices;		
Intensive Support Services	\$2,020,904	\$150,000
Substance Abuse Intensive Outpatient (IOP);		
Partial Hospital;		
Assertive Community Treatment;		
Intensive Home-based Services;		
Multi-systemic Therapy;		
Intensive Case Management ;		
Out-of-Home Residential Services	\$9,676,636	\$
Crisis Residential/Stabilization;		
Clinically Managed 24 Hour Care (SA);		
Clinically Managed Medium Intensity Care (SA) ;		
Adult Mental Health Residential ;		
Youth Substance Abuse Residential Services;		
Children's Residential Mental Health Services ;		

Therapeutic Foster Care;		
Acute Intensive Services	\$60,000	\$200,000
Mobile Crisis;		
Peer-based Crisis Services;		
Urgent Care;		
23-hour Observation Bed;		
Medically Monitored Intensive Inpatient (SA);		
24/7 Crisis Hotline Services;		
Other	\$1,189,360	\$1,500,000
Total	\$40,494,554	\$11,465,000

Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Expenditure Category	FY 2016 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	\$15,978,873
2 . Substance Abuse Primary Prevention	\$4,279,500
3 . Tuberculosis Services	
4 . HIV Early Intervention Services**	
5 . Administration (SSA Level Only)	\$120,000
6. Total	\$20,378,373

* Prevention other than primary prevention

** 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by CDC, National Center for HIV/AIDS, Hepatitis, STD and TB Prevention. The HIV Surveillance Report, Volume 24, will be used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective FY 2016 SABG allotments to establish one or more projects to provide early intervention services for HIV at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state does not meet the AIDS case rate threshold for the fiscal year involved. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would be allowed to obligate and expend FY 2016 SABG funds for EIS/HIV if they chose to do so.

Footnotes:

KENTUCKY PLANS TO CONTINUE TO ALLOCATE AT LEAST 21% OF THE TOTAL BLOCK GRANT AWARD TO ASSURE THAT WE MEET REQUIRED SET-ASIDES.

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Strategy		IOM Target	FY 2016
		SA Block Grant Award	
Information Dissemination	Universal		\$659,446
	Selective		\$7,865
	Indicated		\$4,345
	Unspecified		
	Total		\$671,656
Education	Universal		\$409,513
	Selective		\$8,860
	Indicated		\$9,983
	Unspecified		
	Total		\$428,356
Alternatives	Universal		\$175,078
	Selective		\$486
	Indicated		
	Unspecified		
	Total		\$175,564
Problem Identification and Referral	Universal		\$160,752
	Selective		\$3,417
	Indicated		\$713
	Unspecified		
	Total		\$164,882

Community-Based Process	Universal	\$1,230,292
	Selective	\$3,660
	Indicated	\$645
	Unspecified	
	Total	\$1,234,597
Environmental	Universal	\$371,672
	Selective	
	Indicated	
	Unspecified	
	Total	\$371,672
Section 1926 Tobacco	Universal	
	Selective	
	Indicated	
	Unspecified	\$10,000
	Total	\$10,000
Other	Universal	
	Selective	
	Indicated	
	Unspecified	\$1,222,773
	Total	\$1,222,773
Total Prevention Expenditures		\$4,279,500
Total SABG Award*		\$20,378,373
Planned Primary Prevention Percentage		21.00 %

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

\$50,000 of Resource Development Quality Assurance funding can be attributed to: \$40,000 in Education (Universal); \$10,000 in Environmental

(Universal).

\$10,000 in Resource Development Post-Employment Training can be attributed to Universal Community-Based Process.

\$40,000 of Resource Development Program Development can be attributed to: \$5,000 in Unspecified 1926 Tobacco; \$25,000 in Education (Universal); and \$10,000 in Community-Based Process (Universal).

\$220,000 of Resource Development Research and Evaluation is attributed to: \$20,000 in Education (Universal); \$15,000 in Environmental (Universal), and \$185,000 in Other (Unspecified).

\$15,000 of Resource Development Information Systems can be attributed to Information Dissemination (\$10,000) and \$5,000 in Other (Unspecified).

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award	
Universal Direct	\$2,999,183	
Universal Indirect	\$1,240,343	
Selective	\$24,288	
Indicated	\$15,686	
Column Total	\$4,279,500	
Total SABG Award*	\$20,378,373	
Planned Primary Prevention Percentage	21.00 %	

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

\$300,000 for resource development is included in the Universal Direct row.
 \$35,000 for resource development is included in the Universal Indirect row.

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Targeted Substances	
Alcohol	b
Tobacco	b
Marijuana	b
Prescription Drugs	b
Cocaine	e
Heroin	b
Inhalants	e
Methamphetamine	e
Synthetic Drugs (i.e. Bath salts, Spice, K2)	e
Targeted Populations	
Students in College	b
Military Families	b
LGBT	e
American Indians/Alaska Natives	e
African American	b
Hispanic	b
Homeless	e
Native Hawaiian/Other Pacific Islanders	e
Asian	e
Rural	b
Underserved Racial and Ethnic Minorities	e

Footnotes:

Planning Tables

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award			
	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	\$0	\$20,000	\$0	\$20,000
2. Quality Assurance	\$0	\$0	\$200,000	\$200,000
3. Training (Post-Employment)	\$0	\$0	\$50,000	\$50,000
4. Education (Pre-Employment)	\$0	\$0	\$20,000	\$20,000
5. Program Development	\$40,000	\$70,000	\$0	\$110,000
6. Research and Evaluation	\$220,000	\$45,000	\$0	\$265,000
7. Information Systems	\$0	\$0	\$35,000	\$35,000
8. Total	\$260,000	\$135,000	\$305,000	\$700,000

Footnotes:

The Commonwealth does not anticipate any change in planned expenditures due to the change in the final FY2016 Substance Abuse

Planning Tables

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	Block Grant
MHA Technical Assistance Activities	\$125,000
MHA Planning Council Activities	\$54,000
MHA Administration	\$85,000
MHA Data Collection/Reporting	\$100,000
MHA Activities Other Than Those Above	\$
Total Non-Direct Services	\$364000
Comments on Data: <input type="text"/>	
Footnotes:	

Environmental Factors and Plan

1. The Health Care System and Integration

Narrative Question:

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.²⁶ Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but “[h]ealth system factors” such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.²⁷ It has been acknowledged that there is a high rate of co-occurring mental illness and substance abuse, with appropriate treatment required for both conditions.²⁸ Overall, America has reduced its heart disease risk based on lessons from a 50-year research project on the town of Framingham, MA, outside Boston, where researchers followed thousands of residents to help understand what causes heart disease. The [Framingham Heart Study](#) produced the idea of “risk factors” and helped to make many connections for predicting and preventing heart disease.

There are five major preventable risks identified in the Framingham Heart Study that may impact people who live with mental illness. These risks are smoking, obesity, diabetes, elevated cholesterol, and hypertension. These risk factors can be appropriately modified by implementing well-known evidence-based practices^{29 30} that will ensure a higher quality of life.

Currently, 50 states have organizationally consolidated their mental and substance abuse authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.³¹ Specific to children, many children and youth with mental illness and substance use issues are more likely to be seen in a health care setting than in the specialty mental health and substance abuse system. In addition, children with chronic medical conditions have more than two times the likelihood of having a mental disorder. In the U.S., more than 50 percent of adults with mental illness had symptoms by age 14, and three-fourths by age 24. It is important to address the full range of needs of children, youth and adults through integrated health care approaches across prevention, early identification, treatment, and recovery.

It is vital that SMHAs' and SSAs' programming and planning reflect the strong connection between behavioral, physical and population/public health, with careful consideration to maximizing impact across multiple payers including Medicaid, exchange products, and commercial coverages. Behavioral health disorders are true physical disorders that often exhibit diagnostic criteria through behavior and patient reports rather than biomarkers. Fragmented or discontinuous care may result in inadequate diagnosis and treatment of both physical and behavioral conditions, including co-occurring disorders. For instance, persons receiving behavioral health treatment may be at risk for developing diabetes and experiencing complications if not provided the full range of necessary care.³² In some cases, unrecognized or undertreated physical conditions may exacerbate or cause psychiatric conditions.³³ Persons with physical conditions may have unrecognized mental challenges or be at increased risk for such challenges.³⁴ Some patients may seek to self-medicate due to their chronic physical pain or become addicted to prescribed medications or illicit drugs.³⁵ In all these and many other ways, an individual's mental and physical health are inextricably linked and so too must their health care be integrated and coordinated among providers and programs.

Health care professionals and consumers of mental illness and substance abuse treatment recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.³⁶

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.³⁷ Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between mental and substance abuse treatment providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as federally qualified health centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including electronic health records (EHRs) and telehealth are examples of important strategies to promote integrated care.³⁸ Use of EHRs – in full compliance with applicable legal requirements – may allow providers to share information, coordinate care and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, care, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes³⁹ and ACOs⁴⁰ may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

The Affordable Care Act is an important part of efforts to ensure access to care and better integrate care. Non-grandfathered health plans sold in the individual or the small group health insurance markets offered coverage for mental and substance use disorders as an essential health benefit.

SSAs and SMHAs also may work with Medicaid programs and Insurance Commissioners to encourage development of innovative demonstration projects and waivers that test approaches to providing integrated care for persons with mental illness and substance use disorders and other vulnerable populations.⁴¹ Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.⁴²

One key population of concern is persons who are dually eligible for Medicare and Medicaid.⁴³ Roughly, 30 percent of dually eligible persons have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.⁴⁴ SMHAs and SSAs also should collaborate with Medicaid, insurers and insurance regulators to develop policies to assist those individuals who experience health coverage eligibility changes due to shifts in income and employment.⁴⁵ Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or finding a provider.⁴⁶ SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should ensure access and integrated prevention care and recovery support in all vulnerable populations including, but not limited to college students and transition age youth (especially those at risk of first episodes of mental illness or substance abuse); American Indian/Alaskan Natives; ethnic minorities experiencing health and behavioral health disparities; military families; and, LGBT individuals. SMHAs and SSAs should discuss with Medicaid and other partners, gaps that may exist in services in the post-Affordable Care Act environment and the best uses of block grant funds to fill such gaps. SMHAs and SSAs should work with Medicaid and other stakeholders to facilitate reimbursement for evidence-based and promising practices.⁴⁷ It also is important to note CMS has indicated its support for incorporation within Medicaid programs of such approaches as peer support (under the supervision of mental health professionals) and trauma-informed treatment and systems of care. Such practices may play an important role in facilitating integrated, holistic care for adults and children with behavioral health conditions.⁴⁸

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.⁴⁹ Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists and others will need to understand integrated care models, concepts and practices.

Another key part of integration will be defining performance and outcome measures. Following the Affordable Care Act, the Department of Health and Human Services (HHS) and partners have developed the NQS, which includes information and resources to help promote health, good outcomes and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.⁵⁰

SAMHSA recognizes that certain jurisdictions receiving block grant funds – including U.S. Territories, tribal entities and those jurisdictions that have signed compacts of free association with the U.S. – may be uniquely impacted by certain Affordable Care Act and Medicaid provisions or ineligible to participate in certain programs.⁵¹ However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment and recovery support for persons with, or at risk of, mental illnesses and substance use disorders.

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 charged with coordinating 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 consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?
2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?
6. Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?
7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?
8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?
9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

10. Indicate tools and strategies used that support efforts to address nicotine cessation.
 - Regular screening with a carbon monoxide (CO) monitor
 - Smoking cessation classes
 - Quit Helplines/Peer supports
 - Others _____
11. The behavioral health providers screen and refer for:
 - Prevention and wellness education;
 - Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
 - Recovery supports

Please indicate areas of technical assistance needed related to this section.

²⁶ BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Med Care*. 2011 Jun;49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, *Bulletin of the World Health Organization*, 2013;91:102–123

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²⁷ Research Review of Health Promotion Programs for People with SMI, 2012, <http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper>; About SAMHSA's Wellness Efforts,

<http://www.promoteacceptance.samhsa.gov/10by10/default.aspx>; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, *JAMA*; 2007; 298: 1794-1796; Million Hearts, <http://www.integration.samhsa.gov/health-wellness/samhsa-10x10> Schizophrenia as a health disparity, <http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml>

²⁸ Comorbidity: Addiction and other mental illnesses, <http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses>; Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, *JAMA Psychiatry*. 2014;71(3):248-254. doi:10.1001/jamapsychiatry.2013.3726; <http://www.samhsa.gov/co-occurring/>

²⁹ 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report From the Panel Members Appointed to the Eighth Joint National Committee (JNC 8); *JAMA*. 2014;311(5):507-520.doi:10.1001/jama.2013.284427

³⁰ A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines: 2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk: <http://circ.ahajournals.org/>

³¹ Social Determinants of Health, Healthy People 2020, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>; <http://www.cdc.gov/socialdeterminants/Index.html>

³² Depression and Diabetes, NIMH, <http://www.nimh.nih.gov/health/publications/depression-and-diabetes/index.shtml#pub5>; Diabetes Care for Clients in Behavioral Health Treatment, Oct. 2013, SAMHSA, <http://store.samhsa.gov/product/Diabetes-Care-for-Clients-in-Behavioral-Health-Treatment/SMA13-4780>

³³ J Pollock et al., Mental Disorder or Medical Disorder? Clues for Differential Diagnosis and Treatment Planning, *Journal of Clinical Psychology Practice*, 2011 (2) 33-40

³⁴ C. Li et al., Undertreatment of Mental Health Problems in Adults With Diagnosed Diabetes and Serious Psychological Distress, *Diabetes Care*, 2010; 33(5) 1061-1064

³⁵ TIP 54: Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders, SAMHSA, 2012, <http://store.samhsa.gov/product/TIP-54-Managing-Chronic-Pain-in-Adults-With-or-in-Recovery-From-Substance-Use-Disorders/SMA13-4671>

³⁶ Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. <http://www.nami.org/Content/ContentGroups/CAAC/FG-Integrating.pdf>; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011,

http://www.nami.org/Content/NavigationMenu/State_Advocacy/About_the_Issue/Integration_MH_And_Primary_Care_2011.pdf; Abrams, Michael T. (2012, August 30). *Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and challenges*. Baltimore, MD: The Hilltop Institute, UMBC.

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³⁷ Health Care Integration, <http://samhsa.gov/health-reform/health-care-integration>; SAMHSA-HRSA Center for Integrated Health Solutions, (<http://www.integration.samhsa.gov/>)

³⁸ Health Information Technology (HIT), <http://www.integration.samhsa.gov/operations-administration/hit>; Characteristics of State Mental Health Agency Data Systems, SAMHSA, 2009, <http://store.samhsa.gov/product/Characteristics-of-State-Mental-Health-Agency-Data-Systems/SMA08-4361>; Telebehavioral Health and Technical Assistance Series, <http://www.integration.samhsa.gov/operations-administration/telebehavioral-health> State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, <http://www.americantelemed.org/docs/default-source/policy/ata-best-practice---telemental-and-behavioral-health.pdf?sfvrsn=8>; National Telehealth Policy Resource Center, <http://telehealthpolicy.us/medicaid>; telemedicine, <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html>

³⁹ Health homes, <http://www.integration.samhsa.gov/integrated-care-models/health-homes>

⁴⁰ New financing models, http://www.samhsa.gov/co-occurring/topics/primary-care/financing_final.aspx

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⁴² What are my preventive care benefits? <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); Preventive services covered under the Affordable Care Act, <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>

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⁴⁴ Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, <http://www.cbo.gov/publication/44308>

⁴⁵ BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

⁴⁶ TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014;71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013;70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

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⁴⁹ Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, <http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORk/PEP13-RTC-BHWORk.pdf>; Annapolis Coalition, An Action Plan for Behavioral Health Workforce Development, 2007, <http://annapoliscoalition.org/?portfolio=publications>; Creating jobs by addressing primary care workforce needs, <http://www.hhs.gov/healthcare/facts/factsheets/2013/06/jobs06212012.html>

⁵⁰ About the National Quality Strategy, <http://www.ahrq.gov/workingforquality/about.htm>; National Behavioral Health Quality Framework, Draft, August 2013, <http://samhsa.gov/data/NBHQF>

⁵¹ Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, <http://www.cms.gov/ccio/resources/letters/index.html>; Affordable Care Act, Indian Health Service, <http://www.ihs.gov/ACA/>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plans

#1. The Health Care System and Integration

Narrative Questions:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?

The following are the services available through the newly amended Medicaid State Plan:

Rehab Services:

- Screening
- Assessment
- Screening, Brief Intervention, and Referral to Treatment (SBIRT) *SUD Only*
- Psychological Testing
- Service Planning *MH Only*
- Crisis Intervention (clinic based)
- Mobile Crisis
- Residential Crisis Stabilization
- Partial Hospitalization
- Intensive Outpatient (IOP)
- Day Treatment
- Individual Outpatient Therapy
- Group Outpatient Therapy
- Collateral Outpatient Therapy (Under 21)
- Family Outpatient Therapy
- Peer Support
- Parent/Family Peer Support
- Comprehensive Community Support *MH Only*
- Assertive Community Treatment (ACT) *MH Only*
- Residential Substance Use Treatment *SUD Only*
- Medication Assisted Treatment (MAT) *SUD Only*
- Therapeutic Rehabilitation Program (TRP) *MH Only*

Targeted Case Management Services:

- Targeted Case Management for Children with Severe Emotional Disability (SED) and Adults with Severe Mental Illness (SMI)
- Targeted Case Management for Adolescents and Adults with Substance Use Disorders (Moderate to Severe)
- Targeted Case Management for Individuals with co-occurring BH and Complex Physical Health conditions
- SMI, SED, SUD and Physical Health conditions
- Targeted Case Management for Pregnant Women with Substance Use Disorders

Environmental Factors and Plan

2. Health Disparities

Narrative Question:

In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)⁵², [Healthy People, 2020](#)⁵³, [National Stakeholder Strategy for Achieving Health Equity](#)⁵⁴, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, and people living with HIV/AIDS or other chronic diseases/impairments) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS standards).⁵⁵

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The top Secretarial priority in the Action Plan is to "[a]ssess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."⁵⁶

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, in accordance with section 4302 of the Affordable Care Act, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status.⁵⁷ This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations.⁵⁸ In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the population they intend to serve. 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, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and 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. 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. For states to address the potentially disparate impact of their block grant funded efforts, they will 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).

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?
2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.
3. Are linguistic disparities/language barriers identified, monitored, and addressed?
4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.
5. Is there state support for cultural and linguistic competency training for providers?

Please indicate areas of technical assistance needed related to this section.

⁵²http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁵³<http://www.healthypeople.gov/2020/default.aspx>

⁵⁴<http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf>

⁵⁵<http://www.ThinkCulturalHealth.hhs.gov>

⁵⁶http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁵⁷<http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208>

⁵⁸http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plans

#2. Health Disparities

Kentucky's citizenry is comprised of 86.3% Non-Hispanic Whites, 8% African Americans/Non-Hispanic, 2% American Indian/Alaska Native/Non-Hispanic, 1% Asian/Non-Hispanic, 1% of two or more races/Non-Hispanic and only 4000 additional citizens of races designated as Other. Comparatively, of all mental health clients served the 14 CMHCs, 82% were Non-Hispanic Whites. Of the fourteen CMHCs, there is wide variance in client composition by race, from Non-Hispanic Whites being 53% of the total mental health population served in one region, to 99% in another. All regions struggle to ensure that the staffing ratios with regard to race and ethnicity are comparable. All regions provide cultural competency training and assessment of staff competency in their performance evaluation processes. The CMHCs collect a full set of demographic characteristics about all of the clients that they serve but do not presently collect systematic data on LGBT. There are no federally recognized tribes in Kentucky, nor is it a designated state for HIV/AIDS or TB. There are, however, subpopulations that experience significant disparity in service use, access and outcomes: those who are deaf and hard of hearing; active military and veterans; racial minorities; and individuals who are homeless.

It is estimated that Kentucky has 737,000 persons who are Deaf or Hard of Hearing, with 6% of those expected to meet the designation of SMI. In SFY 2014, the 14 CMHCs collectively served 4,690 unduplicated adults and children who are deaf and hard of hearing. In an effort to support the 14 regional CMHCs in providing linguistically-sensitive services, all CMHCs are compensated for interpreter services through either the MCOS or DBHDID. DBHDID also funds two therapists employed by two of the CMHCs that offer services in ASL or use other assistive devices.

There are two military installations in Kentucky and there are citizens serving in the military and National Guard who living all across the Commonwealth. There are an estimated 23.4 million veterans in the US, and about 2.2 million military service members and 3.1 million immediate family members. Kentucky's Veteran population is 330,599, including approximately 9,000 who are under the age of 25. As of September 2012, there were 24,493 women Veterans, a number that is rapidly trending upwards. Between 2004 and 2006, SAMHSA estimates that over 7% of Veterans met the criteria for a SUD and in the years from 2005-2009, 1,100 members of the Armed Forces took their own lives, equating to one suicide every 36 hours. During SFY 2014, the 14 CMHCs reported providing services to 769 active duty service members and 2301 Veterans (increase of 1% from SFY 2012). The Military and Veterans Administration Hospitals are under Presidential Order to increase the services and manpower needed to treat Service members and Veterans. They have made great strides toward this goal but there continues to be unmet need of Service members, Veterans and their families in Kentucky. There are currently four Veteran Treatment Courts in Kentucky (Christian, Hardin, Fayette and Jefferson Cos.). DBHDID has identified 20 veterans that wish to become certified peer specialists with the intent to establish a Veteran/Military Peer Support Network. For several years, CMHCs have been contractually obligated to designate Military Behavioral Health Coordinators (MBHCs). MBHCs have received training by a team of experts from the U.S. Department of Veterans Affairs, Kentucky National Guard, and the Kentucky Department for Veteran Affairs, and the DBHDID and are charged to coordinate care and enable access to services for those eligible for federal and/or state programs.

Environmental Factors and Plan

3. Use of Evidence in Purchasing Decisions

Narrative Question:

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including mental health and substance abuse services. Over the past several years, SAMHSA has received many requests from CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance abuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states use of the block grants for this purpose. The NQF and the Institute of Medicine (IOM) recommend that evidence play a critical role in designing health and behavioral health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. Since 2001, SAMHSA has sponsored a National Registry of Evidenced-based Programs and Practices (NREPP). NREPP⁵⁹ is a voluntary, searchable online registry of more than 220 submitted interventions supporting mental health promotion and treatment and substance abuse prevention and treatment. The purpose of NREPP is to connect members of the public to intervention developers so that they can learn how to implement these approaches in their communities. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with (SED). The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General⁶⁰, The New Freedom Commission on Mental Health⁶¹, the IOM⁶², and the NQF.⁶³ The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."⁶⁴ SAMHSA and other federal partners (the Administration for Children and Families (ACF), the HHS Office of Civil Rights (OCR), and CMS) have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, identify specific strategies for embedding these practices in provider organizations, and recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. These are services that have not been studied, but anecdotal evidence and program specific data indicate that they are effective. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocols (TIPs)⁶⁵ are best practice guidelines for the treatment of substance abuse. The Center for Substance Abuse Treatment (CSAT) draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private substance abuse treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)⁶⁶ was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

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.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.
2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?
3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?
4. Does the state use a rigorous evaluation process to assess emerging and promising practices?
5. Which value based purchasing strategies do you use in your state:
 - a. Leadership support, including investment of human and financial resources.
 - b. Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
 - c. Use of financial incentives to drive quality.

- d. Provider involvement in planning value-based purchasing.
- e. Gained consensus on the use of accurate and reliable measures of quality.
- f. Quality measures focus on consumer outcomes rather than care processes.
- g. Development of strategies to educate consumers and empower them to select quality services.
- h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.
- i. The state has an evaluation plan to assess the impact of its purchasing decisions.

Please indicate areas of technical assistance needed related to this section.

⁵⁹ [Ibid, 47, p. 41](#)

⁶⁰ United States Public Health Service Office of the Surgeon General (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

⁶¹ The President's New Freedom Commission on Mental Health (July 2003). *Achieving the Promise: Transforming Mental Health Care in America*. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

⁶² Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*. Washington, DC: National Academies Press.

⁶³ National Quality Forum (2007). *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices*. Washington, DC: National Quality Forum.

⁶⁴ <http://psychiatryonline.org/>

⁶⁵ <http://store.samhsa.gov>

⁶⁶ <http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

4. Prevention for Serious Mental Illness

Narrative Question:

SIMs such as schizophrenia, psychotic mood disorders, bipolar disorders and others produce significant psychosocial and economic challenges. Prior to the first episode, a large majority of individuals with psychotic illnesses display sub-threshold or early signs of psychosis during adolescence and transition to adulthood.⁶⁷ The “Prodromal Period” is the time during which a disease process has begun but has not yet clinically manifested. In the case of psychotic disorders, this is often described as a prolonged period of attenuated and nonspecific thought, mood, and perceptual disturbances accompanied by poor psychosocial functioning, which has historically been identified retrospectively. Clinical High Risk (CHR) or At-Risk Mental State (ARMS) are prospective terms used to identify individuals who might be potentially in the prodromal phase of psychosis. While the MHBG must be directed toward adults with SMI or children with SED, including early intervention after the first psychiatric episode, states may want to consider using other funds for these emerging practices.

There has been increasing neurobiological and clinical research examining the period before the first psychotic episode in order to understand and develop interventions to prevent the first episode. There is a growing body of evidence supporting preemptive interventions that are successful in preventing the first episode of psychosis. The National Institute for Mental Health (NIMH) funded the North American Prodromal Longitudinal study (NAPLS), which is a consortium of eight research groups that have been working to create the evidence base for early detection and intervention for prodromal symptoms. Additionally, the Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program, funded by the Robert Wood Johnson Foundation, successfully broadened the Portland Identification and Early Referral (PIER) program from Portland, Maine, to five other sites across the country. SAMHSA supports the development and implementation of these promising practices for the early detection and intervention of individuals at Clinical High Risk for psychosis, and states may want to consider how these developing practices may fit within their system of care. Without intervention, the transition rate to psychosis for these individuals is 18 percent after 6 months of follow up, 22 percent after one year, 29 percent after two years, and 36 percent after three years. With intervention, the risk of transition to psychosis is reduced by 54 percent at a one-year follow up.⁶⁸ In addition to increased symptom severity and poorer functioning, lower employment rates and higher rates of substance use and overall greater disability rates are more prevalent.⁶⁹ The array of services that have been shown to be successful in preventing the first episode of psychosis include accurate clinical identification of high-risk individuals; continued monitoring and appraisal of psychotic and mood symptoms and identification; intervention for substance use, suicidality and high risk behaviors; psycho-education; family involvement; vocational support; and psychotherapeutic techniques.^{70 71} This reflects the critical importance of early identification and intervention as there is a high cost associated with delayed treatment.

Overall, the goal of early identification and treatment of young people at high clinical risk, or in the early stages of mental disorders with psychosis is to: (1) alter the course of the illness; (2) reduce disability; and, (3) maximize recovery.

****It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Please indicate areas of technical assistance needed related to this section.

⁶⁷ Larson, M.K., Walker, E.F., Compton, M.T. (2010). Early signs, diagnosis and therapeutics of the prodromal phase of schizophrenia and related psychotic disorders. Expert Rev Neurother. Aug 10(8):1347-1359.

⁶⁸ Fusar-Poli, P., Bonoldi, I., Yung, A.R., Borgwardt, S., Kempton, M.J., Valmaggia, L., Barale, F., Caverzasi, E., & McGuire, P. (2012). Predicting psychosis: meta-analysis of transition outcomes in individuals at high clinical risk. Arch Gen Psychiatry. 2012 March 69(3):220-229.

⁶⁹ Whiteford, H.A., Degenhardt, L., Rehm, J., Baxter, A.J., Ferrari, A.J., Erskine, H.E., Charlson, F.J., Norman, R.E., Flaxman, A.D., Johns, N., Burstein, R., Murray, C.J., & Vos T. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet. Nov 9;382(9904):1575-1586.

⁷⁰ van der Gaag, M., Smit, F., Bechdolf, A., French, P., Linszen, D.H., Yung, A.R., McGorry, P., & Cuijpers, P. (2013). Preventing a first episode of psychosis: meta-analysis of randomized controlled prevention trials of 12-month and longer-term follow-ups. Schizophr Res. Sep;149(1-3):56-62.

⁷¹ McGorry, P., Nelson, B., Phillips, L.J., Yuen, H.P., Francey, S.M., Thampi, A., Berger, G.E., Amminger, G.P., Simmons, M.B., Kelly, D., Dip, G., Thompson, A.D., & Yung, A.R. (2013). Randomized controlled trial of interventions for young people at ultra-high risk of psychosis: 12-month outcome. J Clin Psychiatry. Apr;74(4):349-56.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

The state was not able to address this EFP at this time.

Environmental Factors and Plan

5. Evidenced Based Practices for First Episode Psychosis (10% of the state's total MHBG award)

Narrative Question:

The Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress through its FY 2016 Omnibus bill, Public Law 114-113, to set aside 10 percent of the Mental Health Block Grant (MHBG) allocation for each state to support evidence-based programs that provide treatment for those with early serious mental illness (SMI) and a first episode psychosis (FEP) – an increase from the previous 5% set aside. This additional 5 percent increase to the set-aside is over the FY 2015 level. The appropriation bill specifically requires the 10 percent set-aside to fund only those evidence-based programs that target FEP. The law specifically stated:

"...the funds from set-aside are only used for programs showing strong evidence of effectiveness and targets the first episode psychosis. SAMHSA shall not expand the use of the set-aside to programs outside of those that address first episode psychosis".

Previous appropriation language (P.L. 113-76 and P.L. 113-235) allowed the use of set aside funds for individuals with early SMI, including those without psychosis. However, the new language specifically requires states to focus their efforts only on FEP.

States that are currently utilizing FY 2016 set-aside funds for early SMI other than psychosis must now refocus their efforts to service only those with FEP. SAMHSA will allow states that already signed a contract or allocated money to their providers using the FY 2016 funds to complete these initiatives through the end of their contract or by the end of September 30, 2016, whichever comes first. States may continue to support these efforts using the general MHBG funds; however, the set-aside allocation must be used for efforts that address FEP. Nothing precludes states from utilizing its non-set-aside MHBG funds for services for individuals with early SMI.

If states have other investments for people at high risk of SMI, they are encouraged to coordinate those programs with early intervention programs supported by the MHBG. This coordination will help ensure high risk individuals are swiftly identified and engaged in evidence-based services should they develop into diagnosable SMI. Please note that the MHBG funds cannot be used for primary prevention or preventive intervention for those at high risk of SMI.

States can implement models which have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode (RAISE) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, every state should be able to begin to move their system toward earlier intervention, or enhance the early intervention services already being implemented.

SAMHSA and NIMH in conjunction with National Association of State Mental Health Program Directors (NASMHPD) will continue to ensure that technical assistance and technical resources are available to states as they develop and implement their plan.

States will be required to revise their two-year plan to propose how they will utilize the 10 percent set-aside funding to support appropriate evidence-based programs for individuals with FEP. Upon submission, SAMHSA will review the revised proposals and consult with NIMH to make sure they are complete and responsive. If a state chooses to submit a plan to utilize the set-aside for evidence-based services other than Coordinated Specialty Care (CSC) approach developed via the RAISE initiative, SAMHSA will review the plan with the state to assure that the approach proposed meets the understanding of an evidence-based approach. With consultation with NIMH as needed, the proposals will be either accepted, or requests for modifications to the plan will be discussed and negotiated with the State. SAMHSA will notify each State once the revised proposals are approved.

This initiative also includes a plan for program evaluation and data collection related to demonstrating program effectiveness. SAMHSA is also required within six months of the appropriations statute enactment to provide a detailed table showing at a minimum each State's allotment, name of the program being implemented, and a short term description of the program. Additional technical assistance and guidance on the expectations for evaluation, data collection and reporting will follow.

States must submit their plan revision request proposal into the FY 2016-2017 Block Grant Application under the following section:

Section III. Behavioral Health Assessment and Plan, C. Environmental Factors and Plan, #5. Evidence-Based Practices for First Episode Psychosis.

The state must revise the following for the 10 percent set-aside for first episode psychosis:

1. An updated description of the states chosen evidence-based practice for the 10 percent set-aside initiative.
2. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.
3. A budget showing how the set-aside and additional state or other supported funds, if any, will be utilized for this purpose.
4. The states provision for collecting and reporting data, demonstrating the impact of this initiative.
5. Any foreseen challenges.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Evidence Based Practices for Early Intervention (5% set aside)
October 2, 2015

At the end of SFY 2014, Kentucky's Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) began implementation efforts regarding service components necessary to address individuals in need of early intervention for first episode of psychosis.

At that time, Kentucky's Division of Behavioral Health (DBH) identified internal staff to begin work on this project, which included program administrators from the adult branch and children's branch, as well as leadership, including the assistant and associate director of DBH. This workgroup began reviewing current Kentucky data related to this population and relevant evidence based material, and developed an initial plan for implementation.

Kentucky chose to begin developing initial capacity to provide targeted coordinated specialty care to youth and young adults between the ages of 15 – 30 with early serious mental illness, including individuals with diagnoses of schizophrenia spectrum and other psychotic disorders, as identified in the DSM-V. (Delusional disorder, schizophrenia, schizoaffective disorder, schizophreniform disorder, other schizophrenia spectrum and other psychotic disorder, or unspecified schizophrenia spectrum and other psychotic disorder.)

The 2014 Block Grant plan emphasized a focus on data collection and planning, with development of training and coaching models and identification of project leaders across the state.

During SFY 2015, DBH worked with the state data contractor, Institute for Pharmaceutical Outcomes and Policy (IPOP), to generate data reports capturing data related to youth and young adults with first episode of psychosis. These data reports were sorted by region and distributed to all CMHC regions. During SFY 2014, data collection found that 906 young adults, age 18-24 years old diagnosed with schizophrenia or other psychotic disorder, were served by one of the four state psychiatric hospitals.

- Appalachian Regional Hospital served 163 individuals.
- Central State Hospital served 224 individuals.
- Eastern State Hospital served 283 individuals.
- Western State Hospital served 236 individuals.

In November of 2014, DBH hosted the first statewide planning meeting for this initiative. Staff from all fourteen (14) Community Mental Health Center (CMHC) regions attended this meeting, as well as staff from the four (4) state psychiatric hospitals. The Commissioner of Kentucky DBHDID opened the meeting, and an informational presentation on the First Episode of Psychosis was provided by the Kentucky DBHDID Medical Director. A panel presentation was provided that included two (2) individuals in recovery from psychosis and one (1) parent of an individual in recovery from psychosis. The panel was able to education the group regarding strengths in the current system as well as gaps in the current system that needed to be addressed in order to provide quality coordinated care for these individuals and their families. A presentation on best practices for early interventions was presented by DBH staff, and reporting requirements for new contract language was discussed.

In November of 2014, CMHC contracts were modified to include the following requirements:

- Identification of a key contact for each CMHC region regarding First Episode of Psychosis programming;

- This contact and other key CMHC staff will attend and participate in the orientation meeting hosted by DBH in November 2014;
- Each CMHC will view and verify region specific data regarding the designated young adult population by age and gender, including the number of individuals residing in each region between the age of 15-30 years old and the number of individuals residing in each region between the age of 15-30 years old who were served by the CMHC and who have been diagnosed with a psychotic disorder;
- Each CMHC will document whether the CMHC has a mechanism to document a client's first episode of psychosis;
- The key contact for each CMHC will identify, outreach to, and mobilize key community providers in order to improve comprehensive supports for youth and young adults at risk of or experiencing first episode of psychosis; and
- The key CMHC contact will identify services and supports that are currently available for the region's population of youth and young adults age 15-30 years old with or at risk of first episode of psychosis.

In January of 2015, another planning meeting was hosted by DBH and included statewide CMHC key contacts, individuals in recovery and family members who were identified as interested in planning for this initiative, and other advocacy groups. The meeting included more education about the best practice of Coordinated Specialty Care, necessary training required, and barriers to supporting this initiative.

In February of 2015, a group of stakeholders, include DBH staff, visited first episode of psychosis programming in Oregon. Tamara Sale, the contact person for Oregon, had already provided some technical assistance via webinar to DBH and CMHC key contacts regarding the Early Assessment and Support Alliance (EASA) model of care. DBH plans to work more with Oregon to provide additional technical assistance as implementation for this initiative continues.

Another planning meeting occurred on March 24, 2015, specifically to discuss upcoming request for applications for start-up site funding and to outline some training and technical assistance related to this initiative.

In April 2015, the Kentucky Behavioral Health Planning and Advisory Council received information regarding this programming for youth and young adults at their annual Finance and Data Committee meeting. This committee recommended block grant funding, in addition to the 5% set aside requirement, for start-up site programming.

Also in April of 2015, DBH hosted a workshop at the System of Care Academy, providing Patricia Deegan's simulation exercise regarding hearing voices that are distressing. Several staff members and advocates for youth services attended this workshop.

In May of 2015, a request for proposals was solicited by DBH and six (6) proposals were received. Proposals were reviewed and two (2) start-up sites were chosen to receive funding of \$200,000 for up to two (2) years to develop Coordinated Specialty Care programming for this target population and begin providing services by January 2016. (Cumberland River Behavioral Health and Mountain Comprehensive Care Center) Start-up sites were required to provide the key components of Coordinated Specialty Care including at a minimum:

- Outreach services;
- Medication management with low doses of atypical antipsychotic medication;
- Peer support services;

- Case management;
- Cognitive behavior therapy;
- Family education and support;
- Housing supports;
- Employment and education support; and
- Occupational therapy.

In June of 2015, DBH hosted a meeting with the two (2) start-up sites and discussed expectations, financial details and timelines for technical assistance and support. In addition, DBH staff identified a faculty member at the University of Louisville to assist with first episode of psychosis training and technical assistance. Dr. Catherine Batscha, Assistant Professor in the University of Louisville, College of Nursing, has extensive knowledge and experience working with first episode of psychosis programming and has agreed to provide some training for Kentucky. Specifically, DBH plans to offer some training events that are overviews of best practices for first episode of psychosis as well as some very specific training in cognitive therapy for psychosis, a best practice for this population. In addition, DBH is working toward developing a learning collaborative with Dr. Batscha and other experts on this topic.

For SFY 2016/2017, DBH plans to provide continued technical assistance and support to the start-up sites and other CMHC staff including:

- Skills training specifically for clinical staff, in providing cognitive behavior therapy for psychosis;
- Broader training on cognitive behavior therapy for psychosis, targeting all providers, not just clinical staff;
- Extensive motivational interviewing training including continued coaching in motivational interviewing skills;
- Mental Health First Aid training that includes community agencies and stakeholders;
- Applied Suicide Intervention Skills Training (ASIST);
- Assessing and Managing Suicide Risk (AMSR) training;
- Training from Early Assessment and Support Alliance (EASA) proponents on specific components of Coordinated Specialty Care;
- Psychiatrists from Vanderbilt University who are experts on treating this population coming to Kentucky to train doctors at state psychiatric hospitals and CMHCs who work with youth and youth adults;
- Training regarding the Structured Interview for Prodromal Syndromes (SIPS) tool; and
- Other training and technical assistance as identified.

Baseline measures are currently the number of youth and young adults with early psychosis who receive community based services in each service region. DBH will also be monitoring the number of state hospital admissions and/or readmissions for these identified individuals. Implementation strategies are being enhanced by leveraging benefits from two (2) other recently received grant awards related to this initiative: Healthy Transitions, a five (5) year grant expanding transition aged care in two (2) service regions; and TTI (Transformation Transfer Initiative) a small grant focusing on enhancing peer support in all levels of care, including crisis services.

DBH will continue to work with the data contractor, IPOP, to develop necessary, accurate reports for this initiative.

**5% Set Aside for Early Interventions for First Episode of Psychosis
Budget Information for Block Grant Application for FFY 2016-17**

SFY 2015 (July 1, 2014-June 30, 2015)

Amount	Recipient	Purpose
\$84,000	\$6,000 to each CMHC region	Initial deliverables to prepare for early intervention services
\$35,000.	IPOP Data Contractor	Initial Data Reporting and reconfiguring for FEP data
\$27,000.	CMHC staff, individuals in recovery, advocacy groups, DBH staff received consultation from Oregon's EASA programming in February 2015	Travel to Oregon to visit EASA programming and talk to EASA staff re: FEP programming
\$10,000	Amazon.com; Patricia Deegan Associates	Program related materials from model programs (books, hearing voices that are distressing training kits, etc.)
\$64,000	DBH staff time dedicated to FEP project	30% of staff project lead; 20% of adult staff time; 20% of children staff time; 10% of associate director time; 10% of assistant director time; 1% of Division Finance staff time; 1% of Department Finance staff time; and 1% of Medical Director time.
\$20,000	Lifeskills, Inc.	Miscellaneous meeting costs; Speaker travel costs and per diem;
TOTAL: \$240,000		

SFY 2016 (July 1, 2015-June 30, 2016)

Amount	Recipient	Purpose
\$400,000	Cumberland River Behavioral Health Mountain Comprehensive Care Center	Funding for 2 Start Up Sites
\$42,000	All 14 CMHC Regions	Funding for continued designation of key contact for FEP; data collection and review; attendance at statewide training and technical assistance events
\$10,000	EASA consultants; Cognitive Behavior Therapy for Psychosis consultants	Trainers and experts for implementation of FEP
\$50,000	Training and consultation from Vanderbilt University medical staff: Dr. Stephan Heckers and Dr. Jeffrey G. Stovall	Conduct Grand Rounds Session with physicians from Eastern State Hospital and CMHCs to increase their knowledge of new best practices in

		<p>pharmacological support for individuals with first episode psychosis.</p> <p>Conduct a learning session with multidisciplinary participants from across the state to provide a general overview of early interventions for FEP and the use of a team based approach to specialty care for young people experiencing a first episode psychosis.</p>
TOTAL: \$502,000		

SFY 2017 (July 1, 2016-June 30, 2017)

Amount	Recipient	Purpose
\$400,000	Cumberland River Behavioral Health Mountain Comprehensive Care Center	Funding for implementation of FEP programming
\$400,000	Through RFP process, determine two additional sites.	Funding for implementation of FEP programming
\$14,000	\$1,000 to each of the 14 CMHCs	Funding for continued designation of key contact for FEP; data collection and review; attendance at statewide training and technical assistance events
\$5,000	EASA consultants; Cognitive Behavior Therapy for Psychosis consultants	Trainers and experts for implementation of FEP
\$30,000	Training and consultation TBD by need expressed but likely to include partnering with Vanderbilt University medical staff: Dr. Stephan Heckers and Dr. Jeffrey G. Stovall	<p>Consultation and training to implementation sites</p> <p>Conduct Grand Rounds Session with physicians increase their knowledge of new best practices in pharmacological support for individuals with first episode psychosis.</p> <p>Conduct a learning session with multidisciplinary participants from across the state to provide a general overview of early interventions for FEP and the use of a team based approach to specialty care for young people experiencing a first episode psychosis.</p>
TOTAL: \$839,000		

MHBG 10% set aside – First Episode of Psychosis

1. Has the state begun updating a description of their chosen evidence-based practice for the early intervention (10% set-aside initiative)?

Kentucky is implementing Coordinated Specialty Care as an evidence based practice for first episode of psychosis. Kentucky is modeling its programming after the Early Assessment and Support Alliance (EASA), and it includes components of Recovery After an Initial Schizophrenic Episode (RAISE) and OnTrack NY best practice programming. Kentucky is requiring Coordinated Specialty Care to include a team based approach with project leadership, outreach and community based services, medication management with low doses of medications, cognitive behavioral therapy, family education and support, employment and education support, occupational therapy, case management and peer support services. Coordinated Specialty Care services are aimed at bridging the gap between child, adolescent, and adult behavioral health programs and are highly coordinated with physical health care.

2. Does the state have an updated/revised description of the plan's implementation status, accomplishments and any changes in the plan?

Kentucky currently has two (2) sites providing Coordinated Specialty Care to individuals with First Episode of Psychosis. Kentucky also has two (2) additional sites providing some of the components of Coordinated Specialty Care through funding from the Healthy Transitions Grant. These two (2) additional sites will be provided additional funds from 10% set aside so they can immediately begin to upgrade their service packages to include the full spectrum of Coordinated Specialty Care to individuals with First Episode of Psychosis. Kentucky has currently sent out requests for applications that are due back to the Department by March 7th. Two (2) additional sites for Coordinated Specialty Care will be awarded funding based on these applications. Kentucky has a plan involving 10% set-aside funding that will assure statewide implementation of Coordinated Specialty Care by the year 2021. Statewide implementation will include evidence based programming at all fourteen (14) Community Mental Health Centers, and possibly programming at other sites.

3. Does the state have planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures?

Kentucky is providing technical assistance and training in several ways. During SFY 2016, the experts from the Early Assessment and Support Alliance (EASA) in Oregon came to Kentucky and provided several days of training and technical assistance in multiple areas. (importance of early access to services and exactly how early the access must be to be successful; how the Coordinated Specialty Care model is supported through a very different system of care than the traditional system of care; importance of a variety of skills by team members providing the evidence based practice – Motivational Interviewing; CBT for Psychosis; Family Psychoeducation; etc; Differential Diagnosis information; Screening Tools; etc.) In addition, Kentucky Division of Behavioral Health (DBH) provided numerous sessions of technical assistance to the funded sites. Technical assistance from both EASA and DBH are ongoing for SFY 2016 and for SFY 2017, to include any new additionally funded sites in the state. In addition, DBH is providing some statewide training for any clinicians potentially working with this population regarding Cognitive Behavioral Therapy for Psychosis, to include an in-depth skills training as well as follow up coaching and supervision. The overall goal is to continue to fund

best practice sites and continue to offer necessary supports in order for these sites to be successful. Kentucky is currently working on an outline of statewide training infrastructure, as well as working out final details for statewide data collection on this population. Both of these should be in place by SFY 2017. During SFY 2015, Kentucky collected some baseline data regarding the target population. Coordinated Specialty Care programs have contract language identifying all required components of the best practice that must be provided. By SFY 2017, Kentucky should be able to begin looking at data more closely for the population being served by these programs.

4. Does the state budget show the set-aside and additional state or other supported funds?

The budget for DBHDID details the amount from MHBG set-aside that is provided to each program for Coordinated Specialty Care. In addition, there are additional State General Funds that are allocated to children with SED, adults with SMI, or individuals in crisis. All programs would have access to all of these funding sources. In addition, Kentucky is a Healthy Transitions Grantee, so there is also available funding for some programming needs from this grant source. Kentucky also received a TTI grant during 2015. Those funds have also been leveraged to support the effort for this target population.

5. Has the state been collecting and reporting data, demonstrating the impact of this initiative?

Kentucky is early in implementation of this best practice. There was initial data collection on both a statewide and regional basis, both from state psychiatric hospital data and community based programming data. DBH staff have been working with the data contractor to identify a method for accurate data collection for this population. Programs have not existed long enough to demonstrate impact through data. This data collection effort will be fully implemented by SFY 2017.

6. Will the state update/revise their assessed need for the target population? Please describe.

Kentucky will continually assess the needs regarding this target population. Any necessary revisions will take place as additional needs arise. At this point, no revisions are necessary. DBH is currently working on a better process for assessing needs for all community based services, including this population. Kentucky's implementation team will be expanded to include other pertinent stakeholders. The team will continually review outcomes.

7. Will the state identify/update a specific diagnostic category (i.e. psychosis, schizophrenia, bipolar, etc.) for the targeted population? Please describe.

Kentucky has chosen to provide targeted Coordinated Specialty Care to youth and young adults between the ages of 15 – 30 with early serious mental illness, including individuals with the diagnoses of schizophrenia spectrum and other psychotic disorders, as identified in the DSM-V. (Delusional Disorder, Schizophrenia, Schizoaffective Disorder, Schizophreniform Disorder, other Schizophrenia Spectrum and other psychotic disorder, or Unspecified Schizophrenia Spectrum and other psychotic disorder). Kentucky is focusing on youth and young adults who have experienced a first episode of psychosis within the last year.

8. Please ensure the state describes their updated/revise proposed evidence based programs. Please describe.

Kentucky is utilizing implementation science as outlined by the National Implementation Research Network throughout the execution of first episode programming. Several evidence

based practices are being utilized in the implementation of first episode programming, including:

Youth/Adult Mental Health First Aid – being provided to community partners within each of the start-up site locations to decrease stigma and enhance outreach and engagement for this population. This is being augmented by specialized workshops for community partners specifically around first episode of psychosis in youth and young adults;

Individual Placement and Support (IPS) Model of Supported Employment – along with the inclusion of supported education, IPS is being used within the Coordinated Specialty Care team. With the assistance of additional grant funding, Kentucky is collaborating with Dr. Marsha Ellison and her team at Transitions Research and Training Center at the University of Massachusetts to enhance IPS for young people to include supported employment and supported education;

Specialized Screening and Assessment Tools – training and support specific to first episode of psychosis programming are being provided to designated staff across the state. These tools include the Prodromal Questionnaire Brief (PQB), the Structured Clinical Interview for DSM-IV Disorders (SCID), and the Structured Interview for Psychosis-Risk Syndromes (SIPS). This will provide teams with more accurate screening, assessment and treatment for youth and young adults that experience psychosis;

Cognitive Behavioral Therapy for Psychosis – training, coaching and follow-up feedback will be provided to clinicians across the state within the next several months. This will provide clinicians with specific tools to utilize when providing treatment to youth and young adults that experience psychosis;

Applied Suicide Intervention Skills Training (ASIST) – for community partners;

Assessing and Managing Suicide Risk (AMSR) – training for mental health staff as youth and young adults with early psychosis are at extremely high risk for suicide;

Early Assessment and Support Alliance (EASA) – is providing overall technical assistance on best practice models for coordinated specialty care integrated within the community mental health center, including starting a new program and implementation of the various components within a program, differential diagnoses, and ongoing site specific technical assistance.

9. **Will the state identify alternative use of the funds other than EBP's (i.e. staff development, regional plan, etc.) Please describe.**

Kentucky will be utilizing funds for staff development regarding issues related to this population across the state as well as six months of start-up site planning. Kentucky will also provide each start-up site a set amount of funds for implementation and staff support for Coordinated Specialty Care. The start-up site planning and some of the staff development involve many things in addition to EBPs. (finding the appropriate staff members for this initiative, integrated services from the children and adult service systems, etc.)

10. **Did the state give an explanation for why this population was chosen? Please describe.**

Kentucky chose the identified population because the set-aside was required for the population with first episode of psychosis. After initial data collection for Kentucky, it was determined that individuals in the targeted age group could have a variety of conditions that included psychosis and that this best practice could assist those individuals. Kentucky began with a target of symptoms within two (2) years, but recently revised this requirement to be only within approximately one (1) year.

11. **Will the state update/revise a description of planned activities? Please describe.**

Kentucky is expecting to have Coordinated Specialty Care available to youth and young adults across the state by 2021. At this time, all community mental health centers are required to designate two (2) key contacts within their agency for first episode of psychosis programming. These individuals will be responsible for disseminated information on first episode of psychosis as well as attend and participate in collaborative meetings and trainings. Each year, an application process will be utilized to provide initial two (2) year funding for up to three (3) start-up sites. Specialized technical assistance, training and support will be provided to each site. All regions will be expected to participate in state wide training and workshops on evidence based practices for first episode programming.

12. Will the state provide an updated/revised budget showing how the 10% will be spent?

MHBG 10% Set-Aside Budget		
Amount	Recipient	Purpose
\$42,000	\$3,000 x 14 (to each CMHC region)	Initial deliverables to prepare for early intervention services
\$400,000	\$200,000 x 2 (2 start-up coordinated specialty care sites)	planning and implementation of coordinated specialty care within 2 start-up sites.
\$100,000	\$50,000 x 2 (Healthy Transition sites)	planning and implementation of coordinated specialty care within Healthy Transitions sites
\$10,000	Patricia Deegan Associates	Program related materials from model programs (books, hearing voices that are distressing training kits, etc.)
\$64,000	DBH staff time dedicated to FEP project	30% of staff project lead; 20% of adult staff time; 20% of children staff time; 10% of associate director time; 10% of assistant director time; 1% of Division Finance staff time; 1% of Department Finance staff time; and 1% of Medical Director time.
\$100,000	Cumberland River	Ongoing EASA Technical Assistance; additional speaker travel costs and per diem;
\$716,000	TOTAL	

Environmental Factors and Plan

6. Participant Directed Care

Narrative Question:

As states implement policies that support self-determination and improve person-centered service delivery, one option that states may consider is the role that vouchers may play in their overall financing strategy. Many states have implemented voucher and self-directed care programs to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment, and recovery services. The major goal of a voucher program is to ensure individuals have a genuine, free, and independent choice among a network of eligible providers. The implementation of a voucher program expands mental and substance use disorder treatment capacity and promotes choice among clinical treatment and recovery support providers, providing individuals with the ability to secure the best treatment options available to meet their specific needs. A voucher program facilitates linking clinical treatment with other authorized services, such as critical recovery support services that are not otherwise reimbursed, including coordination, childcare, motivational development, early/brief intervention, outpatient treatment, medical services, support for room and board while in treatment, employment/education support, peer resources, family/parenting services, or transportation.

Voucher programs employ an indirect payment method with the voucher expended for the services of the individual's choosing or at a provider of their choice. States may use SABG and MHBG funds to introduce or enhance behavioral health voucher and self-directed care programs within the state. The state should assess the geographic, population, and service needs to determine if or where the voucher system will be most effective. In the system of care created through voucher programs, treatment staff, recovery support service providers, and referral organizations work together to integrate services.

States interested in using a voucher system should create or maintain a voucher management system to support vouchering and the reporting of data to enhance accountability by measuring outcomes. Meeting these voucher program challenges by creating and coordinating a wide array of service providers, and leading them through the innovations and inherent system change processes, results in the building of an integrated system that provides holistic care to individuals recovering from mental and substance use disorders. Likewise, every effort should be made to ensure services are reimbursed through other public and private resources, as applicable and in ways consistent with the goals of the voucher program

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plans

6. Participant Directed Care

Kentucky has not implemented voucher or self-directed care programs for individuals with mental health or substance use disorders.

Environmental Factors and Plan

7. Program Integrity

Narrative Question:

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 USC §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 USC § 300x- 55, SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for substance abuse, SAMSHA will release guidance imminently to the states on use of block grant funds for these purposes. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The Affordable Care Act may offer additional health coverage options for persons with behavioral health conditions and block grant expenditures should reflect these coverage options. The MHBG and SABG resources are to be used to support, not supplant, individuals and services that will be covered through the Marketplaces and Medicaid. SAMHSA will provide additional guidance to the states to assist them in complying with program integrity recommendations; develop new and better tools for reviewing the block grant application and reports; and train SAMHSA staff, including Regional Administrators, in these new program integrity approaches and tools. In addition, SAMHSA will work with CMS and states to discuss possible strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance abuse programs, and activities for adults with SMI and children with SED.

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. These strategies may include:(1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (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 use of behavioral health benefits in light of utilization review, medical necessity, etc. 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.

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?
2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?
3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:
 - a. Budget review;
 - b. Claims/payment adjudication;
 - c. Expenditure report analysis;
 - d. Compliance reviews;
 - e. Client level encounter/use/performance analysis data; and
 - f. Audits.
4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.
5. Does the state provide assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How does the state ensure block grant funds and state dollars are used for the four purposes?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plans

#7. 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 MH 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 – Ensures 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 180 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 utilize 100% of their mental health block grant funds allocated for Adults with SMI to support the implementation of evidence-based including Assertive Community Treatment, Supported Employment, Supported Housing and Peer Services. This requirement continues for SFY 2016. 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 population of the CMHC region, the number of uninsured individuals in the region, and the number of individuals each CMHC serves. DBH is exploring adding a similar requirement to the allocation and expenditure of SAPT funding in future years and is in the process of participating in technical assistance from various sources.

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 the 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 and AFM are conducting annual audits to monitor adherence to contract requirements.

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 2016 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, in collaboration with program staff (if applicable).

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 1/12th 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 quarterly 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.

Environmental Factors and Plan

8. Tribes

Narrative Question:

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the [2009 Memorandum on Tribal Consultation](#)⁷⁴ 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.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among 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.

In the context of the block grant funds 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 and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that 67% of American Indian and Alaska Natives live off-reservation. SSAs/SMHAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the state. States shall not require any tribe to waive its sovereign immunity in order to receive funds or 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.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.
2. Describe current activities between the state, tribes and tribal populations.

Please indicate areas of technical assistance needed related to this section.

⁷⁴ <http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plans

#8. 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. Contracted providers are required to collect client demographic information for all individuals served, including race and ethnicity.

Environmental Factors and Plan

9. Primary Prevention for Substance Abuse

Narrative Question:

Federal law requires that states spend no less than 20 percent of their SABG allotment on primary prevention programs, although many states spend more. Primary prevention programs, practices, and strategies are directed at individuals who have not been determined to require treatment for substance abuse.

Federal regulation (45 CFR 96.125) requires states to use the primary prevention set-aside of the SABG to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance abuse. The program must include, but is not limited to, the following strategies:

- Information Dissemination provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the information source to the audience, with limited contact between the two.
- Education builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental capabilities. There is more interaction between facilitators and participants than there is for information dissemination.
- Alternatives provide opportunities for target populations to participate in activities that exclude alcohol and other drugs. The purpose is to discourage use of alcohol and other drugs by providing alternative, healthy activities.
- Problem Identification and Referral aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco, alcohol or other substances legal for adults, and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does not include any activity designed to determine if a person is in need of treatment.
- Community-based Process provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning
- Environmental Strategies establish or changes written and unwritten community standards, codes, and attitudes. The intent is to influence the general population's use of alcohol and other drugs.

States should use a variety of strategies that target populations with different levels of risk. Specifically, prevention strategies can be classified using the IOM Model of Universal, Selective, and Indicated, which classifies preventive interventions by targeted population. The definitions for these population classifications are:

- Universal: The general public or a whole population group that has not been identified based on individual risk.
- Selective: Individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- Indicated: Individuals in high-risk environments that have minimal but detectable signs or symptoms foreshadowing disorder or have biological markers indicating predispositions for disorder but do not yet meet diagnostic levels.

It is important to note that classifications of preventive interventions by strategy and by IOM category are not mutually exclusive, as strategy classification indicates the type of activity while IOM classification indicates the populations served by the activity. Federal regulation requires states to use prevention set-aside funding to implement substance abuse prevention interventions in all six strategies. SAMHSA also recommends that prevention set-aside funding be used to target populations with all levels of risk: universal, indicated, and selective populations.

While the primary prevention set-aside of the SABG must be used only for primary substance abuse prevention activities, it is important to note that many evidence-based substance abuse prevention programs have a positive impact not only on the prevention of substance use and abuse, but also on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. This reflects the fact that substance use and other aspects of behavioral health share many of the same risk and protective factors.

The backbone of an effective prevention system is an infrastructure with the ability to collect and analyze epidemiological data on substance use and its associated consequences and use this data to identify areas of greatest need. Good data also enable states to identify, implement, and evaluate evidence-based programs, practices, and policies that have the ability to reduce substance use and improve health and well-being in communities. In particular, SAMHSA strongly encourages states to use data collected and analyzed by their SEOWs to help make data-driven funding decisions. Consistent with states using data to guide their funding decisions, SAMHSA encourages states to look closely at the data on opioid/prescription drug abuse, as well as underage use of legal substances, such as alcohol, and marijuana in those states where its use has been legalized. SAMHSA also encourages states to use data-driven approaches to allocate funding to communities with fewer resources and the greatest behavioral health needs.

SAMHSA expects that state substance abuse agencies have the ability to implement the five steps of the strategic prevention framework (SPF) or an equivalent planning model that encompasses these steps:

1. Assess prevention needs;
2. Build capacity to address prevention needs;
3. Plan to implement evidence-based strategies that address the risk and protective factors associated with the identified needs;
4. Implement appropriate strategies across the spheres of influence (individual, family, school, community, environment) that reduce substance abuse and its associated consequences; and
5. Evaluate progress towards goals.

States also need to be prepared to report on the outcomes of their efforts on substance abuse- related attitudes and behaviors. This means that state-funded prevention providers will need to be able to collect data and report this information to the state. With limited resources, states should also look for opportunities to leverage different streams of funding to create a coordinated data driven substance abuse prevention system. SAMHSA expects that states coordinate the use of all substance abuse prevention funding in the state, including the primary prevention set-aside of the SABG, discretionary SAMHSA grants such as the Partnerships for Success (PFS) grant, and other federal, state, and local prevention dollars, toward common outcomes to strive to create an impact in their state's use, misuse or addiction metrics.

Please consider the following items as a guide when preparing the description of the state's system:

1. Please indicate if the state has an active SEOW. If so, please describe:
 - The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);
 - The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and
 - The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).
2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. Please describe if the state has:
 - a. A statewide licensing or certification program for the substance abuse prevention workforce;
 - b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and
 - c. A formal mechanism to assess community readiness to implement prevention strategies.
5. How does 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)?
6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.
7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.
8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.
9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?
10. What process data (i.e. numbers served, participant satisfaction, attendance) 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?
11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

The state was not able to address this EFP at this time.

Environmental Factors and Plan

Primary Prevention for Substance Abuse Prevention

Please consider the following items as a guide when preparing the description of the state's system:

1. Please indicate if the state has an active SEOW. If so, please describe:

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Response: Kentucky's SEOW remains very active and meets quarterly. The SEOW Membership has been expanded to include members of: The Kentucky Violent Death Reporting System and the Kentucky Injury Prevention and Research Center (KIPRIC). These new members will enable to more fully integrate suicide data and drug overdose data into our needs assessments. KIPRIC was recently the recipient of a CDC grant to reduce drug overdose deaths. We are also currently seeking the participation of the Kentucky National Guard. The SEOW recently produced a report on youth e-cigarette which was presented at the last SEOW and shared with our Regional Prevention Center Directors at our recent prevention planning summit. The SEOW collects prevalence data, consequence data, risk and protective factor and intervening variable data (where available). Data is collected on the entire spectrum of the population – children, youth, young adults, adults, older adults, Service Members, Veterans and Family, (SMVF) and the LGTBQ population. Data is pulled from a number of state and federal surveys including: NSDUH, BRFSS, YRBS, KIP, KSP, Kids Count, Kentucky Cancer Registry, Poison Control, and Kentucky Center for School Safety, Area Resource File, CDC Wonder, Dartmouth Atlas of Healthcare, Gallup Healthways Well-being Index, Kentucky All Scheduled Prescription Reporting System, Kentucky Department for Community Based Services, Kentucky Office of Vital Statistics, etc.

2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.

Response: The SEOW needs assessment continues to drive our Block Grant prevention planning. The 2015 needs assessment revealed that youth that have one or more families in the military have higher prevalence rates for almost all drugs in the ATOD spectrum and are much more likely to have behavioral health problems – depression, suicide ideation, attempted, then youth who do not have members in the

military. As a result of this data we are working with our Regional Prevention Network to explore ways to provide prevention services to this population. RPC Directors recently met to answer the following questions in order to initiate the planning process:

Step I: Profile population needs, resources and readiness to address needs and gaps

- 1) What substance abuse prevention services are you currently providing to the Service Members, Veterans and their Families (SMVF) population in your region?
- 2) How would you characterize your region's awareness of the need for substance abuse prevention services for the SMVF individuals in your region?
- 3) On a scale from 1-10, one being not ready, and 10 being very ready to work with the military, where would you place your RPC in terms of its readiness to work SMVF individuals in your community in a culturally appropriate manner? What would your RPC need to move along the continuum of readiness?
- 4) Are there organizations in your region that serve the SMVF individuals? (See RPC resource assessment for an initial listing.)
- 5) Aside from KIP, what other mechanisms are in place within your region to collect data on the SMVF individuals?
- 6) How can you find more data related to substance use/abuse and military spouses and children? (includes use by military spouses and children as well as impact on military spouses and children by using/abusing spouses)
- 7) How many/which schools (including public and private: middle, high, and colleges) in your regions have ROTC programs?
- 8) Identify other military-related organizations in your communities? If you are unsure of military-related organizations, where might you go to get this information? Do you already have a liaison working/serving on your local boards? If yes, what is the contact name(s) and branch or service?
- 9) How many veteran-serving organizations are in your region? Are there any Veteran-serving organizations that are not included in the resource assessment?
- 10) Taking into consideration the particular culture of these organizations, how will you approach these organizations in a culturally responsive or appropriate way? What are three ideas or questions you would want to discuss with them?
- 11) How can you get information (qualitative) on substance abuse trends among the members of the Kentucky Army National Guard and/or the Army in your region?
- 12) What additional resources will you need to complete this needs assessment?
- 13) What are the barriers have you encountered in your previous efforts to collect needs and resource data on the SMVF population?

Step II: Mobilize and/or build capacity to address needs of the military and their families in a culturally appropriate way

1) Based on what you know about the composition of the prevention coalitions/KY-ASAP Boards in your region, what other stakeholders should be involved to enable them to deliver effective and culturally appropriate prevention services to the military?

2)Based on what you know now, what kind of training/TA do you anticipate your RPC and your coalitions will initially need to deliver prevention services to the SMVF individuals?

How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?

Response: The Kentucky Prevention System continues to rely on the high quality prevention training that is offered through the Kentucky School of Alcohol and Other Drug Studies, Prevention Academy and the Kentucky Prevention Network. State Prevention Staff are actively involved in the planning and content of each of these training venues. We have sought additional technical assistance from the SECAPT.

4. Please describe if the state has:

a. A statewide licensing or certification program for the substance abuse prevention workforce;

Response: All Regional Prevention Center staff are required to be Certified Prevention Specialists within three years of their hire date. The Kentucky Board of Certified Prevention Professionals (KCBPP) determines whether individuals have met the knowledge, training and educational requirement for the Certified Prevention Specialist (CPS). The Board is composed of representatives from the ATOD prevention field across Kentucky and continually updates and implements standards for prevention specialists in the state. The certification process includes 150 hours of training in identified domains, 2,000 hours of professional ATOD prevention experience, and a passing score on an international examination. Not only does certification enhance the field of alcohol, tobacco and other drug prevention but more importantly, assures the quality of service to the individuals and communities served by approximately 90 certified prevention specialist across the Commonwealth. Quality of services, competence, professional growth, ethical conduct and continuing education are all benefits of certification.

b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce;

Response: As stated above, Kentucky holds three prevention trainings a year. (KY School, Prevention Academy and KPN) State Prevention Staff serve on the Planning Committees. Content is determined by

a needs assessment conducted annually with the Regional Prevention Center Directors and through our monthly RPC meetings.

c. A formal mechanism to assess community readiness to implement prevention strategies.

Response: All Regional Prevention Centers are required to assess community readiness and address readiness gaps for each of the counties they serve in their annual work plans. The work plans are built around the five steps of the SPF and are monitored by state staff.

5. How does 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: The Prevention Branch uses data from the SEOW Needs and resource assessment and works with its network of Regional Prevention Centers to determine culturally appropriate evidence based strategies that are best suited for its communities.

6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.

Response: The priorities identified in of our PFS 2015 application have become priorities of our prevention system. However, since the majority of the our prevention set aside goes to fund the Regional Prevention Center Systems, there is little funding left over to incentivize communities to do planning in those identified areas. This is why Kentucky has chosen a regional approach. The Regional Prevention Centers are responsible for drafting work plans based on the local needs of the counties they serve.

7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.

Response: The Evidence-Based workgroup has been integrated into our SEOW. The primary focus of the SEOW thus far has been determining state priorities through needs assessment. The EBWG has not made any recent recommendations about evidence-based strategies. However as we begin to address the needs of the SMVF population we will need guidance on appropriate strategies for this population.

8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.

Response: State does not direct fund any strategies through its Block Grant dollars. The determination of strategies is made by the Regional Prevention Center Directors, based on local needs, resource and readiness assessments. Work plans are monitored at the state level to ensure that the strategies are consistent with CSAP's criteria for identifying and selecting evidence based interventions.

9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?

Response: The RPC work plans are monitored by the Quality Assurance Branch. The Regional Prevention Center Budgets must account for all Block Grant Dollars allocated. The funds are tied back to specific deliverables.

10. What process data (i.e. numbers served, participant satisfaction, attendance) 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 State collects a variety of process data through its Prevention data System Kentucky's Prevention Data System (PDS). Our PDS is patterned after CSAP's Minimum Data Set to collect information related to the type of primary prevention services used to reduce and prevent substance abuse among the residents of Kentucky. The PDS collects information on types of strategies implemented, numbers served, high risk population served, gender served, ethnicity served, age groups, as well as amount of staff time devoted to planning and implementation of each strategy. We use this data to determine to what extent we have been able to serve priority populations such as the SMVF and to determine if the types and amounts of service provided are adequate to produce the desired outcomes. The SEOW/Advisory Council will assist in the process.

11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

Response: the SEOW/Advisory Group will monitor consequence, prevalence and risk and protective factor data through the biannual KIP Survey, BRFSS NSDUH and YRBS and make recommendations based on outcome data

Please indicate areas of technical assistance needed related to this section.

- The Regional Prevention Center Directors have requested technical assistance in identifying effective evidence-based strategies for the SMVF population and as well as capacity building and planning in this area.

Environmental Factors and Plan

Primary Prevention for Substance Abuse Prevention

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Response: The Prevention Branch uses data from the SEOW Needs and resource assessment and works with its network of Regional Prevention Centers to determine culturally appropriate evidence based strategies that are best suited for its communities. For example, Generation Rx, a prevention curriculum that was developed by Kentucky to address prescription drug abuse in Appalachia was reviewed by both the SEOW and Regional Prevention center staff from the all the Regional Prevention Center Directors in all the Appalachian region to ensure that content consistent with Appalachian culture. A similar process was used to develop a methamphetamine curriculum called "The Ice that Burns".

6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.

Response: The priorities identified in of our PFS 2015 application have become priorities of our prevention system. However, since the majority of the our prevention set aside goes to fund the Regional Prevention Center Systems, there is little funding left over to incentivize communities to do planning in those identified areas. This is why Kentucky has chosen a regional approach. The Regional Prevention Centers are responsible for drafting work plans based on the local needs of the counties they serve.

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Category	Strategy/Program
1. Information Dissemination	I Won't Be the One, MEDS (Monitor Educate Dispose or Secure) REEL Action, Youth PSA Contests, information on location of permanent Rx drop boxes.
2. Education	WISE, Project Alert, Too Good for Drugs, LifeSkills, Server Training in Alcohol Regulations (STAR), Generation Rx , Brain Train,
3. Community-Based Process	Town Hall Meetings, training on smoke free policies, e-cigarettes, and social host ordinances, creating regional law enforcement task forces to address UAD. Training on medical marijuana
4. Alternative Strategies	Making Healthy Choices, Project Prom, Mentoring Programs,
5. Identification and Referral	SBIRT, Random Drug testing with referral, Prime for Life, TEG TAP, Question Persuade and Refer (QPR).
6. Environmental	Social Host Ordinances, Smoke Free School Grounds, Smoke Free Communities, Alcohol Compliance Checks, Tobacco Compliance Checks, Point of Sales Strategies for Tobacco, Sticker Shock, Party Patrols, Social Norms Campaigns

9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?

Response: The RPC work plans are monitored by the Quality Assurance Branch. The Regional Prevention Center Budgets must account for all Block Grant Dollars allocated. The funds are tied back to specific deliverables.

10. What process data (i.e. numbers served, participant satisfaction, attendance) 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 State collects a variety of process data through its Prevention data System Kentucky's Prevention Data System (PDS). Our PDS is patterned after CSAP's Minimum Data Set to collect information related to the type of primary prevention services used to reduce and prevent substance abuse among the residents of Kentucky. The PDS collects information on types of strategies implemented, numbers served, high risk population served, gender served, ethnicity served, age groups, as well as amount of staff time devoted to planning and implementation of each strategy. We use this data to determine to what extent we have been able to serve priority populations such as the SMVF and to determine if the types and amounts of service provided are adequate to produce the desired outcomes. The SEOW/Advisory Council will assist in the process.

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Environmental Factors and Plan

Primary Prevention for Substance Abuse Prevention

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Response: The SEOW needs assessment continues to drive our Block Grant prevention planning. The 2015 needs assessment revealed that youth that have one or more families in the military have higher prevalence rates for almost all drugs in the ATOD spectrum and are much more likely to have behavioral health problems – depression, suicide ideation, attempted, then youth who do not have members in the military. As a result of this data we are working with our Regional Prevention Network to explore ways to provide prevention services to this population. RPC Directors recently met to answer the following questions in order to initiate the planning process:

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- 1) What substance abuse prevention services are you currently providing to the Service Members, Veterans and their Families (SMVF) population in your region?
- 2) How would you characterize your region's awareness of the need for substance abuse prevention services for the SMVF individuals in your region?
- 3) On a scale from 1-10, one being not ready, and 10 being very ready to work with the military, where would you place your RPC in terms of its readiness to work SMVF individuals in your community in a culturally appropriate manner? What would your RPC need to move along the continuum of readiness?
- 4) Are there organizations in your region that serve the SMVF individuals? (See RPC resource assessment for an initial listing.)
- 5) Aside from KIP, what other mechanisms are in place within your region to collect data on the SMVF individuals?
- 6) How can you find more data related to substance use/abuse and military spouses and children? (includes use by military spouses and children as well as impact on military spouses and children by using/abusing spouses)
- 7) How many/which schools (including public and private: middle, high, and colleges) in your regions have ROTC programs?
- 8) Identify other military-related organizations in your communities? If you are unsure of military-related organizations, where might you go to get this information? Do you already have a liaison working/serving on your local boards? If yes, what is the contact name(s) and branch or service?
- 9) How many veteran-serving organizations are in your region? Are there any Veteran-serving organizations that are not included in the resource assessment?

10) Taking into consideration the particular culture of these organizations, how will you approach these organizations in a culturally responsive or appropriate way? What are three ideas or questions you would want to discuss with them?

11) How can you get information (qualitative) on substance abuse trends among the members of the Kentucky Army National Guard and/or the Army in your region?

12) What additional resources will you need to complete this needs assessment?

13) What are the barriers have you encountered in your previous efforts to collect needs and resource data on the SMVF population?

Step II: Mobilize and/or build capacity to address needs of the military and their families in a culturally appropriate way

1) Based on what you know about the composition of the prevention coalitions/KY-ASAP Boards in your region, what other stakeholders should be involved to enable them to deliver effective and culturally appropriate prevention services to the military?

2)Based on what you know now, what kind of training/TA do you anticipate your RPC and your coalitions will initially need to deliver prevention services to the SMVF individuals?

How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?

Response: The Kentucky Prevention System continues to rely on the high quality prevention training that is offered through the Kentucky School of Alcohol and Other Drug Studies, Prevention Academy and the Kentucky Prevention Network. State Prevention Staff are actively involved in the planning and content of each of these training venues. We have sought additional technical assistance from the SECAPT.

4. Please describe if the state has:

a. A statewide licensing or certification program for the substance abuse prevention workforce;

Response: All Regional Prevention Center staff are required to be Certified Prevention Specialists within three years of their hire date. The Kentucky Board of Certified Prevention Professionals (KCBPP) determines whether individuals have met the knowledge, training and educational requirement for the Certified Prevention Specialist (CPS). The Board is composed of representatives from the ATOD prevention field across Kentucky and continually updates and implements standards for prevention specialists in the state. The certification process includes 150 hours of training in identified domains, 2,000 hours of professional ATOD prevention experience, and a passing score on an international

examination. Not only does certification enhance the field of alcohol, tobacco and other drug prevention but more importantly, assures the quality of service to the individuals and communities served by approximately 90 certified prevention specialist across the Commonwealth. Quality of services, competence, professional growth, ethical conduct and continuing education are all benefits of certification.

b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce;

Response: As stated above, Kentucky holds three prevention trainings a year. (KY School, Prevention Academy and KPN) State Prevention Staff serve on the Planning Committees. Content is determined by a needs assessment conducted annually with the Regional Prevention Center Directors and through our monthly RPC meetings.

c. A formal mechanism to assess community readiness to implement prevention strategies.

Response: All Regional Prevention Centers are required to assess community readiness and address readiness gaps for each of the counties they serve in their annual work plans. The work plans are built around the five steps of the SPF and are monitored by state staff.

5. How does 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: The Prevention Branch uses data from the SEOW Needs and resource assessment and works with its network of Regional Prevention Centers to determine culturally appropriate evidence based strategies that are best suited for its communities. For example, Generation Rx, a prevention curriculum that was developed by Kentucky to address prescription drug abuse in Appalachia was reviewed by both the SEOW and Regional Prevention center staff from the all the Regional Prevention Center Directors in all the Appalachian region to ensure that content consistent with Appalachian culture. A similar process was used to develop a methamphetamine curriculum called "The Ice that Burns".

6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.

Response: The priorities identified in of our PFS 2015 application have become priorities of our prevention system. However, since the majority of the our prevention set aside goes to fund the Regional Prevention Center Systems, there is little funding left over to incentivize communities to do planning in those identified areas. This is why Kentucky has chosen a regional approach. The Regional Prevention Centers are responsible for drafting work plans based on the local needs of the counties they serve.

7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.

Response: The Evidence-Based workgroup has been integrated into our SEOW. The primary focus of the SEOW thus far has been determining state priorities through needs assessment. The EBWG has not made any recent recommendations about evidence-based strategies. However as we begin to address the needs of the SMVF population we will need guidance on appropriate strategies for this population.

8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.

Response: State does not direct fund any strategies through its Block Grant dollars. The determination of strategies is made by the Regional Prevention Center Directors, based on local needs, resource and readiness assessments. Work plans are monitored at the state level to ensure that the strategies are consistent with CSAP's criteria for identifying and selecting evidence based interventions. Therefore we cannot project what strategies/programs will be implemented throughout the next block grant planning cycle. However, a review of the Prevention Data from last year reveals that the following strategies are currently being funded by block grant dollars in various regions of the state:

Category	Strategy/Program
1. Information Dissemination	I Won't Be the One, MEDS (Monitor Educate Dispose or Secure) REEL Action, Youth PSA Contests, information on location of permanent Rx drop boxes.
2. Education	WISE, Project Alert, Too Good for Drugs, LifeSkills, Server Training in Alcohol Regulations (STAR), Generation Rx , Brain Train,
3. Community-Based Process	Town Hall Meetings, training on smoke free policies, e-cigarettes, and social host ordinances, creating regional law enforcement task forces to address UAD. Training on medical marijuana
4. Alternative Strategies	Making Healthy Choices, Project Prom, Mentoring Programs,
5. Identification and Referral	Prime for Life, TEG TAP, Question Persuade and Refer (QPR).
6. Environmental	Social Host Ordinances, Smoke Free School Grounds, Smoke Free Communities, Alcohol Compliance Checks, Tobacco Compliance Checks, Point of Sales Strategies for Tobacco, Sticker Shock, Party Patrols, Social Norms Campaigns

9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?

Response: The RPC work plans are monitored by the Quality Assurance Branch. The Regional Prevention Center Budgets must account for all Block Grant Dollars allocated. The funds are tied back to specific deliverables.

10. What process data (i.e. numbers served, participant satisfaction, attendance) 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 State collects a variety of process data through its Prevention data System Kentucky's Prevention Data System (PDS). Our PDS is patterned after CSAP's Minimum Data Set to collect information related to the type of primary prevention services used to reduce and prevent substance abuse among the residents of Kentucky. The PDS collects information on types of strategies implemented, numbers served, high risk population served, gender served, ethnicity served, age groups, as well as amount of staff time devoted to planning and implementation of each strategy. We use this data to determine to what extent we have been able to serve priority populations such as the SMVF and to determine if the types and amounts of service provided are adequate to produce the desired outcomes. The SEOW/Advisory Council will assist in the process.

11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

Response: the SEOW/Advisory Group will monitor consequence, prevalence and risk and protective factor data through the biannual KIP Survey, BRFSS NSDUH and YRBS and make recommendations based on outcome data

Please indicate areas of technical assistance needed related to this section.

- The Regional Prevention Center Directors have requested technical assistance in identifying effective evidence-based strategies for the SMVF population and as well as capacity building and planning in this area.

Environmental Factors and Plan

10. Quality Improvement Plan

Narrative Question:

In previous block grant applications, 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, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and 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 to this application, states should submit a CQI plan for FY 2016-FY 2017.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

The state was not able to address this EFP at this time.

Environmental Factors and Plan

11. Trauma

Narrative Question:

Trauma⁷⁵ is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems⁷⁶. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses, and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders. Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences. However, most people go without these services and supports.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often themselves re-traumatizing, making it necessary to rethink doing “business as usual.” These public institutions and service settings are increasingly adopting a trauma-informed approach guided by key principles of safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues, and incorporation of trauma-specific screening, assessment, treatment, and recovery practices.

To 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 approach consistent with “SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach”.⁷⁷ 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 supportive and avoid traumatizing the individuals again. It is suggested that the states uses SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma⁷⁸ paper.

Please consider the following items as a guide when preparing the description of the state’s system:

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?
2. Describe the state’s policies that promote the provision of trauma-informed care.
3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?
4. Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?

Please indicate areas of technical assistance needed related to this section.

75 Definition of Trauma: Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.

76 <http://www.samhsa.gov/trauma-violence/types>

77 <http://store.samhsa.gov/product/SMA14-4884>

78 *Ibid*

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

12. Criminal and Juvenile Justice

Narrative Question:

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one third meet criteria for having co-occurring substance abuse and mental health problems. Successful diversion from or re-entering the community from detention, jails, and prisons is often dependent on engaging in appropriate substance use and/or mental health treatment. Some states have implemented such efforts as mental health, veteran and drug courts, crisis intervention training and re-entry programs to help reduce arrests, imprisonment and recidivism.⁷⁹

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 use 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.^{80 81} 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 use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.⁸²

Expansions in insurance coverage will mean that many individuals in jails and prisons, who generally have not had health coverage in the past, will now be able to access behavioral health services. Addressing the behavioral health needs of these individuals can reduce recidivism, improve public safety, reduce criminal justice expenditures, and improve coordination of care for a population that disproportionately experiences costly chronic physical and behavioral health conditions. Addressing these needs can also reduce health care system utilization and improve broader health outcomes. Achieving these goals will require new efforts in enrollment, workforce development, screening for risks and needs, and implementing appropriate treatment and recovery services. This will also involve coordination across Medicaid, criminal and juvenile justice systems, SMHAs, and SSAs.

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. 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 a 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 consider the following items as a guide when preparing the description of the state's system:

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?
2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Do the SMHA and SSA coordinate 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. Are cross-trainings provided 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?

Please indicate areas of technical assistance needed related to this section.

⁷⁹ <http://csqjusticecenter.org/mental-health/>

⁸⁰ The American Prospect: In the history of American mental hospitals and prisons, *The Rehabilitation of the Asylum*. David Rottman, 2000.

⁸¹ 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.

⁸² 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, McNeil, Dale E., and Renée L. Binder. [OJJDP Model Programs Guide](#)

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions? No

2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders? this is beginning to occur in the Juvenile Justice arena.

3. Do the SMHA and SSA coordinate 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? Yes

4. Are cross-trainings provided 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? Yes

Environmental Factors and Plan

13. State Parity Efforts

Narrative Question:

MHPAEA generally requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applied to M/SUD benefits are no more restrictive than the requirements or limitations applied to medical/surgical benefits. The legislation applies to both private and public sector employer plans that have more than 50 employees, including both self-insured and fully insured arrangements. MHPAEA also applies to health insurance issuers that sell coverage to employers with more than 50 employees. The Affordable Care Act extends these requirements to issuers selling individual market coverage. Small group and individual issuers participating in the Marketplaces (as well as most small group and individual issuers outside the Marketplaces) are required to offer EHBs, which are required by statute to include services for M/SUDs and behavioral health treatment - and to comply with MHPAEA. Guidance was released for states in January 2013.⁸³

MHPAEA requirements also apply to Medicaid managed care, alternative benefit plans, and CHIP. ASPE estimates that more than 60 million Americans will benefit from new or expanded mental health and substance abuse coverage under parity requirements. However, public awareness about MHPAEA has been limited. Recent research suggests that the public does not fully understand how behavioral health benefits function, what treatments and services are covered, and how MHPAEA affects their coverage.⁸⁴

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. SMHAs and SSAs should collaborate with their state's Medicaid authority in ensuring parity within Medicaid programs.

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.

Please consider the following items as a guide when preparing the description of the state's system:

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?
2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?
3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

Please indicate areas of technical assistance needed related to this section.

⁸³ <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf>

⁸⁴ Rosenbach, M., Lake, T., Williams, S., Buck, S. (2009). Implementation of Mental Health Parity: Lessons from California. *Psychiatric Services*. 60(12) 1589-1594

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

The state was not able to address this EFP at this time.

Environmental Factors and Plan

14. Medication Assisted Treatment

Narrative Question:

There is a voluminous literature on the efficacy of FDA-approved medications for the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for medication-assisted treatment of these disorders is described in SAMHSA TIPs 40⁸⁵, 43⁸⁶, 45⁸⁷, and 49⁸⁸. SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to use MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

SAMHSA strongly encourages states to require the use of FDA-approved MATs for substance use disorders where clinically indicated (opioid use disorders with evidence of physical dependence, alcohol use disorders, tobacco use disorders) and particularly in cases of relapse with these disorders. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?
2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?
3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?

Please indicate areas of technical assistance needed related to this section.

⁸⁵ <http://store.samhsa.gov/product/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction/SMA07-3939>

⁸⁶ <http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214>

⁸⁷ <http://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA13-4131>

⁸⁸ <http://store.samhsa.gov/product/TIP-49-Incorporating-Alcohol-Pharmacotherapies-Into-Medical-Practice/SMA13-4380>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plans

#14 Medication Assisted Treatment

Narrative Questions:

There is a voluminous literature on the efficacy of FDA-approved medications for the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for medication-assisted treatment of these disorders is described in SAMHSA TIPs 40⁸⁵, 43⁸⁶, 45⁸⁷, and 49⁸⁸. SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to use MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

SAMHSA strongly encourages states to require the use of FDA-approved MATs for substance use disorders where clinically indicated (opioid use disorders with evidence of physical dependence, alcohol use disorders, tobacco use disorders) and particularly in cases of relapse with these disorders. SAMHSA is asking for input from states to inform SAMHSA's activities. Please consider the following items as a guide when preparing the description of the state's system:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?

- Kentucky develops and recruits presenters for a medication-assisted treatment-specific “track” within the Kentucky School of Alcohol and Other Drug Studies
- The Kentucky State Opioid Treatment Authority (SOTA) provides on-site training periodically to stakeholders

2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?

- Kentucky successfully wrapped up a one-day Neonatal Abstinence Syndrome training led by Dr. Hendree Jones, which was attended by more than 300 individuals
- Kentucky has planned another training to be led by Dr. Lori Devlin-Phinney regarding Neonatal Opioid Withdrawal Syndrome, and has registrations for approximately 500 individuals

3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?

- Kentucky performs annual SOTA inspections, and OTN Diversion control policies
- The SOTA and the OTN network are working together on a diversion and disaster preparedness committee
- SOTA worked closely with the Kentucky Board of Medical Licensure on a new regulation for OBOT: 201 KAR 9:270

Environmental Factors and Plan

15. Crisis Services

Narrative Question:

In the on-going development of efforts to build an evidence-based robust system of care for persons diagnosed with SMI, SED and addictive disorders and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises.

SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](#)⁸⁹,

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports being used to address crisis response include the following:

Crisis Prevention and Early Intervention:

- Wellness Recovery Action Plan (WRAP) Crisis Planning
- Psychiatric Advance Directives
- Family Engagement
- Safety Planning
- Peer-Operated Warm Lines
- Peer-Run Crisis Respite Programs
- Suicide Prevention

Crisis Intervention/Stabilization:

- Assessment/Triage (Living Room Model)
- Open Dialogue
- Crisis Residential/Respite
- Crisis Intervention Team/ Law Enforcement
- Mobile Crisis Outreach
- Collaboration with Hospital Emergency Departments and Urgent Care Systems

Post Crisis Intervention/Support:

- WRAP Post-Crisis
- Peer Support/Peer Bridgers
- Follow-Up Outreach and Support
- Family-to-Family engagement
- Connection to care coordination and follow-up clinical care for individuals in crisis
- Follow-up crisis engagement with families and involved community members

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Crisis Services Technical Assistance Requests for SFY 2016-2017

KY would like technical assistance to achieve the following goals in our crisis system of care:

1. Increase cross-training of behavioral health and I/DD staff at state and regional levels.
2. Increase crisis providers' capacity to serve adults and children experiencing a substance-related crisis.
3. Improve crisis data collection and reporting.
4. Develop a model pre-service training curricula for crisis services providers and/or crisis hotline providers.

Footnotes:

Environmental Factors and Plans

15. Crisis Services

The Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) has a vision that all Kentuckians shall have access to a robust behavioral health crisis prevention and emergency response system of care. The fourteen community mental health centers (CMHCs) serve as the backbone and “safety net” for Kentucky’s crisis system of care and new opportunities are developing as Kentucky’s behavioral health provider network and service infrastructure expands in response to implementation of the Affordable Care Act and other catalysts for change.

Timeline of the Development of the Emergency/Crisis Services System of Care in Kentucky

1986-1991 – Pathways, Inc., a CMHC, in northeastern Kentucky developed the first residential crisis stabilization program for adults in Kentucky with funds from a Robert Wood Johnson Foundation grant. The program closed when the grant expired and replacement funding could not be secured.

1994 – The issue of criminalization of mental illness in Kentucky received national media attention as “The Worst State in the Nation” in response to the high number of individuals being jailed while awaiting evaluation for involuntary evaluation. As a result, legislative revisions were made to KRS 202A, 202B, and 645. In addition, Administrative Regulation 908 KAR 2:090 was crafted and allowed for crisis stabilization units to be developed to reduce psychiatric hospitalizations.

1995 – Program development meetings with directors of crisis stabilization programs were initiated. Uniform data collection was established and basic utilization data elements were created including, unduplicated client count (admissions), duplicated client count, total number of bed days, and average length of stay. Paper data reports were submitted to the department until July 1, 2004, when a service code was created to capture crisis stabilization as a provided service in the event data set.

1996 – Kentucky River Community Care and Mountain Community Care Centers opened children’s crisis stabilization units (CSUs) in Jackson and Prestonsburg, respectively and Bluegrass established mobile crisis and emergency therapeutic foster care services.

1996 - DBHDID conducted a series of program development meetings with representatives from the CMHCs. These meetings provided an overview of the department’s vision of crisis stabilization services for children. By 2002, ten of the fourteen CMHCs had established child crisis stabilization programs. Most of these programs were modeled after the adult residential programs, but some non-residential programs were also developed. The programs provided a variety of crisis services including assessments, intensive in-home therapy, crisis foster care placement and day treatment.

1997 – The adult residential crisis stabilization programs began using the Brief Psychiatric Rating Scale (BPRS), an outcome measurement tool that measured symptom severity upon admission and discharge. A calculated “change score” represented a measure of symptom reduction as a result of the intervention.

1999 – The Community Mental Health Center License Regulation (902 KAR 20:091) was amended to include residential crisis unit standards.

2002 – DBHDID prepared a white paper on the status of adult and child crisis stabilization program in Kentucky. The information was used in an attempt to secure funding to complete the crisis network.

2003 – DBHDID introduced performance indicators for crisis stabilization programs in conjunction with the Annual Plan and budget process.

2004 – Every CMHC within Kentucky developed an Adult and Child Crisis Service Program. A major change from the initial years of adult program development was that several regions developed mobile crisis “programs” instead of crisis stabilization units. The primary crisis intervention service of programs was mobile crisis services.

2005 – The child residential crisis stabilization programs began using the Brief Psychiatric Rating Scale for Children (BPRS-C), an outcome measurement tool that measures symptom severity upon admission and discharge. A change score is calculated that represents a measure of symptom reduction as a result of the intervention.

2006 – Funding was appropriated to bring each CMHC up to \$400,000 for each adult and child crisis program. Additional funds were appropriated for the urban areas of the state (Lexington and Covington). A line item in the state’s budget to the Louisville area established the David Block Crisis Stabilization program.

2013 – DBHDID convened a series of stakeholder meetings late in the year to discuss Kentucky’s Emergency’s Response and Crisis Prevention System in a changing healthcare environment, including alternative reimbursement methods for the CMHCs, ideal array of services, ideal benefit packages for individuals without insurance coverage, outcome measures, data needs, and a statewide crisis hotline.

2014 – Three crisis services are approved to become Medicaid billable on January 1st: residential crisis stabilization, mobile crisis, and crisis intervention.

2014 – DBHDID developed standards for the three new Medicaid billable crisis services.

2015 – DBHDID made a wide sweeping change to its contract with the fourteen community mental health centers. It reviewed and revised deliverables and introduced performance indicators, including one performance indicator for the crisis stabilization programs. The CMHCs’ incentive for achieving the outcome was one percent (1%) of their adult and/or child crisis state general fund fiscal year allocation.

Guiding Principles

1. Respect

Emergency services programs and staff respect the needs and wishes of each person in crisis. They value and protect the rights, privacy and confidentiality of each person in crisis, unless the person presents an imminent risk and confidentiality would compromise the required intervention.

1.1 Preferred Practice: Each system considers the strengths and resources of the person in crisis, including the family and community

1.2 Preferred Practice: Each program collaborates with others involved with the person in crisis whenever appropriate and possible.

2. Comprehensive Array

The design of the statewide emergency service system needs to be broad and comprehensive in order to account for geographic and regional variations and client or family needs in emergency situations.

- 2.1 Preferred Practice: Each system will be flexible to account for regional differences.
- 2.2 Preferred Practice: Each system will have a method to determine needs for crisis interventions that may include mobile crisis outreach, a crisis stabilization unit or both.
- 2.3 Preferred Practice: Crisis emergency services are seen as a primary practice to prevent suicide and crimes against others in the community. All regional staff receives training in suicide prevention, assessment and intervention.

3. Accessibility

The Regional Board is responsible for providing behavioral health emergency responses to all citizens living in their jurisdictions, regardless of age, diagnosis, priority population group or agency of origin.

- 3.1 Preferred Practice: Each region is served by a hotline that operates 24/7/365.
- 3.2 Preferred Practice: Each Regional Board has at least one designated place where an evaluation can be completed, including law enforcement initiated cases.
- 3.3 Preferred Practice: Each Regional Board values crisis services as a critical element to an essential community safety net to prevent suicide and other unnecessary loss of human potential.
- 3.4 Preferred Practice: Transportation resources are available within the region to permit rapid access to services.

4. Timeliness

Quick response times are a critical feature of an effective behavioral health emergency system.

- 4.1 Preferred Practice: A reasonable response time for a face to face interaction with a clinician is 30 minutes for a walk-in crisis assessment.
- 4.2 Preferred Practice: On a crisis call, the individual or family member will be able to speak to a clinician within 15 minutes.

5. Inclusion

Every person has the right to receive a timely, effective emergency response from their Regional Board.

- 5.1 Preferred Practice: Each Regional Board will have the capacity to respond to individuals in crisis with mental health disorders, development and intellectual disabilities, persons requiring drug or alcohol detoxification, individuals with co-occurring disorders or acquired brain injuries.

6. Least Restrictive Setting

Emergency Services preserve community placement whenever possible and prevent institutionalization, hospitalization or increased levels of care. Services preserve natural supports of the individual experiencing the emergency to the greatest extent possible.

- 6.1 Preferred Practice: Each region has a secure, safe environment that is non-stigmatizing to conduct crisis evaluations and interventions.
- 6.2 Preferred Practice: When possible, each region makes use of natural community supports, crisis prevention plans, support groups, and peer-run centers.

7. Accountability

The emergency service system is accountable to individuals, their caregivers, families, communities and funding sources.

- 7.1 Preferred Practice: The emergency services system will reduce the use of higher levels of care. The Regional Board will be able to demonstrate a relationship between crisis intervention activities and the reduction of hospital admission/utilization rates.

7.2 Preferred Practice: The Regional Board will demonstrate a relationship between crisis intervention services (diversion activities) and the criminal justice system so that law enforcement and jails experience fewer cases of individuals in a behavioral health crisis.

7.3 Preferred Practice: The Regional Board will maintain reasonable cost planning for financial accountability and financial sustainability. Crisis Intervention Services will fall within DBHDID cost brackets for child interventions, adult interventions, involuntary assessments and hotline services.

8. Collaboration

Program design and delivery should be developed through a collaborative process that includes all pertinent stakeholders, including law enforcement, private and public hospitals, consumers, youth and family members.

8.1 Preferred Practice: Consumers, youth and family members are included in the annual process for designing and improving the emergency crisis services system.

8.2 Preferred Practice: Memoranda of Understanding or other formal mechanisms exist with key stakeholders in the community to outline roles and responsibilities.

9. Data Informed

Decision making at the individual and systems level is guided by data.

9.1 Preferred Practice: So that information is available for decision making, all Regional Boards will report crisis services data faithfully and consistently using the DBHDID data system.

9.2 Preferred Practice: Data will show a relationship between crisis services provided and the impact on the emergency services system. Data will be used to drive quality improvement activities.

10. Evidenced Based Practice

Emergency Services responses need to be delivered in a holistic manner using evidenced based and best practices.

10.1 Preferred Practice: Trauma informed care is a guiding practice in all crisis services.

10.2 Preferred Practice: Standardized tools (such as the Mental Health Triage Tool, CTRS, TAS, LOCUS, CALOCUS, and ASAM-PPC) are used for determining the level of care needed.

10.3 Preferred Practice: All services need to be co-occurring capable as measured by the DDCAT or DDMHT.

11. Cultural Competence

Emergency Services are provided by staff that is culturally competent.

11.1 Preferred Practice: All regions shall have culturally competent staff with access to language and culturally appropriate resources to meet clients' needs.

12. Community Awareness

The procedure for accessing emergency behavioral health services should be common knowledge in the community.

12.1 Preferred Practice: The toll free crisis hotline number, a description of the available crisis services, and how to access those services should have prominent placement on the agency website and other community outreach materials.

12.2 Preferred Practice: Law enforcement, first responders and other community partners should receive training on how to access crisis services.

Sources of Funding

Behavioral health crisis services at the CMHCs are provided with the following blended funding:

State General Funds

The department provides state general funds for crisis services and for services for diverting individuals from the justice system. The department allocated approximately \$14.4 M for SFY 2016 to the CMHCs for crisis services and for services for diverting individuals from the justice system.

Federal and Local Funds

In addition to state general funds, statewide the CMHCs allocated approximately \$250,000 of their mental health block grant funds set aside for children for crisis services. This equaled 5% of the fourteen CMHCs' total MHBG allocation and 3% of the state's total MHBG allocation.

A few CMHCs receive funds through local taxes and may allocate part or all of that funding to crisis services.

Medicaid Billable Services

On January 1, 2014, the following three crisis services were approved for payment by the Centers for Medicaid and Medicare Services (Note: These are the revised definitions included in the subsequent Medicaid State Plan Amendment approved 10-7-2014):

- **Crisis Intervention** shall be a therapeutic intervention provided for the purpose of immediately reducing or eliminating risk of physical or emotional harm to the client, or others. This service shall be provided as an immediate relief to the presenting problem or threat. It must be followed by non-crisis service referral, as appropriate. It must be provided in a face-to-face, one-on-one encounter between the provider and the client. Crisis intervention may include further service prevention planning such as lethal means reduction for suicide risk and substance use relapse prevention. It is a clinic based service and must be provided by a independently licensed practitioner or through a billing supervisor that is independently licensed. Rendering Practitioners may include practicing as an individual, a provider group, or as part of a licensed organization.
- **Mobile Crisis** is a multi-disciplinary team based intervention that ensures access to acute mental health and substance use services and supports. The service aims to affect symptom or harm reduction, or to safely transition an individual in acute crisis to the appropriate least restrictive level of care. Mobile crisis services are provided face-to-face and available in locations outside the provider's facility (e.g., home or community) 24 hours per day, 7 days per week and 365 days per year. This service is provided in duration of less than 24 hours and is not an overnight service. Mobile crisis involves all supports and services necessary to provide integrated crisis prevention, assessment, disposition, intervention, continuity of care recommendations, and follow-up services.
- **Residential Crisis Stabilization** services are provided in Crisis Stabilization Units. Crisis Stabilization Units are community-based, residential programs that offer an array of services including screening, assessment, treatment planning, psychiatric services, individual, group and family therapy, service planning and peer support in order to stabilize a crisis and divert the individual from a higher level of care. It is not part of a hospital. They are used when individuals in a behavioral health emergency cannot be safely accommodated within the community, and are not in need of hospitalization but need overnight care. Authorized Providers for CSU services must be employed by an organization licensed to operate a CSU.

Community Mental Health Centers – Kentucky’s Safety Net

DBHDID requires CMHCs to provide emergency behavioral health services to all individuals who seek services when in an emergency. Crisis services are provided to all individuals in crisis who request assistance regardless of payor source or ability to pay. The primary purpose of crisis services is to assess the individual in crisis to determine services needed and assist him/her in receiving the least restrictive, most effective treatment available, and referral to needed follow-up services. The CMHC’s system shall serve individuals with mental health disorders, substance use disorders and individuals with intellectual and developmental disorders. The CMHC must provide services twenty-four hours per day, seven (7) days per week. The CMHC must provide or arrange for the provision of the following services under this contract, and as described in the CMHC’s approved Plan and Budget (P&B) submission for the current fiscal year, to each individual presenting in a crisis or emergency situation, depending on one’s individualized plan of care:

- Assessment and Screening
- Psychiatric Evaluation
- Medication Management/Medication
- Crisis Intervention (clinic based)
- Residential Crisis Stabilization (residential services aligned with new Medicaid covered service)
- Mobile Crisis (face-to-face services provided in the community)
- Access to Medical or Non-Medical Detoxification Services
- Transportation

CMHCs are required by contract to ensure individuals in crisis have access to a team of professionals, which shall include a prescriber (Psychiatrist/Advanced Practice Registered Nurse (APRN) and other staff trained in crisis response such as crisis clinician, nurse, peer support specialist, I/DD staff trained in risk assessment and mitigation, or other behavioral health providers knowledgeable about the needs of a specific population).

CMHCs use DBHDID funding until the crisis is resolved (up to 72 hours anticipated) or the individual is referred to another level of care, however, the CMHC is expected to seek reimbursement from all possible payor sources for all individuals once the crisis is stabilized. The CMHC shall not require co-payments from individuals served for emergency behavioral health services funded by DBHDID.

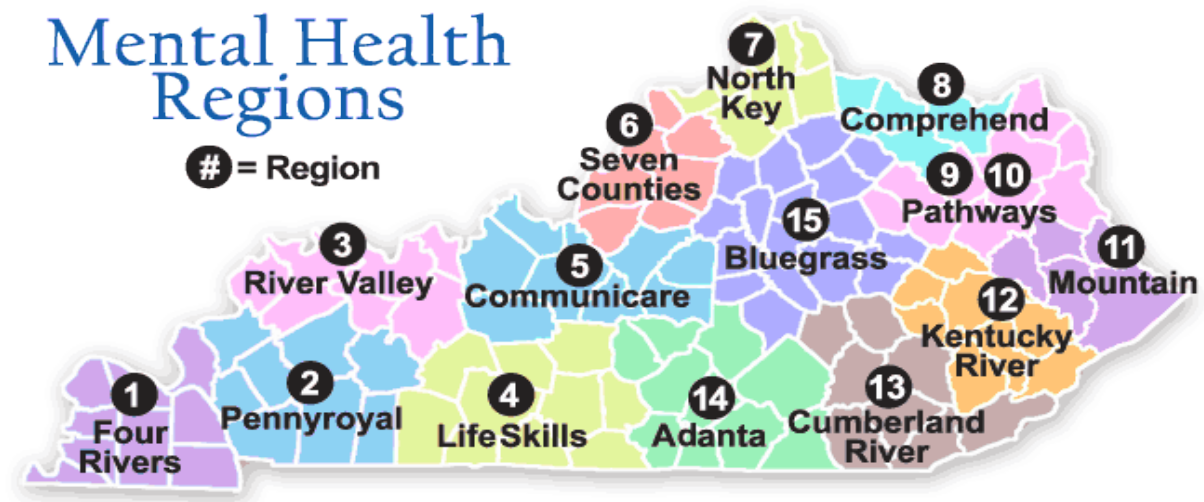
CMHCs are required by contract to ensure that each client that receives crisis services shall have a Service Plan. The service plan shall include a written description of the individual’s immediate assessed needs, a specific description of the crisis intervention and stabilization services to be provided and a plan of follow-up care after discharge or documentation of referral to another level of care. Upon discharge from the crisis service, the individual shall have developed a Safety Plan with one’s provider, if appropriate and applicable. This brief plan shall include steps to be taken by the individual or the individual’s family or significant others should the person become a danger to himself or others. The plan shall include a description of concrete steps to be taken to minimize safety risks.

Kentucky's Adult and Child Crisis Stabilization Unit Sites

CMHC	Adult Programs	# of Adult Beds	Child Programs	# of Child Beds
Four Rivers Behavioral Health	1539 Cuba Road Mayfield, KY 42066	8		
RiverValley Behavioral Health, Inc.	1100 Walnut Street Owensboro, KY 42301	8		
LifeSkills, Inc.	822 Woodway Drive Bowling Green, KY 42101	8	501 Chestnut Street Bowling Green, KY 42101	9
Communicare, Inc.	100 Gray Street Elizabethtown, KY 42701	8	1311 N. Dixie Avenue, Bldg D. Elizabethtown, KY 42701	12
Seven Counties Services, Inc.	Contracts with Wellspring. David Block Center CSU 841 E. Chestnut Street Louisville, KY 40204	8	914 E. Broadway 3rd Floor Louisville, KY 40204	12
Seven Counties Services, Inc.	Contracts with Wellspring Samuel B. Todd CSU 120 W. St. Catherine Street Louisville, KY 40203	8		
Comprehend, Inc.			211 Wood Street Maysville, KY 41056	8
Pathways, Inc.	201 22nd Street Ashland, KY 41101	8	411 Bishop Court Morehead, KY 40351	6
Mountain Comprehensive Care Center	1324 South Lake Drive Prestonsburg, KY 41653	8	150 S. Front Avenue Prestonsburg, KY 41653	6
Kentucky River Community Care			3826 Hwy 15 South Jackson, KY 41339	12
Cumberland River Behavioral Health, Inc.	349 Riverbend Road London, KY 40744	8	2932 Level Green Road Corbin, KY 40701	10
The Adanta Group	119 Herriford Circle Road Jamestown, KY 42629	8		
Bluegrass.org	3479 Buckhorn Drive #106 Lexington, KY 40515	4		
	Statewide Subtotal =	84		75
	Statewide Total Number of Beds =		159	

Kentucky Behavioral Health Crisis Services

24 Hour Toll Free Telephone Numbers



①	Four Rivers Behavioral Health	(800) 592-3980
②	Pennyroyal Center	(877) 473-7766
③	RiverValley Behavioral Health	(800) 433-7291
④	LifeSkills, Inc.	(800) 223-8913
⑤	Communicare	(800) 641-4673
⑥	Seven Counties Services	(800) 221-0446
⑦	NorthKey Community Care	(877) 331-3292
⑧	Comprehend, Inc.	(877) 852-1523
⑩	Pathways, Inc.	(800) 562-8909
⑪	Mountain Comprehensive Care Center	(800) 422-1060
⑫	Kentucky River Comprehensive Care	(800) 262-7491
⑬	Cumberland River	(888) 435-7761
⑭	The Adanta Group	(800) 633-5599
⑮	Bluegrass	(800) 928-8000

Outcomes

The Department implemented performance-based contracts for SFY 2015 and included eleven (11) performance indicators into the CMHC contract. One of the goals was to increase access to crisis services by 5% from the previous fiscal year and two performance indicators were created for crisis services, one for adult crisis services and one for children's. A crisis service was defined as one of the following:

- Residential Crisis Stabilization
- Mobile Crisis
- Crisis Intervention
- I/DD Crisis Prevention

The incentive for achieving the target was one percent (1%) of the Center's state general fund crisis allocation for children and adults.

The Department collaborated with staff at the University of Kentucky to develop a monthly compliance report for each indicator. These reports are maintained online and refreshed monthly so that all regional and department are able to stay abreast of performance. Appendix A is an example of one CMHC's crisis compliance report.

Changes were made in performance based contracting for crisis services for FY 2016. First, the CMHCs have two (2) performance targets to achieve this year. Second, there are three indicators, two measuring readmissions and then the same indicator as SFY 2015. Below are the indicators:

1. Measure Name: Psychiatric Hospital Admissions for Adults Receiving Crisis Stabilization Services

Measure #1 applies to only regions 01, 02, 03, 04, 05, 06, 07, 10, 11, 13, 14, 15

The DBHDID shall assess the psychiatric hospital admission rate for clients receiving adult crisis stabilization services. The performance indicator is defined as the percentage of adult clients who received a residential crisis stabilization service per CMHC during the monitoring period who are admitted to a state-owned or state-contracted psychiatric hospital (ARH-Hazard Psychiatric Unit, Central State Hospital, Eastern State Hospital, Western State Hospital) in 30 days or less of the date of the last residential crisis stabilization service. Hospital admissions that occur on the same day or within 1 day from the last day of an episode of care of residential crisis stabilization services do not apply. Goal is to decrease by 1% the center's percentage as calculated for the same monitoring period during the previous state fiscal year (SFY2015).

Goal: Increase Effectiveness of Residential Crisis Services

Risk: 1% of crisis funding

2. Measure Name: Readmissions for Children Receiving Crisis Stabilization Services

Measure #1 applies to only regions 04, 05, 06, 08, 10, 11, 12, 13

The DBHDID shall assess the crisis stabilization unit readmission rate for clients receiving child crisis stabilization services. The performance indicator is defined as the percentage of child clients who received a residential crisis stabilization service per CMHC during the monitoring period who are readmitted to the same residential crisis stabilization unit in 30 days or less from the day of the last residential crisis stabilization service episode. Readmissions that occur on the same day or within 1 day of the last day of an episode of care of residential crisis

stabilization services do not apply. The goal is that the percentage of clients readmitted to crisis stabilization units will be no more than 12% of admissions to the same crisis stabilization unit within a 30 day period.

Goal: No more than 12% of clients admitted to a children's crisis stabilization unit will have a readmission to the same crisis stabilization unit within a 30 day period.

Risk: 1% of crisis funding

3. Measure Name: Crisis Service Utilization by Adults and Children

Measure #3 applies to only regions 01, 02, 03, 07, 08, 12, 14, 15

The DBHDID shall assess the utilization of crisis services for adults (Clients/1,000 Census – Adult) and for children (Clients/1,000 Census – Children). The performance indicator is defined as the number of adult or child clients at each center who received a crisis service (Residential Crisis Stabilization – MH Adult, MH Child, MH Non-Residential Crisis Response, Crisis Intervention, or I/DD Crisis Prevention) during the monitoring period of the current state fiscal year. The client count is divided by the regions' total adult or child population (per 2010 U.S. Census). That result is then multiplied by 1,000 to show clients per 1,000 persons in the region. Goal is to increase emergency response and crisis services over the previous year by 3%.

Goal: Increase access to crisis services

Risk: 1% of crisis funding

DBHDID may conduct an annual program performance and compliance site review of the CMHC's program. Monitoring will consist of an off-site review of appropriate data and documentation, as well as an on-site review of operations and documentation. A summary report will be provided to CMHC within 60 days of the review and may require submission of a corrective action plan.

Diversion from the Justice System

The CMHC crisis programs provide a range of services and supports to divert individuals from the justice system and higher and inappropriate levels of care, such as the following:

- Involuntary hospitalization evaluations;
- Involuntary admission evaluations for individuals with developmental or intellectual disabilities;
- Provide and arrange non-secure transportation services and reimburse law enforcement for secure transport;
- Attend commitment hearings with clients;
- They collaborate with local crisis intervention teams to provide trainings and participate on advisory team meetings;
- Provide training and consultation to local jails; and
- Provide training and consultation to local juvenile detention centers.

Below is statewide data for fiscal year 2015. The data reveals that CMHC staff are providing more than twenty-three involuntary hospitalization evaluations for adults for every one involuntary hospitalization evaluation of a

child and almost 150 evaluations of adults for every one involuntary admission evaluation of an individual with IDD. Thirty-nine percent of the individuals evaluated required emergency transportation.

There are 89 jails and 4 juvenile detention centers in Kentucky. CMHCs provided 18,792 consultation calls to these facilities. This averages 202 calls per facility for the year.

Diversion from the Justice System Objective – SFY 2015	Total
Number of involuntary psychiatric evaluations provided to adults (evaluations pursuant to KRS 202A).	12,410
Number of involuntary psychiatric evaluations provided to children (evaluations pursuant KRS 645).	529
Number of involuntary admission evaluations provided to adults with developmental or intellectual disabilities (evaluations pursuant to KRS 202B)	83
Number of emergency transports provided to adults or children.	4,849
Number of calls for consultation provided to jails and juvenile detention centers.	18,792

Summary

As Kentucky’s Emergency Response and Crisis Prevention System prepares to enter its fourth decade, there are many exciting initiatives to rally around – the expanding behavioral health network of crisis services providers; continuous quality assurance of services, reporting and outcomes; the young adult peer support bridging initiative; excellence in suicide care and suicide prevention as you will read about in section 20; increasing cross-training of behavioral health and I/DD providers; and ensuring a competent workforce. DBHDID values its relationship with the many stakeholders who have an interest in Kentucky’s behavioral health emergency services and crisis response system and looks forward to continuing to improve this system of care for children and adults who experience a behavioral health crisis.

Environmental Factors and Plan

16. Recovery

Narrative Question:

The implementation of recovery-based approaches is imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.

Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of health (access to quality health and behavioral health treatment), home (housing with needed supports), purpose (education, employment, and other pursuits), and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. This includes the use of psychotropic or other medications for mental illnesses or addictions to assist in the diminishing or elimination of symptoms as needed. Further, the use of psychiatric advance directives is encouraged to provide an individual the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly. Resolution of symptoms through acute care treatment contributes to the stability necessary for individuals to pursue their ongoing recovery and to make use of SAMHSA encouraged recovery resources.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see [SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders](#).

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- | | | |
|--------------------------------------------|-------------------------------------------------------|------------------------------------------------------------------|
| • Drop-in centers | • Family navigators/parent support partners/providers | • Mutual aid groups for individuals with MH/SA Disorders or CODs |
| • Peer-delivered motivational interviewing | • Peer health navigators | • Peer-run respite services |
| • Peer specialist/Promotoras | • Peer wellness coaching | • Person-centered planning |
| • Clubhouses | • Recovery coaching | • Self-care and wellness approaches |
| • Self-directed care | • Shared decision making | • Peer-run crisis diversion services |
| • Supportive housing models | • Telephone recovery checkups | • Wellness-based community campaign |
| • Recovery community centers | • Warm lines | |
| • WRAP | • Whole Health Action Management (WHAM) | |
| • Evidenced-based supported | | |

SAMHSA encourages states to take proactive steps to implement recovery support services, and is seeking input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, 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.

Recovery is based on the involvement of consumers/peers and their family members. States should 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 engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system.

Please consider the following items as a guideline when preparing the description of the state's system:

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?
2. How are treatment and recovery support services coordinated for any individual served by block grant funds?
3. 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?
4. 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? Does the state have an accreditation program, certification program, or standards for peer-run services?
5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?
6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).
7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?
8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.
9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.
10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?
11. Describe how the state is supporting the employment and educational needs of individuals served.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

16. Recovery

The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) has long supported the provision of recovery oriented services and supports to all individuals served by the public behavioral health system. The strategic plan for DBHDID includes Mission and Vision statements that include “.....facilitating recovery....”, “....administration and delivery of evidence based services and supports that are individually focused....”, and organizational values including choice and self-determination, excellence and respect. Strategic DBHDID goals include: Promote inclusion in community-based settings for individuals with disabilities; and Promote resiliency, recovery and inclusion in community living.

For many years, DBHDID has partnered with statewide advocacy organizations that represent individuals in recovery from behavioral health disorders and their family members. These partnerships have resulted in countless training opportunities, implementation of various initiatives, promotion of recovery oriented services and supports, and more awareness of the need and benefits of such services and supports.

Currently, DBHDID formally partners with four (4) statewide advocacy organizations: People Advocating Recovery (PAR), an advocacy group governed by and supporting individuals in recovery from substance use disorders; Kentucky System Transformation: Advocating Recovery Supports (KYSTARS), a training and technical assistance center that is governed by and supporting individuals in recovery from behavioral health disorders, family members, and providers; Kentucky Partnership for Families and Children (KPFC), an organization that is governed by and supporting children and youth in recovery from behavioral health disorders and their family members; and the National Alliance on Mental Illness (NAMI) Kentucky Chapter, an organization governed by and supporting family members of individuals in recovery from behavioral health disorders.

DBHDID also has less formal partnerships with other advocacy organizations including Mental Health Coalition, Mental Health America (both of Kentucky and of Northern Kentucky and Southwestern Ohio), and Kentucky Chapter of the Psychiatric Rehabilitation Association (KyPRA).

In 2004, the Department merged two divisions to create the Division of Mental Health and Substance Abuse, in an effort to integrate statewide efforts. During SFY 2009, the Department renamed the Division, Division of Behavioral Health, and made further efforts at statewide integration. In 2011, DBHDID hired a Recovery Services Coordinator, a self-identified individual in recovery from behavioral health disorders, to work within the Division to further integrate statewide efforts and to assist with implementing recovery principles across all service arrays.

One initiative that has been led by the Recovery Services Coordinator is the implementation of adult peer run programs across the state. During SFY 2013, a request for application (RFA) was initiated, utilizing some Mental Health Block Grant funds to contract with CMHCs to develop adult peer run programming. These RFAs included a requirement to follow the SAMHSA toolkit for Consumer Operated Services (COS) and create a steering committee or advisory board including a majority of individuals in recovery and their family members. DBHDID provided start-up funding and technical assistance for this programming. The partnership with KYSTARS included technical assistance and training opportunities for this initiative. At this point, DBHDID has assisted with funding of eight (8) programs, in seven (7) CMHC regions.

For SFY 2016, DBHDID is anticipating providing start-up funds in a similar manner for drop in centers for youth and young adults, similar to “Youth Move Oregon” programming. DBHDID

was provided impetus for providing this initiative through the awarding of some grant opportunities, including the 5% set aside of Mental Health Block Grant funding for developing early interventions for first episode of psychosis.

DBHDID has provided training for adult and family peer support specialists for many years, beginning in 2006. Although peer support was not yet a Medicaid billable service, a few CMHCs and at least one (1) state psychiatric hospital hired adult and family peers. In 2008, a DBH regulation was passed into law, guiding implementation efforts. However, the regulation specified adult peer support only for individuals with serious mental illness or a co-occurring disorder. During SFY 2013, DBH formed a peer support workgroup, including peers and stakeholders from both mental health and substance use disorder programming, both inside DBH and from CMHCs. This workgroup focused on integrating the peer support specialist training curriculum to include both mental health and substance use disorders. The result was a thirty (30) hour training curriculum, provided by individuals in recovery that would be provided for all adults in recovery from behavioral health disorders. SAMHSAs working definition of behavioral health recovery, including the four (4) dimensions and the ten (10) principles, were integrated into this training curriculum. Since 2013, adult peer support specialist trainings have been completed in an integrated fashion, including all individuals, regardless of diagnoses. Peer specialists who were certified then began working in various types of programming across the state, including substance use disorder programs. In addition, the workgroup made suggestions of necessary changes to the current DBH adult peer support regulation, to be inclusive of all individuals. When peer support became a Medicaid billable service in January of 2014, more revisions were necessary to the regulation. During SFY 2015, the revised peer support regulations were finalized. Kentucky now has three (3) types of peer support that are billable through Medicaid: adult peer support; youth peer support; and family/parent peer support. Each service is available through both mental health and substance use disorder programming. Also, beginning in SFY 2015, DBH added language to CMHC contracts requiring the hiring of at least 2.0 FTE adult peer support specialists to work with individuals moving out of personal care homes and other institutions. All CMHCs began to hire peers. At present, all CMHCs have hired at least one (1) adult peer specialist, and most have hired several. CMHCs have had to rewrite hiring policies, supervision policies and overcome other obstacles that have traditionally made hiring peers difficult. As of May of 2015, approximately eighty-six (86) adult peer specialists were working in the CMHCs, most of them on a part-time basis. One (1) state psychiatric facility had hired an adult peer specialist, and another state psychiatric facility contracted with an organization to provide several peer specialists to work with individuals hospitalized at their facility. Several CMHCs also have hired family/parent peer specialists and a few CMHCs have hired youth peer specialists. In the SFY 2016 CMHC contracts, there is a new requirement to hire at least 2.0 FTE adult peer support specialists for substance use disorder programming. Peer support is expected to grow in all areas across the state.

Assertive Community Treatment (ACT) also became a Medicaid billable service in January of 2014. DBH required CMHCs to include peer specialists on their ACT teams, in an effort to enhance the focus on the recovery of the individual being served. Although Supported Employment and Supportive Housing were not part of the new Medicaid State Plan Amendment, and therefore not Medicaid billable services for Kentucky, DBH also provided some guidance around these evidence based practices and their promotion of recovery. In SFY 2015 CMHC contracts, each CMHC was required to provide supported employment through the Individual Placement and Support (IPS) Dartmouth model and supported housing through the Permanent Supportive Housing (PSH) SAMHSA model. As of April 2015, all CMHCs had supported employment programming for adults with SMI and most had a housing coordinator and were working toward PSH model.

DBHDID worked collaboratively with Kentucky Medicaid to submit the State Plan Amendment that was approved by CMS in January of 2014. DBH contributed some recovery oriented language and some person centered planning requirements were included in service descriptions. In addition, DBH developed a service standards workgroup and many standards, designed to guide delivery of services in a recovery oriented manner, were incorporated into contracts and practices.

DBH has embraced SAMHSAs working definition of recovery in its programming and has made efforts to incorporate these recovery oriented ideals across the state. Some efforts made by DBH to promote recovery principles and recovery oriented practice for the state workforce includes the following:

- Advancing Recovery Conference in March of 2014 in collaboration with KyPRA. Offered national speakers, Darby Penney of the “Suitcase Exhibit” and Stephen LeMaster, person centered planning. Also included a panel discussion with a team of stakeholders from various state agencies and a peer who had moved to independent housing from a personal care home. Targeted all staff, including peer specialists, who were working with individuals wanting to move from institutions into independent housing;
- Webinar hosted by DBH in February of 2014 for all CMHC and other contracted entities who supervised adult peer specialists. Discussed recovery principles, issues related to hiring and supervising peers;
- Workshops on Developing Readiness for Change, hosted by DBH in collaboration with KyPRA. Provided by team consisting of a professional and a peer, discussing the importance of individualized care and recovery orientation;
- Workshop in June of 2014, on Crisis Planning, specifically for individuals with SMI, provided by DBH in collaboration with KyPRA. Provided by a team of a professional and a peer. Focused on importance of utilizing peer support and other available supports to enhance recovery;
- Webinar hosted by DBH in April 2014 for all CMHC and other contracted entities who supervised adult peer specialists. Discussed continued issues related to hiring and supervising peers and promoting recovery;
- Series of Webinars hosted by DBH in fall of 2013 and spring of 2014 related to implementation of the Interim Settlement Agreement. Focused on education of stakeholders, including a variety of state agencies and CMHCs on the principles of recovery and the importance of individualized care; and
- Statewide Targeted Case Management Conference in March 2015. Had workshops taught by peers that focused on the definition of recovery, the principles of recovery, ethics related to recovery oriented services, and the dimensions of recovery.

DBH has also been dedicated to the implementation of person centered planning across the state. In SFY 2015, all CMHC contracts included a requirement for the provision of person centered planning for all adults with SMI. DBH partnered with two (2) national consultants on person centered planning, Janis Tondora, PsyD., from Yale University and Diane Grieder, M.Ed., from Alipar, Inc. Beginning in SFY 2015, the following efforts were made regarding person centered planning and shared decision making:

- Two (2) day workshop on person centered planning in Morehead, Kentucky, by Janis Tondora and Diane Grieder. Focused on individuals working at CMHCs and other contracted entities as part of the Interim Settlement Agreement. Focused on an overview of recovery principles and shared decision making, stages of recovery/stages of change, and hands on implementation of a strengths based assessment and treatment planning process;
- A series of technical assistance phone calls/webinars, hosted by DBH, provided by Janis Tondora and Diane Grieder, to assist regional staff with honing person centered skills in a medical necessity environment;

- Two (2) day workshop on person centered planning in Hopkinsville, Kentucky, by Janis Tondora and Diane Grieder. Focused on individuals working at CMHCs and other contracted entities as part of the Interim Settlement Agreement. Focusing on an overview of recovery principles and shared decision making, stages of recovery/stages of change, and hand on implementation of a strengths based assessment and treatment planning process;
- Webinars for targeted state agencies on the process of person centered planning and shared decision making hosted by DBH and provided by Janis Tondora and Diane Grieder;
- A series of technical assistance coaching calls to CMHCs and other contracted entities to discuss and guide training for implementation of the person centered planning model in various agencies;
- Development of a recovery oriented indicators tool, by Janis Tondora and Diane Grieder, to further guide implementation and monitoring of the initiative; and
- Key note speaker at the statewide Targeted Case Management Conference in March 2015 was Janis Tondora, discussing person centered planning and shared decision making for all individuals.

Since 1989, DBH has supported the Oxford House model for individuals in recovery from substance use disorders. DBH has been partnering with organizations such as Kentucky Housing Corporation (KHC) to support housing that fits the Oxford House model. Partnerships also include the Department for Veteran's Affairs to provide additional funding for the establishment of Veteran Oxford Houses. The Oxford House model is evidence based and provides support for six (6) to twelve (12) individuals in recovery from substance use disorders to live in a recovery oriented environment of their choice, paying their own rent and utilities, and establish common housing guidelines in a democratic manner with other residents.

In February 2014, Kentucky's governor announced the kyhealthnow initiative, an effort to improve the health and wellness of Kentucky's citizens. This initiative outlined seven (7) key health goals for Kentucky to work toward during the next five (5) years. These initiatives include:

- Reduce Kentucky's rate of uninsured individuals to less than 5%;
- Reduce Kentucky's smoking rate by 10%;
- Reduce the rate of obesity among Kentuckians by 10%;
- Reduce Kentucky cancer deaths by 10%;
- Reduce cardiovascular deaths by 10%;
- Reduce the percentage of children with untreated dental decay by 25% and increase adult dental visits by 10%; and
- Reduce deaths from drug overdose by 25% and reduce by 25% the average number of poor mental health days of Kentuckians.

An executive order following, establishing an oversight team to provide oversight of the efforts to meet these goals. This team includes several departments within the Cabinet for Health and Family Services including the Department of Public Health and DBHDID, as well as the Office of Health Policy. The governor also executed an order to expand the prohibition of all tobacco products and e-cigarettes in executive branch buildings in Kentucky. This order took effect November 20, 2014. This order impacts 33,000 state workers, 2,888 state owned building and hundreds of thousands of visitors.

During SFY 2013, CMHC contracts included the requirement to designate a staff person to coordinate Veteran's services. DBH also designated a program administrator to focus on coordinating services to satisfy statewide behavioral health needs for the Veteran population. Kentucky has two (2) Veteran's Medical Centers, two (2) military bases, and a variety of other

service related resources. However, CMHCs serve many Veterans across the state for behavioral health issues for a variety of reasons. Currently, DBH is working to develop a peer support network for Veterans who receive services through the public behavioral health system. Many Veterans in recovery from behavioral health issues have been certified as peer support specialists. Some of those are working in the veteran's medical centers and others are working in CMHCs or for private providers.

On May 1, 2015, DBH convened a meeting of recovery staff across programs, to discuss peer support/recovery planning. This meeting resulted in a consensus statement on peer support from DBH which included the following:

- DBH promote SAMHSAs principles of recovery and believes that all individuals can recovery, leaders will find value in this framework and DBH has a role in changing attitudes;
- DBH adopts SAMHSAs working definition of adult behavioral health recovery and the ten (10) guiding principles of recovery;
- DBH adopts a working definition of system of care for children with emotional disorders, including accompanying guiding principles;
- DBH has a vital role to ensure peer support is embedded in the public behavioral health system and that:
 - Peer support is essential to recovery
 - DBH is obligated to provide strong leadership in this area
 - DBH is obligated to lead in development of a strong workforce that can deliver high quality services (Pillars of Peer Support)
 - DBH should set standards around Kentucky peer support
 - Formal and informal peer support has value
 - Peers have a valued role in a variety of service settings
 - Lived experience is a key feature of the peer support role
 - Programs and services should incorporate a recovery approach and fully involve people with lived experience in program/services design, development, implementation and evaluation
 - Peers should have a defined role and this role should be clearly communicated and understood by all staff
 - DBH should incorporate best practices in the delivery of peer support
 - Supervisors have a key role in raising awareness and in supporting growth and development of peer support
 - DBH needs to partner with individuals in recovery, youth and family members, supervisors, staff, agency leadership, and community stakeholders in raising awareness and promoting their principles and values

Lastly, DBHDID has an Olmstead Plan to address the needs of individuals in restrictive environments and their rights to reside in communities of their choice. (See Environmental Factors and Plan #17). In addition, the Cabinet entered into an Interim Settlement Agreement in August of 2013 with Kentucky Protection and Advocacy, to move individuals with SMI out of personal care homes and into communities of their choice. (See Environmental Factors and Plan #17)

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead

Narrative Question:

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in [Olmstead v. L.C., 527 U.S. 581 \(1999\)](#), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated arrangement appropriate and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to Section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office of Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other residences that have institutional characteristics to house persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.
2. How are individuals transitioned from hospital to community settings?
3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?
4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan:

Environmental Factors: #17. Community Living and the Implementation of Olmstead

Kentucky has an Olmstead Compliance Plan in response to the landmark civil rights case of Olmstead in 1999, when the Supreme Court held that it is discriminatory and unlawful for governments to keep persons with disabilities in segregated settings when they are capable and desire to reside in the community. Kentucky's first Olmstead Compliance Plan was in 2002. The Cabinet established a committee to continually review and update progress on Olmstead goals. Kentucky's current Olmstead Plan consists of nine (9) goals:

1. All persons with any disability will experience meaningful, inclusive and integrated lives in their community supported by an array of services, in a setting of which they choose, according to individual need, with input from their families and legal guardians as required.
2. Education/Outreach to prevent facility placement, with input from his/her family and legal guardian, as required.
3. Assure that persons with disabilities are not incarcerated for minor offenses that are a result of their disability. Assure persons with disabilities who leave correctional institutions or other institutions are able to access needed community based services with family and legal guardian input, as required.
4. All transition age youth (14-25 years old) will have a seamless transition to adulthood through the effective and efficient use of evidence based programs and practices that are developmentally appropriate, according to individual choice and need with family and guardian input, as required.
5. Increase available, accessible, quality, and affordable community housing.
6. Ensure a safe and appropriate transition from an institution to a community setting.
7. Kentuckians with disabilities will have choices for competitive, meaningful, and sustainable employment in the most integrated setting, according to individual choice and need, with input from families and guardians, as required.
8. Individuals with disabilities will have access to reliable, cost-effective, and accessible transportation choices that support the essential elements of life such as employment, housing, education, and social connections.
9. Ensure allocation of quantifiable, measurable tasks in regard to the elements of the Olmstead plan, including regular updates in order to ensure that the Commonwealth progresses toward the vision of protecting the rights of persons with disabilities. In order to do so, the Commonwealth will sustain a Cabinet level Olmstead Committee, measure progress on strategies, and update the Olmstead plan on a minimum of twice a year.

In the process of implementing the first Olmstead Compliance Plan, DBHDID developed more supports for individuals with serious mental illness. Behavioral health funding is made available specifically for individuals in institutions who meet the Olmstead criteria. Each of four (4) state psychiatric hospital catchment areas receives \$200,000 each year to serve individuals in their area. Regional Olmstead committees were formed, consisting of DBH representatives and staff from CMHCs, state psychiatric hospitals, and other community stakeholders. Currently these committees meet monthly, at each state psychiatric facility to discuss individual needs and resources specific to each catchment area. In addition, a statewide quarterly Olmstead committee was developed and is hosted by DBH, and includes representatives from DBH, CMHCs, state psychiatric facilities, state nursing facilities, specialized personal care homes, National Alliance on Mental Illness (NAMI) and other community partners. This quarterly meeting allows a structure to discuss systemic issues and possible barriers to implementation of necessary community services.

Housing services are essential in this process. DBH provides funding to the Kentucky Housing Corporation (KHC) specifically for Olmstead Housing Initiative (OHI) vouchers. These vouchers are to serve the Olmstead population and can be used in a variety of ways including for rent, security deposits, furniture, utility deposits, etc. These vouchers are often the flexible funding

needed to make a transition successful. At present, DBH provides \$386,000 per year for OHI vouchers. In addition, DBH provides funding to the Louisville Metro Housing Authority that provides fifty (50) OHI vouchers for individuals who meet Olmstead criteria in Jefferson County.

In August 2013, the Cabinet for Health and Family Services entered into an Interim Settlement Agreement (ISA) with Kentucky Protection and Advocacy, to avoid litigation concerning the institutionalization of adults with SMI who resided in personal care homes in Kentucky. Estimates of persons impacted under this agreement range as high as 2,300 individuals, with an original list of 130 individuals with SMI who expressed a desire to move out of personal care homes and into housing in the community. The agreement was to move at least six hundred (600) individuals with SMI out of personal care homes within a three (3) year period. As a result of ISA, efforts were made by DBH to create a new and expanded system of care for these individuals. DBH contracted with CMHCs to provide Direct Intervention: Very Early Response Treatment System (DIVERTS) services across the state to individuals with SMI who expressed a desire to live in the community. Kentucky's new Medicaid State Plan Amendment was approved by CMS a few months later, in January of 2014, making the new service system more sustainable.

DIVERTS services consists of the following evidence based services and supports for individuals with SMI:

- Assertive Community Treatment (ACT);
- Peer Support;
- Supported Employment;
- Supportive Housing;
- Targeted Case Management; and
- Crisis Services.

CMHC contracts were rewritten and required provision of DIVERTS services for individuals moving out of personal care homes and for individuals at risk of readmission to a personal care home, hospital or other institution. DBHDID provided approximately \$7 Million of funding for the first year and approximately \$6 Million of funding for the next two (2) years for the ISA. These funds were made available partially from state psychiatric facility budgets, thus "rebalancing" some behavioral health funding into the community. CMHCs developed new services and began providing in reach to individuals with SMI in personal care homes and other institutions. DBH program administrators were reorganized in an effort to assist with program development and the terms of the ISA. An entirely new web-based data system was created to track ISA data and milestones.

The desired outcomes of the ISA are as follows:

- Individuals with a serious mental illness, who reside in the Commonwealth of Kentucky, are afforded the opportunity for safe, productive and fully integrated lives within their chosen communities;
- The Kentucky Cabinet for Health and Family Services ensures resources and the delivery of supports to individuals; via policy implementation, oversight, funding, and provision of technical expertise for related Community Mental Health Center activities; and
- Terms identified within the Interim Settlement Agreement are met or exceeded; with progress and quality measured by defined formal reports and established processes.

Due to the ISA, several collaborative efforts have resulted in positive changes in the service system. For example, collaboration with the Department for Medicaid Services and the Department for Community Based Services resulted in a change in the traditional state supplement for individuals with SMI living in personal care homes. The program is now called Community Integration Supplement (CIS) and can now be effective for these individuals as an

effort to prevent institutionalization, not just available when they are in an institution. Another example is the collaboration with the Department for Aging and Independent Living (DAIL) and their state guardianship office. State guardians are collaborating with service providers in securing community housing for their individuals with SMI. In addition, because of ISA, \$1 Million in additional funding was made available in SFY 2016 to KHC specifically for OHI vouchers targeting individuals served under ISA.

DBH is currently working on several issues related to Olmstead and ISA, including leveraging a Transformation Transfer Initiative (TTI) grant award to assist with developing peer bridging services through state psychiatric facilities. Also, funding from the 5% set aside for Early Interventions for First Episode of Psychosis is being leveraged to positively affect these initiatives as well. DBH is working with CMHCs to provide technical assistance to strengthen the new service system and work toward full Medicaid sustainability for all relevant necessary services. DBH is currently working toward a strategic plan for ISA in hopes to continue and strengthen efforts for this vulnerable population. In the future, DBH hopes to focus more on outcomes vs infrastructure.

Lastly, DBH has a long term goal of preventing unnecessary admission into institutions, including personal care homes and psychiatric hospitals, and assisting individuals with SMI to move toward their paths to recovery as early as possible and with individualized, quality supports and services.

Environmental Factors and Plan

18. Children and Adolescents Behavioral Health Services

Narrative Question:

MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious mental disorder that contributes to substantial impairment in their functioning at home, at school, or in the community.⁹⁰ Most mental health disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.⁹¹ For youth between the ages of 10 and 24, suicide is the third leading cause of death.⁹²

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.⁹³ Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

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 more than 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.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or substance use disorders and co-occurring disorders and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child's, youth's and young adult's functioning in their home, school, and community. The system of care approach provides individualized services, is family driven and youth guided, and builds on the strengths of the child, youth or young adult and their family and promotes recovery and resilience. Services are delivered in the least restrictive environment possible, and using evidence-based practices while providing effective cross-system collaboration, including integrated management of service delivery and costs.⁹⁴

According to data from the [National Evaluation of the Children's Mental Health Initiative](#) (2011), systems of care⁹⁵:

- reach many children and youth typically underserved by the mental health system;
- improve emotional and behavioral outcomes for children and youth;
- enhance family outcomes, such as decreased caregiver stress;
- decrease suicidal ideation and gestures;
- expand the availability of effective supports and services; and
- save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious 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 consider the following items as a guide when preparing the description of the state's system:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious 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?
6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?
7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

Please indicate areas of technical assistance needed related to this section.

⁹⁰ Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

⁹¹ Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

⁹² Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

⁹³ The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

⁹⁴ Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from <http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010>.

⁹⁵ Department of Health and Human Services. (2013). Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions: Joint CMS and SAMHSA Informational Bulletin. Available from <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf>.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plans

#18. Child and Adolescent BH Services

Narrative 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 serious mental and substance use disorders?*

The state has an established system of care approach and is currently implementing its fourth SAMHSA Grant around Children's system of Care. More detail is available in Criteria 1 and 3 in Section II –Planning Step 1, of this document.

2. *What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance use, and co-occurring disorders?*

Contracted providers are required through contract to ensure that all treatment and service plans are individualized, strengths-based and person centered. Monitoring of records and continually training and technical assistance are provided aimed at compliance with these services standard practices.

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.)?*

This is addressed at length in Criterion 1 and 3 of Section II – Planning Step 1 of this document.

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?*

The most exciting among several initiatives to ensure this is the launching of the KY Institute for Excellence in BH to support publicly funded providers to learn about and implement EBPs with fidelity.

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?*

Kentucky will monitor and track service utilization, costs and outcomes in a variety of ways. Again, these are discussed in the Criterion included in Section II of this document and highlighted below:

- *Data analysis, data sharing with other child serving agencies, and qualitative data gathering*
- *Financial Mapping*
- *Annual Plan and Budget Submission with quarterly and semi-annual reporting requirements*
- *Consultation from national leaders in financing and program development (Sheila Pires, Collette Croze, Mary Armstrong, etc.)and with local providers and other state agency partners*
- *IMPACT Outcomes Management System for Children with SED who are receiving High Fidelity Wraparound/Targeted Case Management (TCM) services*

6. *Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?*

DBHIDD has ongoing collaboration with multiple representatives from the KY Department for Education through the SIAC and other initiatives and will strive to continue these to collectively address the needs of children, youth and families.

7. *What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.*

*Twenty one is the age at which services from the child/adolescent system end and there is currently much work being done to address the population of transition aged youth, including those aging out of foster care/child welfare system. **The Youth Aging Out of Foster Care Committee** is chaired by KY Protection and Advocacy and meets monthly to collaborate on issues related to youth in foster care transitioning to adulthood and the services and supports that can be provided to these individuals.*

The Department has a process in place to provide consultation for transition aged youth with BH concerns. (See attached.)

Department for Behavioral Health, Developmental and Intellectual Disabilities
Transition Age Youth (TAY) Consultation Process
March 6 2014

Purpose: To develop an internal procedure that can be initiated by providers for consultation with the DBHDID regarding service needs for youth and young adults between 14-25 years old who are in out of home care and who need recommendations to include in a transition plan to adult oriented permanent, stable living situations and treatment for behavioral health/developmental and/or intellectual disabilities.

Vision: That all youth and young adults with behavioral health, developmental and/or intellectual disability issues who are in need of adult oriented permanent, stable living situations and treatment needs will be able to access these services seamlessly, utilizing a person-centered planning approach to care.

Consultation Eligibility:

- Youth or young adults between 14-25 years old
- Have behavioral health and/or developmental or intellectual disability
- They are presently in out of home care
- Consultation is needed to assist in providing recommendations regarding adult oriented permanent, stable living situations and treatment for behavioral health or developmental disability needs to include in a transition plan.
- **It is expected that consultation will be utilized at least 6 months prior to the youth's 18th birthday or at least 6 months prior to discharge from present living situation in order to provide purposeful recommendations for a seamless transition to an adult oriented permanent, stable living situation/treatment provider.**

DBHDID Personnel/Technology Involved:

1st Point of Contact (POC):

- One office based staff available by phone/fax/email for each Division in order to ensure a lead and back-up POC.
- They will receive all pertinent information from referrals for the TAY Consultation Team
- Qualities/Characteristics – an active listener, can ask open ended questions, engaging, they don't cut people off, thorough, organized – can gather information and send it on in an organized/coordinated fashion.

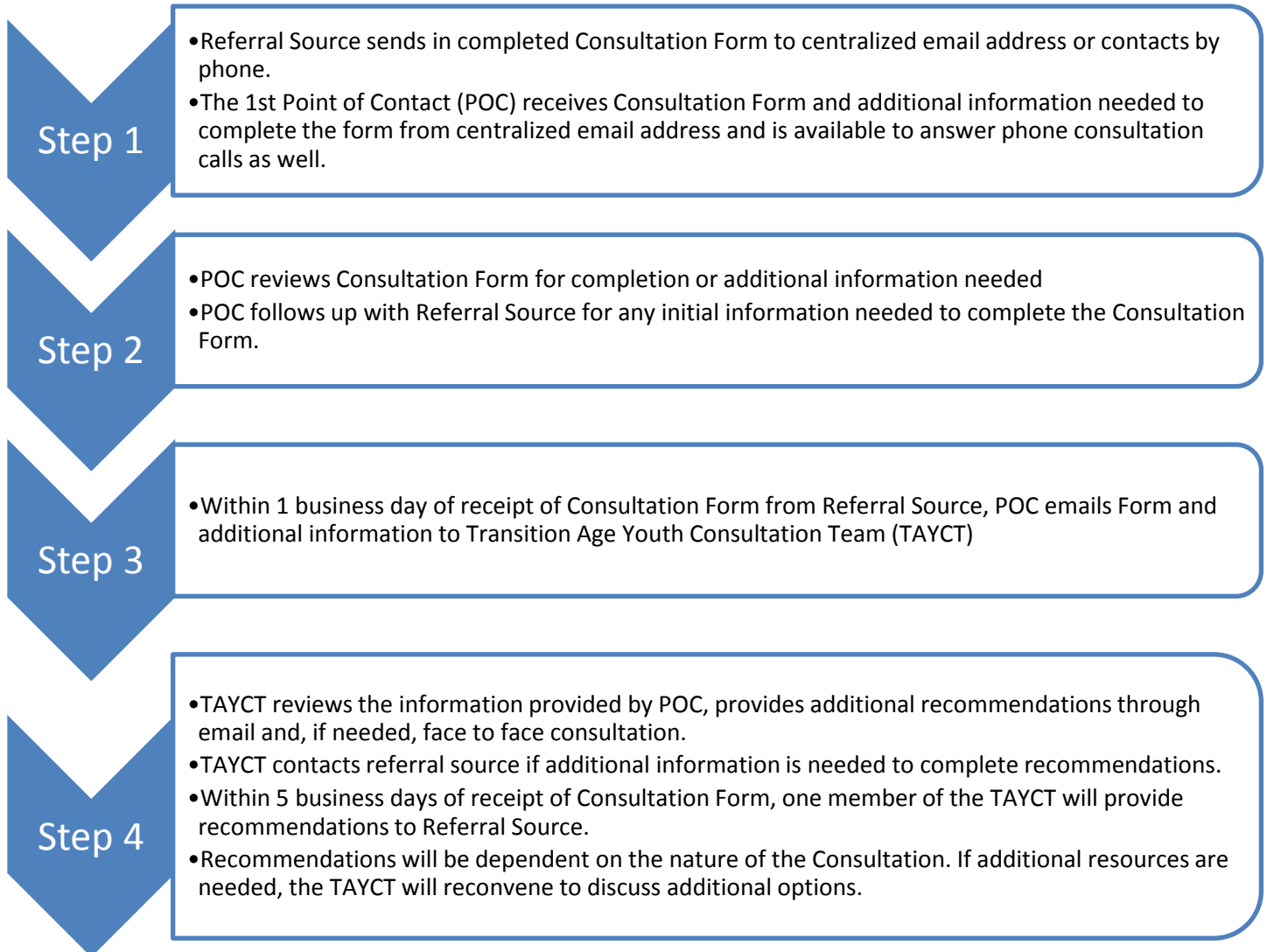
TAY Consultation Team (TAYCT):

- Clinical personnel who have knowledge of transition age youth issues as well as potential treatment and living situation resources (at least one person from DID and OTEB, one person from DBH – Children's Branch and one person from DBH – Adult Branch).
- Within the DBH – A Children's branch team member will provide consultation for children under 18 years of age and an Adult branch team member will provide consultation for adults 18 years of age and older, although both will be included on the Consultation Team and can provide consultation on all referrals as needed.
- These staff will need to be able to respond to consultation requests on an as needed basis within 5 business days

Centralized Email/Phone#/Fax#:

- Centralized contact information such as tayconsultation@ky.gov will be developed for referral sources to use to send in Consultation referral form and additional information.
- The 1st Point of Contact will receive consultation forms and information from this email account, by phone or by fax

Transition Age Youth (TAY) Consultation Process



Additional Items to Consider:

- Need to review the MOU between DID and DCBS related to TAY and placement
- May want to consider developing a centralized website for all TAY resources
- May want to consider providing a short webinar or training on transition planning for providers (that includes why to start early, various resources, the importance of youth guided treatment)

Department for Behavioral Health, Developmental and Intellectual Disabilities
Transition Age Youth (TAY) Consultation Form
March 2014

Date of Referral for Consultation:

Time of Referral for Consultation:

Referral Name:

Referral Phone #:

Referral Email Address:

Consumer/Client Name:

Birthdate:

Diagnosis:

IQ:

TWIST # (if in DCBS Custody):

TWIST Placement Log if in DCBS Custody (please attach)

What are the youth's/young adult's specific wishes regarding a permanent, stable living situation and treatment needs:

Present Challenges:

Reason for Referral:

Referral Source's Recommendations for Care:

What type of services/supports are you hoping to get information about?

Current Placement:

Potential discharge date from present placement:

Reason for potential discharge from present placement:

Have you consulted with the Regional Interagency Council (RIAC) prior to this request for consultation?

Yes No – If no, please state the reason:

If you consulted with the RIAC, please indicate the date of consultation and recommendations received from the RIAC.

Environmental Factors and Plan

19. Pregnant Women and Women with Dependent Children

Narrative Question:

Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant ([Title XIX, Part B, Subpart II, Sec.1922 \(c\)](#)). A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a "set-aside" was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations. MOE provisions require that the state expend no less than an amount equal to that spent by the state in a base fiscal year for treatment services designed for pregnant women and women with dependent children.

For guidance on components of quality substance abuse treatment services for women, States and Territories can refer to the following documents, which can be accessed through the SAMHSA website at <http://www.samhsa.gov/women-children-families>: *Treatment Improvement Protocol (TIP) 51, Substance Abuse Treatment; Addressing the Specific Needs of Women; Guidance to States; Treatment Standards for Women with Substance Use Disorders; Family-Centered Treatment for Women with Substance Abuse Disorders: History, Key Elements and Challenges*.

Please consider the following items as a guide when preparing the description of the state's system:

1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.
2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.
3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.
4. Discuss who within your state is responsible for monitoring the requirements in 1-3.
5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)
 - a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
 - b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?
6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)
 - a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
 - b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

KIDS NOW Plus

2015 Annual Outcome Report



Reductions in substance use

95%

The number of clients reporting illegal drug use decreased from 44% in the 30 days before pregnancy to 2% in the 30 days before the baby was born

100%

The number of clients reporting alcohol use decreased from 37% in the 30 days before pregnancy to 0% in the 30 days before the baby was born

67%

The average number of cigarettes clients reported smoking decreased 67% from 19 in the 30 days before pregnancy to 6 in the 30 days before the baby was born

EXECUTIVE SUMMARY

The KIDS NOW Plus case management program was implemented in eight sites across the state to increase positive birth outcomes for pregnant women in Kentucky who are at risk for negative birth outcomes.

This report summarizes outcome study findings for the KIDS NOW Plus case management program by examining birth and infant outcomes as well as: (1) substance use; (2) mental health; (3) intimate partner violence; and (4) quality of life. Specifically, this report describes outcomes for 136 pregnant KIDS NOW Plus program clients who participated in the KIDS NOW Plus case management program, completed a face-to-face intake interview with program staff between January 2013 and June 2014, completed a 6-month follow-up after the birth of their baby, were served in a KNP region, and who had a match to the vital statistics data set.

KIDS NOW Plus clients reported behavioral health risks associated

with negative birth outcomes including high rates of smoking, alcohol and illegal drug use, depression or anxiety, and intimate partner abuse. Overall, clients were an average of 24 weeks pregnant when they entered the program and were in the program an average of 18 weeks. Clients were about 25 years old (4% of which were 18 and under) and almost one quarter had less than a high school diploma or GED. The majority of clients (71%) were unemployed at prenatal intake and about half of clients had difficulty meeting basic or healthcare needs for financial reasons in the 6 months before they found out they were pregnant.

Compared to a matched comparison group of women who gave birth during the same timeframe, clients in the program used more clinical services such as individual substance abuse or mental health therapy, intensive outpatient, and group therapy. Besides the additional clinical services received by pregnant women in KIDS NOW Plus case management, significantly more clients were enrolled in Women Infants and Children (WIC).

In spite of the risk factors the KIDS NOW Plus mothers had before participating in the program, their birth outcomes were very positive overall, and were nearly identical to the general population of mothers and babies. After controlling for factors such as mother's age, education, area of residence, and

Despite significant risk factors, **KIDS NOW Plus mothers had birth outcomes that were very positive overall and were similar to the general population of mothers and babies.**

Reductions in mental health symptoms

63%

The number of women who met study criteria for depression decreased 63% from 18% in the 6 months before pregnancy to 7% in the past 6 months at postnatal follow-up

55%

The number of women who met study criteria for generalized anxiety decreased 55% from 32% in the 6 months before pregnancy to 15% in the past 6 months at postnatal follow-up

73%

The average number of days in the past 30 days clients reported their mental health was not good decreased 73% from 9.6 days at prenatal intake to 2.6 days at postnatal follow-up

smoking status at birth, the two groups of mothers had similar birth outcomes for the percentage of babies born premature, babies' average birth weight, percentage of mothers experiencing birthing problems, percentage of babies taken to the neonatal intensive care unit, percentage of women breastfeeding and the average highest APGAR score.

All the mothers in the follow-up sample reported their babies were doing "good" or "great" and both the mother and the baby's father were very excited about the baby. The majority of clients felt confident about being the mother of an infant and felt that life with a new baby was very manageable. Also, the majority of clients had someone to turn to for emotional support both during pregnancy and after the birth of the baby.

Furthermore, fewer pregnant mothers reported substance use while in the program compared to before being pregnant. And, these reductions were sustained six months after the birth of their baby. In addition, significantly fewer

clients reported smoking after becoming involved in KIDS NOW Plus, and those who did smoke, smoked fewer cigarettes compared to before pregnancy. Specifically, there was a 33% reduction in the number of clients who reported smoking which is notably different from previous years which found stable rates of smoking throughout pregnancy and at postnatal follow-up.

There was also a reduction in depression, anxiety, and co-occurring depression and anxiety from intake to follow-up. Clients who did experience mental health problems reported significantly fewer symptoms after becoming involved in KIDS NOW Plus. These improvements in mental health problems were sustained after the birth of the baby.

In addition, clients' reported physiological symptoms associated with stress decreased significantly from prenatal intake to postnatal follow-up.

The safety of the women involved in KIDS NOW Plus also improved. The number of clients who reported any intimate partner abuse significantly decreased after becoming involved in the KIDS NOW Plus case management program.

In addition to these targeted risk factors, there were improvements in other general areas of the mothers' lives after becoming involved in the KIDS NOW Plus program including a reduction in chronic pain and improved overall health. Women also reported improved economic conditions with significantly fewer clients reporting having difficulty meeting basic living or health care needs as a result of financial problems.

Clients reported significantly higher

There was a **33% reduction in the number of pregnant clients who reported smoking** which is notably different from previous years which found stable rates of smoking.

Increase in safety

46%

The number of clients who reported experiencing any type of intimate partner abuse decreased 46% from 27% in the 6 months before pregnancy to 15% in the past 6 months at postnatal follow-up

67%

Compared to the six months before pregnancy, the percentage of clients reporting being a victim of psychological abuse decreased 67% in the 6 months after the baby was born (from 22% to 7%, respectively)

78%

The number of clients who reported being a victim of physical abuse decreased 78% from 13% in the 6 months before pregnancy to 3% in the past 6 months at postnatal follow-up

quality of life after the program, having significantly more positive feelings and significantly less negative feelings, and an overall greater satisfaction with life at postnatal follow-up compared to prenatal intake.

Further, program clients were overwhelmingly satisfied with KIDS NOW Plus case management services they received. In particular, clients reported they learned about the risks of tobacco, alcohol and drugs during pregnancy, had improvements in their mental health, felt safer from intimate partner violence, believed they had

a healthier pregnancy, and felt better about themselves as direct results of their participation in the KIDS NOW Plus program. Also, the majority of clients indicated they would recommend the program to a friend.

Overall, evaluation results indicate that the KIDS NOW Plus case management program has been successful in facilitating positive changes in clients in a variety of inter-related risk factors including substance use, mental health symptoms and intimate partner violence. Results also indicate clients appreciate their

experiences in the program and have a better quality of life after participation. These changes suggest there would be significant benefit in sustaining and expanding the KIDS NOW Plus program to serve more high-risk pregnant women across the state.

Clients reported they **learned about the risks of tobacco, alcohol and drugs during pregnancy**, had **improvements in their mental health, felt safer from intimate partner violence**, believed they **had a healthier pregnancy**, and **felt better about themselves** as direct results of their participation in the KIDS NOW Plus program



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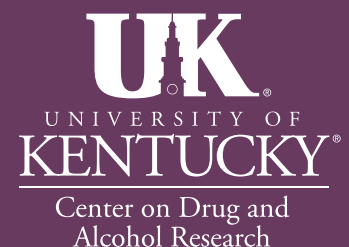
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Prenatal assessments for the entire period examined were completed between January 2013 and June 2014. Postnatal assessments completed between August 2013 and August 2014 for women who women gave birth between January 2013 and January 2014.

Suggested citation: Logan, TK, Scrivner, A., & Cole, J. (2015). *KIDS NOW Plus 2015 Annual Outcome Report*. Lexington, KY: University of Kentucky, Center on Drug and Alcohol Research.

OVERVIEW OF THE REPORT

This report presents the results of an outcome evaluation of the KIDS NOW Plus case management program. This outcome evaluation was conducted by the Behavioral Health Outcome Study team at the University of Kentucky Center on Drug and Alcohol Research (UK CDAR) at the request of the Division of Behavioral Health in the Department for Behavioral Health, Developmental and Intellectual Disabilities. The evaluation results are organized into 13 main sections as outlined below.

Section 1: Introduction and Evaluation Method. This section briefly describes the KIDS NOW Plus case management program and how clients are selected into the outcome evaluation.

Section 2: Description of KIDS NOW Plus Case Management Program Clients Who Were Followed-Up. Section 2 describes the KIDS NOW Plus client characteristics for the 136 clients who completed a prenatal intake between January 2013 and June 2014 and completed a six month postnatal follow-up assessment between August 2013 and August 2014. Characteristics examined include risk status, age, race, marital status, metropolitan/non-metropolitan status, socioeconomic status (i.e., education, employment, public assistance and socioeconomic hardships), and living situation.

Section 3: Clinical Services. This section examines case management services received by KIDS NOW Plus clients while in the program as well as mental health diagnosis. In addition, it compares services received by KIDS NOW Plus clients to those received by women with similar socioeconomic characteristics who gave birth during the same time period but who were not part of the program.

Section 4: Pregnancy Status. Section 4 describes the clients' pregnancy status at prenatal intake as well general feelings and attitudes towards their pregnancies including: (1) expectations and feelings about the baby; (2) general information regarding the pregnancy/baby; and (3) planned method of birth control. Comparisons are made from prenatal intake to postnatal follow-up where applicable.

Section 5: Birth Events and Outcomes: KIDS NOW Plus Case Management Clients Compared to the General Population of Mothers within the Regions Served by KIDS NOW Plus. This section uses the Kentucky Vital Statistics birth data to examine (1) general risk factors; (2) targeted risk factors available from the Vital Statistics data set; and (3) birth events and outcomes of 136 KIDS NOW Plus case management clients and their babies compared to others in the state who had babies during the same period (between January 2013 and January 2014) but who did not participate in the KIDS NOW Plus Case Management study (n = 34,888).¹

Section 6: Substance Use. This section of targeted risk factors examines change in: (1) overall substance use (illegal drug and alcohol use); (2) use of illegal drugs, alcohol, and cigarettes; (3) problems experienced with substance use; (4) readiness for substance abuse treatment; and (5) substance abuse treatment and self-help meetings. Past 30-day and past-6-month substance use are examined separately where applicable.

Section 7: Mental Health. This section examines changes in self-reported mental health for the following factors: (1) depression; (2) generalized anxiety; (3) exposure to traumatic events; and, (4) number of days physical and mental health were poor. Past 30-day and past-6-month mental health symptoms are examined separately where applicable.

Section 8: Partner Abuse and Sexual Assault. This section examines changes in intimate partner abuse and violence such as: (1) psychological abuse, (2) coercive control, (3) physical abuse, and (4) sexual violence by any type

¹ Section 5 compares birth events and outcomes of KIDS NOW Plus mothers to the general population of mothers who resided in regions served by KIDS NOW Plus and who also gave birth during the same time period. Appendix D compares birth events and outcomes for three mutually exclusive groups including: (1) mothers involved in KIDS NOW Plus case management services; (2) a comparison group of mothers matched on selected characteristics (race, age, education, metropolitan/non-metropolitan residence, marital status and smoking status); and (3) a randomly selected group of mothers from the general population.

of perpetrator, from prenatal intake to postnatal follow-up. Past 30-day and past-6-month partner abuse measures are examined separately where applicable.

Section 9: Physical Health. Section 9 describes chronic health problems reported at prenatal intake and change in physical health status of clients from prenatal intake to postnatal follow-up including: (1) current health; (2) chronic pain; and (3) emergency room usage.

Section 10: Emotional Support. This section focuses on two main changes in emotional support: (1) the number of people the individual said they could count on for emotional support; and (2) client satisfaction with the level of emotional support from others.

Section 11: Stress and Quality of Life. This section examines changes in stress and quality of life including the following factors: (1) health consequences of stress; (2) quality of life ratings; (3) positive and negative experiences; and (4) satisfaction with life.

Section 12: Client Satisfaction with KIDS NOW Plus Case Management. This section describes four aspects of client satisfaction assessed by clients who completed a postnatal follow-up: (1) overall program satisfaction; (2) ratings of program experiences; (3) if the client would recommend the program to a friend; and (4) what clients found most useful from the program.

Section 13: Conclusion and Study Limitations. This section summarizes the report findings, discusses limitations, and describes implications of the main findings.

SECTION 1: INTRODUCTION AND EVALUATION METHOD

This section briefly describes the KIDS NOW Plus case management program and how clients were selected into the outcome evaluation.

KIDS NOW Plus is a state-funded prevention, outreach, and case management program aimed at reducing substance use during pregnancy. Alcohol, tobacco, and illicit drug use during pregnancy have been shown to negatively influence fetal development (including significantly decreased birth weight, and shorter gestational age) and women's health.^{2,3,4,5,6} In addition, substance use is often related to mental health problems and an increased risk of partner abuse and sexual assault.^{7,8} All three of these interrelated risk factors increase the likelihood of negative birth outcomes.^{9,10} Additionally, risks of negative birth outcomes are increased when women using alcohol and illegal drugs avoid obtaining prenatal care due to fear of losing custody of their babies or fear of being arrested.¹¹

The overall goal of the KIDS NOW Plus case management program is to increase positive birth outcomes for pregnant women in Kentucky who are at risk for negative birth outcomes by reducing these three targeted risk factors that impact the health of the pregnant mother, fetal development, and birth outcomes. The program has two components including providing: 1) substance abuse prevention education to pregnant women at all risk levels, and 2) client-centered intensive case management services to women at risk for substance abuse during pregnancy (referred to in this report as KIDS NOW Plus program).

The KIDS NOW Plus program case managers provide support, referrals, information, and other needed services (e.g., transportation) based on a client-centered format. This intervention focuses on meeting clients' needs as they evolve over time, as different risks manifest, and needs change as the pregnancy progresses.¹² By focusing on clients' needs, client-centered intensive case management encourages continued engagement in clinical services and helps with a

² Bailey, B. A., McCook, J. G., Hodge, A., & McGrady, L. (2012). Infant birth outcomes among substance using women: why quitting smoking during pregnancy is just as important as quitting illicit drug use. *Maternal and Child Health Journal*, *16*(2), 414-422.

³ Gouin, K., Murphy, K., & Shah, P. S. (2011). Effects of cocaine use during pregnancy on low birth weight and preterm birth: systematic review and metaanalyses. *American Journal of Obstetrics and Gynecology*, *204*(4), 340-e1-12.

⁴ Behnke, M., Smith, V. C., Levy, S., Ammerman, S. D., Gonzalez, P. K., Ryan, S. A., ... & Watterberg, K. L. (2013). Prenatal substance abuse: short-and long-term effects on the exposed fetus. *Pediatrics*, *131*(3), e1009-e1024.

⁵ Pinto, S. M., Dodd, S., Walkinshaw, S. A., Siney, C., Kakkar, P., & Mousa, H. A. (2010). Substance abuse during pregnancy: effect on pregnancy outcomes. *European Journal of Obstetrics & Gynecology and Reproductive Biology*, *150*(2), 137-141.

⁶ Young, N.K., Gardner, S., Otero, C., Dennis, K., Chang, R., Earle, K., & Amatetti, S. (2007). *Substance-Exposed Infants: State Responses to the Problem*. National Center on Substance Abuse and Child Welfare.

⁷ Logan, T., Walker, R., Jordan, C. & Leukefeld, C. (2006). *Women and victimization: contributing factors, interventions, and implications*. Washington, DC: American Psychological Association Press.

⁸ Kessler, R., McGonagle, K., Zhao, S., Nelson, C. Hughes, M., Eshleman, S., Wittchen, H., & Kendler, K. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: Results from the National Comorbidity Survey. *Archives of General Psychiatry*, *51*, 8-19.

⁹ Shah, P. S., & Shah, J. (2010). Maternal exposure to domestic violence and pregnancy and birth outcomes: a systematic review and meta-analyses. *Journal of Women's Health*, *19*(11), 2017-2031.

¹⁰ Schetter, C. D., & Tanner, L. (2012). Anxiety, depression and stress in pregnancy: implications for mothers, children, research, and practice. *Current Opinion in Psychiatry*, *25*(2), 141-148.

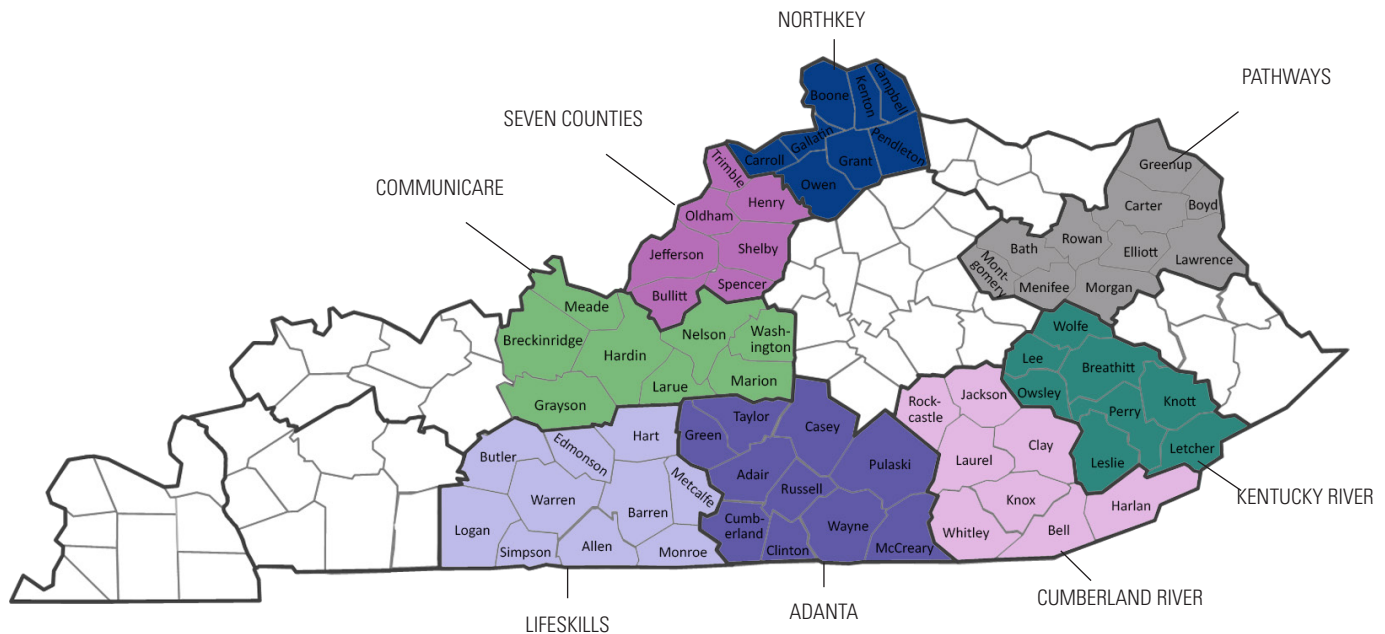
¹¹ Roberts, S.C & Nuru-Jeter, A. (2010). Women's perspectives on screening for alcohol and drug use in prenatal care. *Women's Health Issues*, *3*, 193-200.

¹² Austin, L. (2013). Treatment Planning and Case Management in Community. *The Praeger Handbook of Community Mental Health Practice: Working in the local community*, *1*, 83.

variety of practical needs.^{13,14} KIDS NOW Plus case managers use evidence-based practices, including Motivational Interviewing, to promote engagement in vital services such as substance abuse and mental health treatment and partner violence services, and to encourage consistent prenatal care.^{15,16}

The KIDS NOW Plus case management program is part of the Governor's Office of Early Childhood's Kentucky Invests in Developing Success NOW (KIDS NOW) program supported by Tobacco Settlement funds. The KIDS NOW Plus program is administered by the Division of Behavioral Health in the Department for Behavioral Health, Developmental and Intellectual Disabilities. Eight of Kentucky's regional community mental health centers (see Figure 1) are provided Tobacco Settlement funds along with Substance Abuse Prevention and Treatment Block Grant funding to manage the KIDS NOW Plus program for total program funding of about \$1.1 million dollars annually.

FIGURE 1. MAP OF KENTUCKY COMMUNITY MENTAL HEALTH REGIONS PROVIDING KIDS NOW PLUS SERVICES



Pregnant women who are referred to the KIDS NOW Plus case management program are first screened for eligibility. Typically women are referred by community organizations such as health departments, private OB/GYN providers, child welfare caseworkers, pregnancy crisis centers, domestic violence shelters and community mental health center clinicians. The screening tool used by KIDS NOW Plus referral sources is the "Substance Use During Pregnancy Questionnaire" which assesses a variety of risks including substance use, mental health, and intimate partner violence, any of which make a woman eligible for case management services. Adolescents (under age 18) are also eligible regardless of other risk factors.

EVALUATION METHOD

The KIDS NOW Plus outcome evaluation includes a face-to-face intake interview by program staff from the eight sites

¹³ Center for Substance Abuse Treatment. Comprehensive Case Management for Substance Abuse Treatment. Rockville (MD): Substance Abuse and McLaughlin, C. P., & Kaluzny, A. D. (2000). Building client centered systems of care: choosing a process direction for the next century. *Health Care Management Review, 25*(1), 73-82.

¹⁴ Sheedy C. K., and Whitter M. (2009). *Guiding Principles and Elements of Recovery-Oriented Systems of Care: What Do We Know From the Research?* HHS Publication No. (SMA) 09-4439. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

¹⁵ Ingersoll, K. S., Ceperich, S. D., Hettema, J. E., Farrell-Carnahan, L., & Penberthy, J. K. (2013). Preconceptional motivational interviewing interventions to reduce alcohol-exposed pregnancy risk. *Journal of Substance Abuse Treatment, 44*(4), 407-416.

¹⁶ May, P. A., Marais, A. S., Gossage, J. P., Barnard, R., Joubert, B., Cloete, M., et al. (2013). Case management reduces drinking during pregnancy among high-risk women. *The International Journal of Alcohol and Drug Research, 2*(3), 61-70.

shown above to assess targeted factors such as substance use, mental health symptoms, intimate partner violence, and other factors such as education, employment status, and living situation prior to pregnancy and while involved in the program. Between January 2013 and June 2014, 560 pregnant women completed a prenatal intake interview that was submitted electronically within 90 days of the assessment.^{17,18} Characteristics for all women who had completed intakes are presented in Appendix A.

At prenatal intake, clients are offered the opportunity to be contacted for a postnatal follow-up interview. If consent to be contacted for a follow-up is given by the client, an interviewer at UK CDAR contacts that client about 6 months after the birth of their baby (based upon estimated due date reported by the client at prenatal intake). UK CDAR obtains verbal consent to complete the follow-up survey. Client responses to the follow-up interviews are kept confidential to facilitate accurate reporting of client outcomes and satisfaction with program services. The UK CDAR team begins their efforts to locate and conduct follow-up interviews with women who agreed to be contacted for the follow-up one month before their target month (six months after the birth of their baby) for the follow-up interview and continues their efforts until the women have completed the follow-up interview or for two months after the target month, whichever comes first.

Out of the 560 prenatal intakes that were completed between January 2013 and June 2014, 276 clients were not yet in the targeted follow-up date range (that is, they had either not yet reached their estimated due date or it had not been 6 months from their estimated due date by the end of the fiscal year) and were, therefore, automatically ineligible to be in this follow-up sample. Of the remaining 284 clients who were in the targeted date range to complete a postnatal follow-up, 46 did not consent to be contacted by follow-up staff, 44 were not eligible at the time of the follow-up because they were in jail or another controlled environment ($n = 6$), because their baby was not living with them ($n = 15$), or other reasons such as invalid contact data ($n = 23$). Of the remaining 194 clients, postnatal follow-up assessments were completed with 162 clients (an 83.5% follow-up rate). See Appendix B for more details about follow-up methods and eligibility.

The clients who completed a follow-up ($n = 162$) were compared to clients who did not complete a follow-up for a variety of reasons ($n = 122$ ¹⁹) on selected factors. Results showed very few differences in demographics, substance use, mental health or intimate partner violence victimization (see Appendix C). A greater number clients who completed a follow-up had two or more chronic health problems, reported experiencing a serious fall while pregnant, and more of them reported alcohol use in the 6 months before pregnancy compared to clients who did not complete a follow-up survey.

To be included in the analysis for this outcome report, there were also four additional criteria: (1) clients had to have been in the program for 30 days or longer before the birth of their baby²⁰; (2) clients had to have matching information from the Kentucky Vital Statistics birth event data set in order to compare birth outcomes; (3) clients had to report living in the regions served by the KIDS NOW Plus program²¹; and, (4) the client had to give permission for UK CDAR to access their birth event data. If any of these criteria were not met, the client was not included in the outcome analysis. With this criteria in mind, although 162 clients had postnatal follow-up assessments, 10 cases were not included in

¹⁷ 564 pregnant women entered the program and completed a prenatal intake during these time periods; however, for 4 clients, the date between when the intake assessment was completed and when it was submitted to UK CDAR was greater than 90 days and, therefore, these clients were not included in this analysis.

¹⁸ The intake and postnatal assessment were changed in January 2013; therefore, this analysis includes clients who completed the latest version of the assessment to the end of fiscal year 2014.

¹⁹ Of the 122 who were within the targeted follow-up window but did not complete a follow-up assessment, 46 did not consent to participate in the follow-up and 44 were not eligible for follow-up because they were in jail or a controlled environment, the baby was not living with them, or the client had invalid contact data. In addition, 32 cases expired and could not be completed within the follow-up window.

²⁰ Clients who completed a postnatal follow-up assessment ($n = 162$) entered the KIDS NOW Plus case management program between November 2012 and December 2013.

²¹ Regions were restricted to account for access to community based resources.

the analysis because the number of days between when the client entered the program and the date they gave birth was less than 30 days. In addition, 9 clients did not reside in regions served by KIDS NOW Plus and 5 clients did not have a match in the birth event data set which could be due to an incorrect social security number, name or birthdate. Finally, 2 clients did not give permission to access their birth event data. This left a follow-up sample of 136 women who gave birth between January 2013 and January 2014, and completed a postnatal follow-up assessment between August 2013 and August 2014²² (an average of 6.4 months after giving birth).

²² Because the client needed to have their baby and have a six month postnatal follow-up, prenatal intakes for the postnatal follow-up sample fell between January 2013 and November 2013.

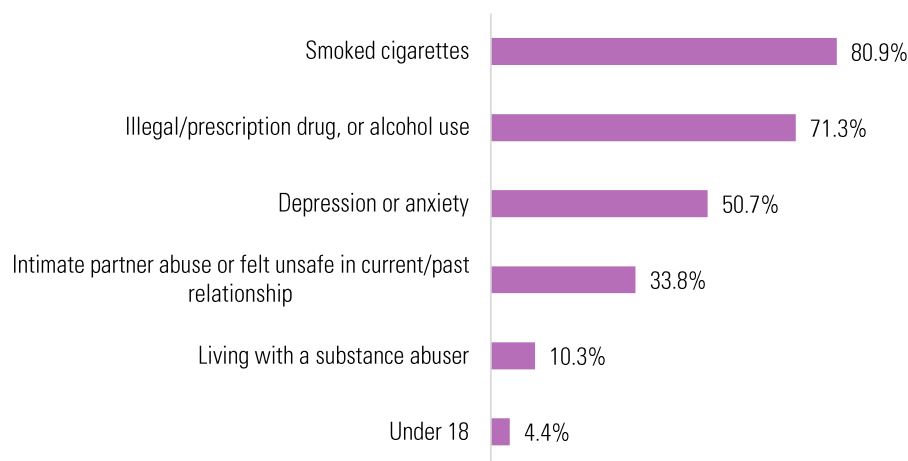
SECTION 2: DESCRIPTION OF KIDS NOW PLUS CASE MANAGEMENT PROGRAM CLIENTS WHO WERE INCLUDED IN THE POSTNATAL FOLLOW-UP ANALYSIS

Section 2 describes the KIDS NOW Plus client characteristics for the 136 clients who completed a six month postnatal follow-up assessment between August 2013 and August 2014 and met the criteria to be included in the analysis for this report. Characteristics examined include race, metropolitan/non-metropolitan status, marital status, socioeconomic status (i.e., education, employment, public assistance and socioeconomic hardships), living situation, and physical health.

RISK STATUS

Figure 2.1 shows that of the 136 clients who completed a six month postnatal follow-up assessment and met criteria to be included in this report, 97.1% (n = 132 clients), fit into at least one of the major risk factor categories assessed in the intake interview.²³ Overall, 80.9% of clients reported cigarette use, 71.3% reported drug or alcohol use at intake, 50.7% reported depression or anxiety, 33.8% reported intimate partner abuse and/or feeling unsafe in either their current relationship or because of a partner from a previous relationship, 10.3% of clients reported currently living with someone who has drug or alcohol problems, and 4.4% were under the age of 18.

FIGURE 2.1. PERCENTAGE OF CLIENTS FALLING INTO AT LEAST ONE TARGETED RISK FACTORS ASSESSED (N = 136)



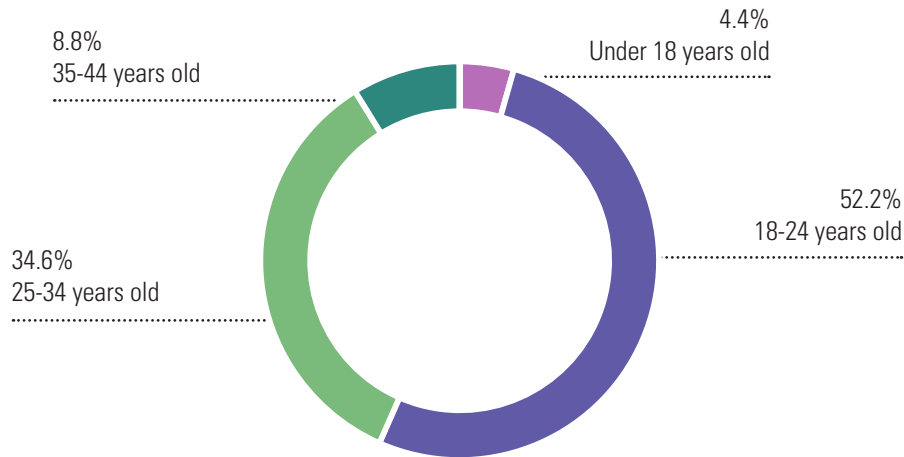
CLIENT CHARACTERISTICS

AGE

At intake, the average age of clients who were included in the 6-month postnatal follow-up sample was about 25 years old. Most clients were between the ages of 18 and 24 (52.2%) or between 25 and 34 years old (34.6%). A little over 4% of clients were under the age of 18 and 8.8% were between 35 and 44 years old (see Figure 2.2).

²³ Calculation includes 6 months before pregnancy, 30 days before pregnancy and past 30 days at prenatal intake.

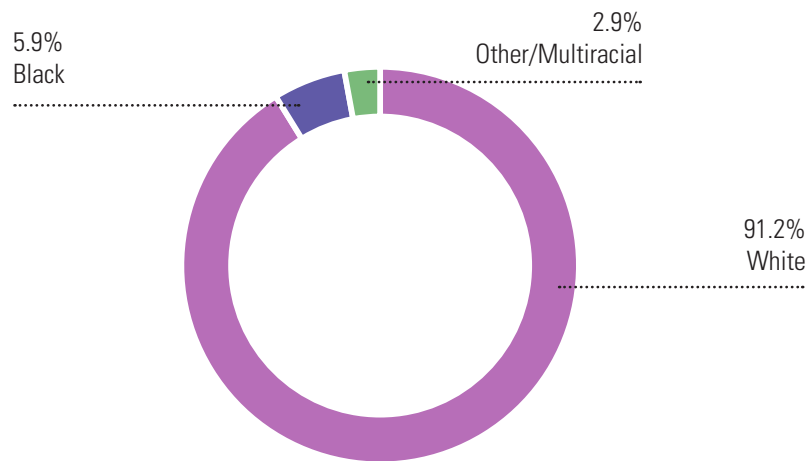
FIGURE 2.2. AGE CATEGORIES (N = 136)



RACE

The vast majority of the follow-up sample was White (91.2%), with a minority 5.9% reporting Black as their race (see Figure 2.3).

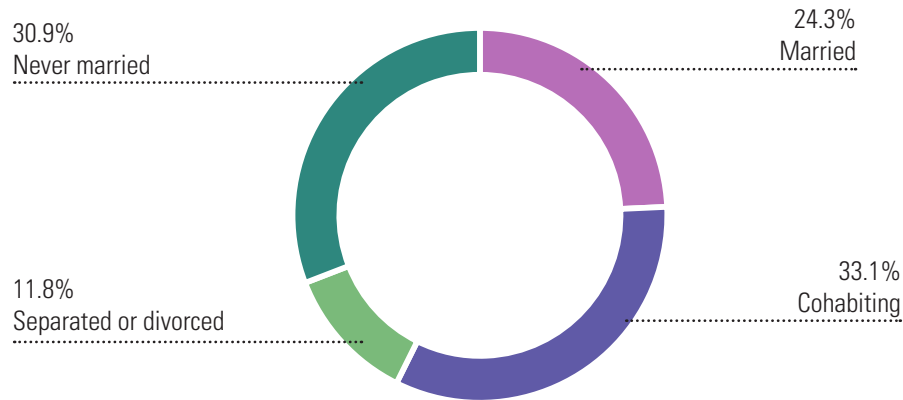
FIGURE 2.3. RACIAL MAKE-UP OF CLIENTS (N = 136)



MARITAL STATUS

Over half of clients were either married (24.3%) or cohabiting (33.1%). Of these clients (n = 78), 89.7% reported their partner was the father of the baby with whom they were pregnant. Less than one-third of clients (30.9%) were never married and 11.8% were either divorced or separated (see Figure 2.4).

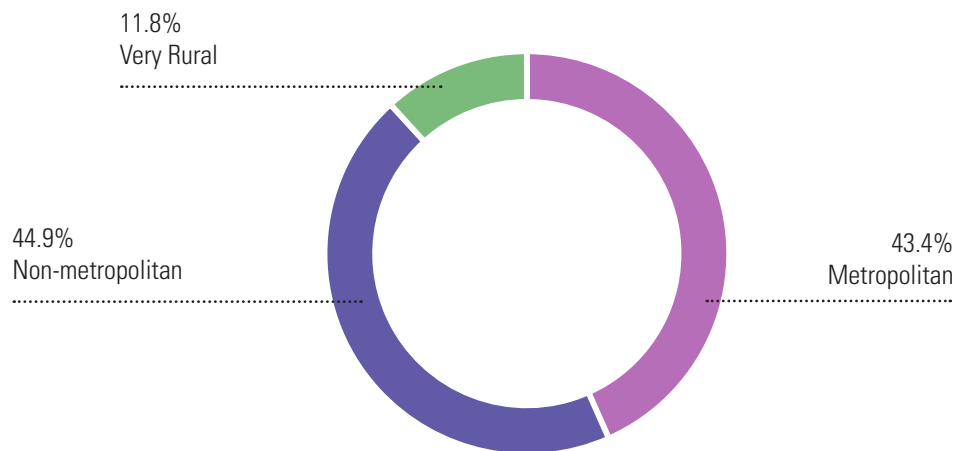
FIGURE 2.4. MARITAL STATUS AT PRENATAL INTAKE (N = 136)



METROPOLITAN/NON-METROPOLITAN STATUS

Rural-Urban Continuum Codes (or Beale codes) for the county in which the mother lived when she gave birth are obtained from the U.S. Department of Agriculture.²⁴ Counties are classified based upon population, socioeconomic indicators, commuting flow and adjacency to a metro area as derived from the U.S. Census Bureau. Figure 2.5 shows similar proportions of women were from metropolitan (43.4%) and non-metropolitan areas (44.9%) while 11.8% were from very rural areas.

FIGURE 2.5. TYPE OF COMMUNITY CLIENTS LIVED IN (N = 136)



Note: Metropolitan/non-metropolitan status was based upon Beale codes assigned to the county in which the mother reported residing in the birth event data set

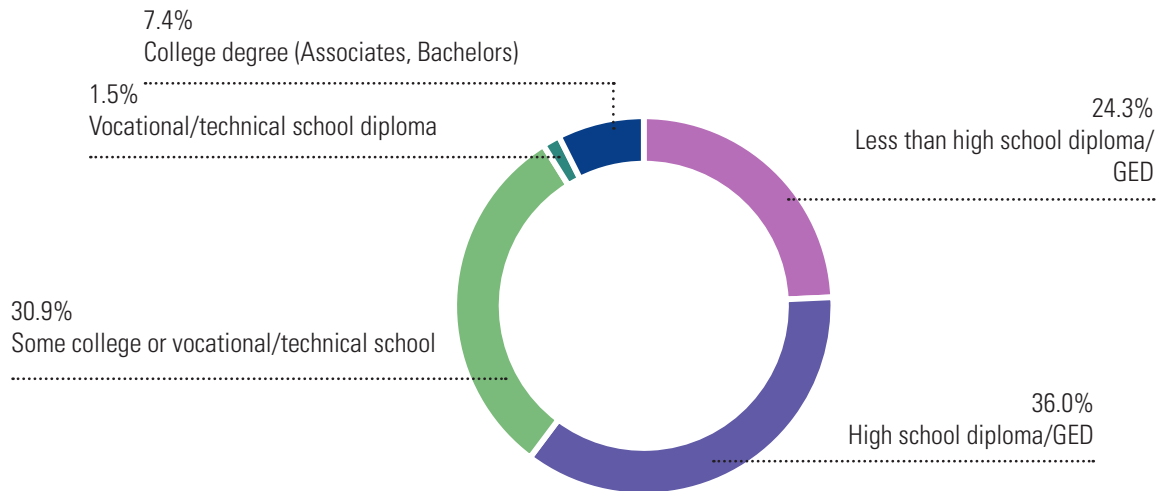
SOCIOECONOMIC STATUS INDICATORS

EDUCATION

Figure 2.6 shows that less than one-quarter (24.3%) of clients had less than a high school education or GED and another 36.0% had a high school diploma or GED. About 3 in 10 clients had some college or vocational/technical school.

²⁴ Rural-Urban Continuum Codes used to classify counties are obtained from the USDA found at <http://www.ers.usda.gov/data-products/rural-urban-continuum-codes.aspx#.UxoE4YWwV8H>.

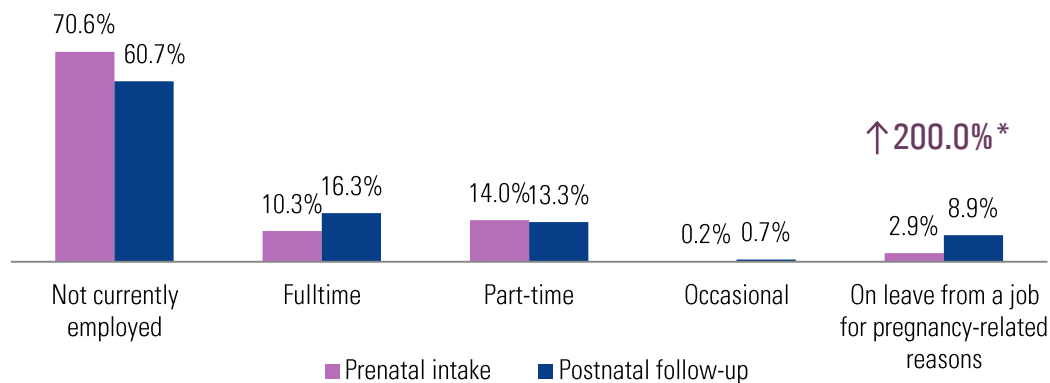
FIGURE 2.6. LEVEL OF EDUCATION OF POSTNATAL FOLLOW-UP SAMPLE (N = 136)



EMPLOYMENT STATUS

The number of clients reporting their current employment status did not change significantly from prenatal intake to postnatal follow-up. At prenatal intake, 70.6% of clients reported being unemployed and at postnatal follow-up, this percentage decreased to 60.7% (see Figure 2.7). In addition, the percentage of women who reported being employed (full-time or part-time) increased from 10.3% at prenatal intake to 16.3% at postnatal follow-up. There was a significant increase in the number of clients reporting they were on leave from their job for pregnancy-related reasons.

FIGURE 2.7. CURRENT EMPLOYMENT STATUS AT PRENATAL INTAKE AND POSTNATAL FOLLOW-UP (N = 136)^a

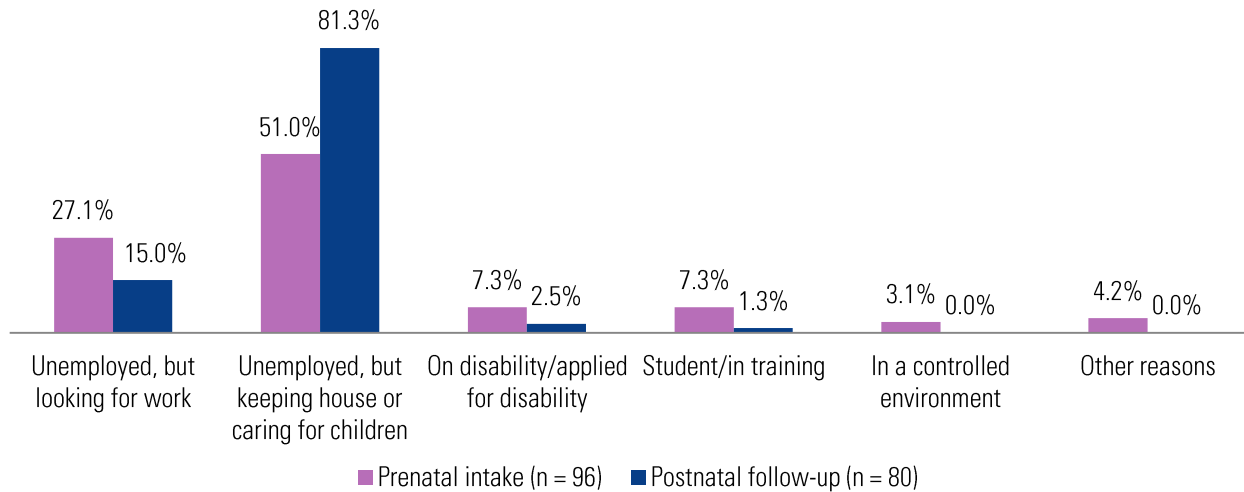


a—Question skipped for one client at follow-up.

Of the clients who were employed full-time, the average hourly wage clients reported increased only slightly from \$7.85 at prenatal intake to \$8.54 at postnatal follow-up.

Of the clients who reported they were not currently employed at each point, fewer clients indicated they were looking for work at postnatal follow-up compared to prenatal intake. In addition, 81.3% reported they were keeping house or caring for children full-time compared to 51.0% of clients at prenatal intake.

FIGURE 2.8. REASON FOR UNEMPLOYMENT AT PRENATAL INTAKE AND POSTNATAL FOLLOW-UP^a



a—Question skipped for 3 clients at follow-up.

Over 77% of clients at prenatal intake and 80.0% of clients at postnatal follow-up expected to be employed in the next 12 months.

PUBLIC ASSISTANCE AND MEDICAL INSURANCE

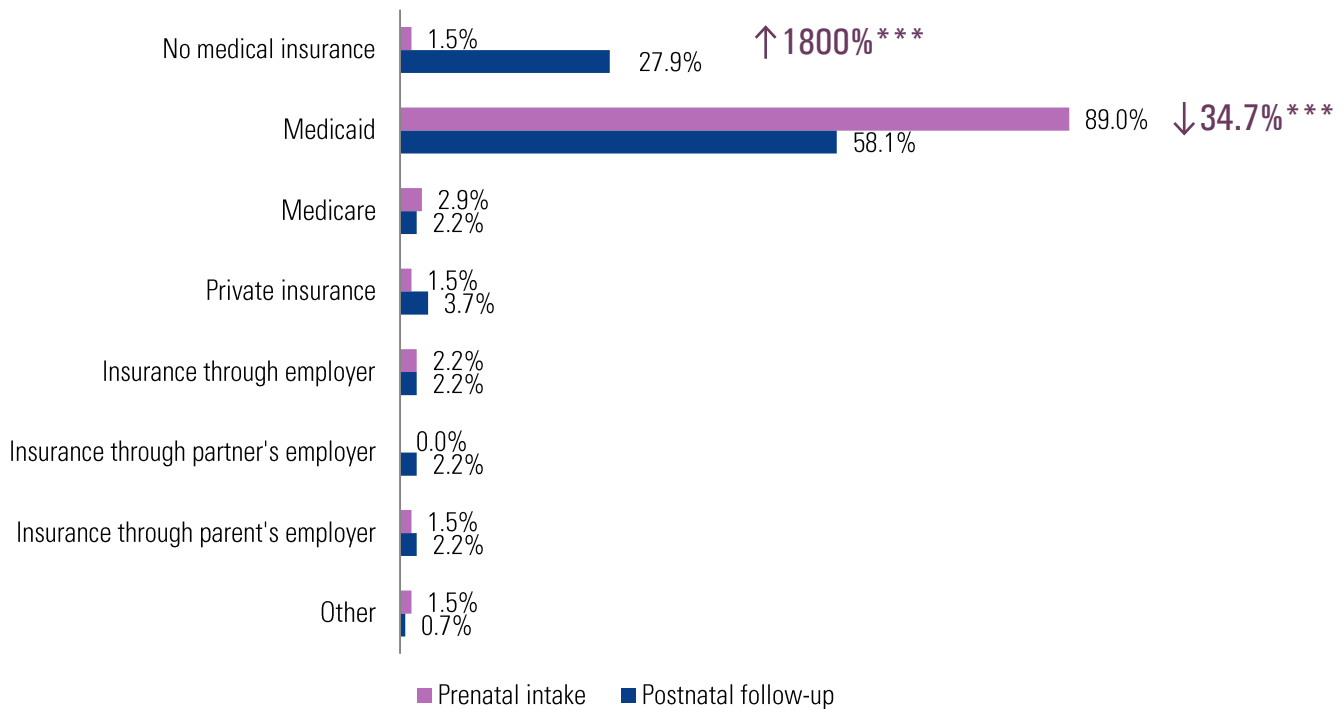
Clients were asked at postnatal follow-up what type of public assistance they received during their pregnancy and what type of medical insurance they had.

The vast majority of clients (97.1%) reported receiving public assistance while they were pregnant and involved in KIDS NOW Plus and 89.0% reported currently receiving public assistance at postnatal follow-up (not depicted in a figure).

The majority of clients who received public assistance reported receiving Supplement Nutrition Assistance Program (SNAP) (78.3% during pregnancy and 79.2% at postnatal).

At prenatal intake, only 1.5% of clients reported having no medical insurance compared to 27.9% at postnatal follow-up (a significant increase of 1800.0%; see Figure 2.9). In addition, 89.0% of clients reported having Medicaid, but at postnatal follow-up, 58.1% of clients reported having Medicaid (a 34.7% significant decrease).



FIGURE 2.9. REPORTED MEDICAL INSURANCE AT PRENATAL INTAKE AND POSTNATAL FOLLOW-UP (N = 136)^a

***p <.001

a—Question skipped for one client at follow-up.

DIFFICULTY MEETING BASIC LIVING AND HEALTH CARE NEEDS

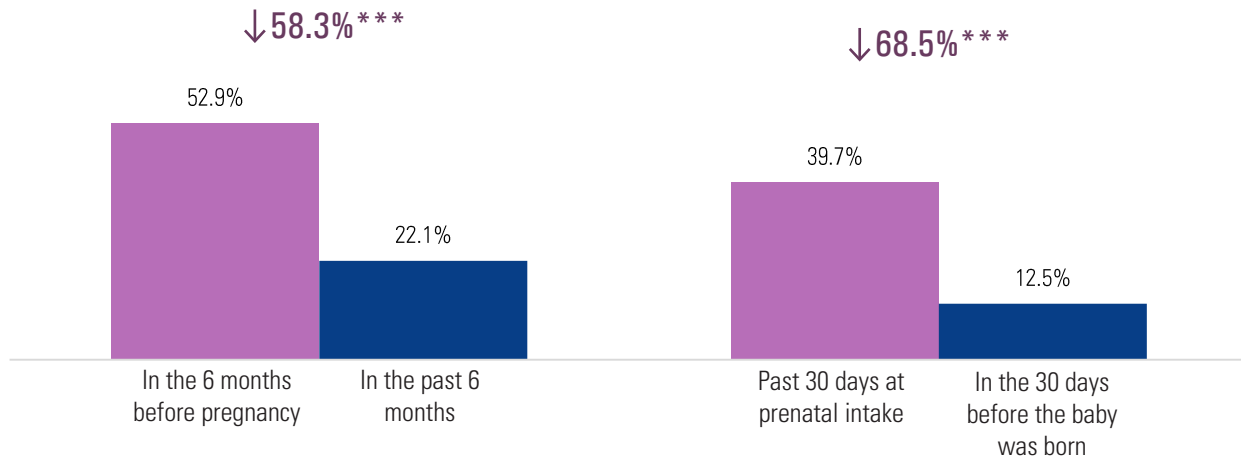
Economic hardship may be a better indicator of the actual day-to-day stressors clients face than a measure of income. Therefore, the prenatal intake and postnatal follow-up surveys included several questions about clients' ability to meet expenses for basic needs and food insecurity.²⁵ Clients were asked eight items, five of which asked about inability to meet basic living needs such as food, shelter, utilities, and telephone, and three items asked about inability to receive medical care for financial reasons. Overall, fewer clients report difficulty meeting any of their basic needs while they were involved in the KIDS NOW Plus case management program and after the birth of the baby.

In general, the number of clients who reported having difficulty meeting basic needs such as food, shelter, telephone, and utilities decreased significantly from prenatal intake to postnatal follow-up (see Figure 2.10). In the 6 months before becoming pregnant, a little more than half (52.9%) of clients reported they were unable to meet at least one of the basic living needs for financial reasons and 22.1% of clients reported difficulty meeting basic needs in the past 6 months at postnatal follow-up (a significant decrease of 58.3%).

Almost 40% of clients reported having difficulty in the past 30 days at prenatal intake. In the 30 days before the baby was born, 12.5% of clients had difficulty meeting basic needs such as food, shelter or utilities (a significant decrease of 68.5% compared to the past 30 days at intake).

²⁵ (SIPP; She, P., & Livermore, G. (2007). Material hardship, poverty, and disability among working-age adults. *Social Science Quarterly*, 88(4), 970-989.

FIGURE 2.10. DIFFICULTY IN MEETING BASIC NEEDS FOR FINANCIAL REASONS AT PRENATAL INTAKE AND POSTNATAL FOLLOW-UP (N = 136)^a



*** p < .001

Significance tested with z-test for proportions

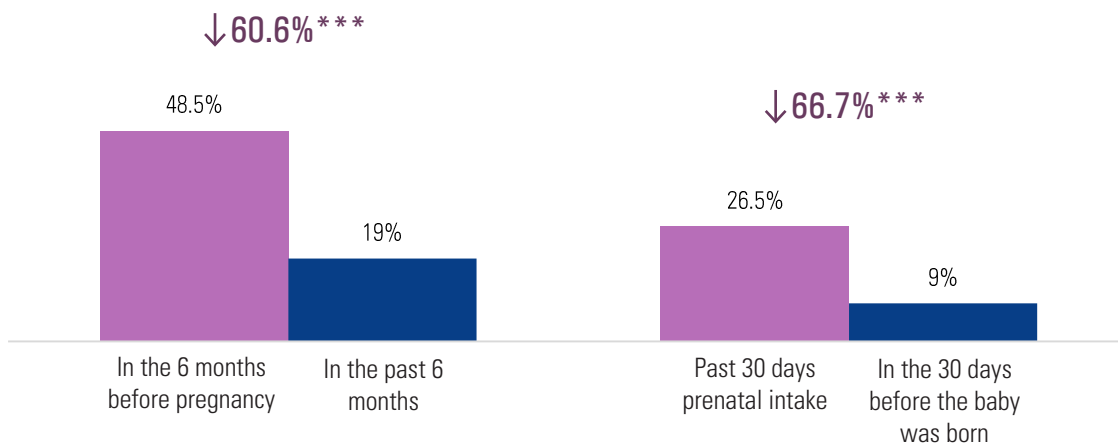
a—Question skipped for one client at follow-up.

Similarly, 48.5% of clients reported their household had difficulty meeting health care needs (such as not going to the doctor, not having a prescription filled, or not going to the dentist because of financial reasons) in the 6 months before pregnancy (see Figure 2.11). Less than 20% of clients reported they had difficulty meeting health care needs in the past 6 months at follow-up (a 60.6% significant decrease compared to the 6 months before the client was pregnant).

In the past 30 days at prenatal intake, 26.5% of clients reported their household had difficulty meeting health care needs because of financial reasons (see Figure 2.11). In the 30 days before the baby was born, 8.8% of clients reported difficulty which is a 66.7% significant decrease compared to the past 30 days at prenatal intake.

FEWER CLIENTS REPORTED DIFFICULTY MEETING ANY BASIC OR HEALTH CARE NEEDS WHILE PREGNANT AND INVOLVED IN THE KIDS NOW PLUS PROGRAM

FIGURE 2.11. DIFFICULTY IN MEETING HEALTH CARE NEEDS FOR FINANCIAL REASONS AT PRENATAL INTAKE AND POSTNATAL FOLLOW-UP (N = 136)^a



*** p < .01

Significance tested with z-test for proportions

a—Question skipped for two clients at follow-up.

LIVING SITUATION

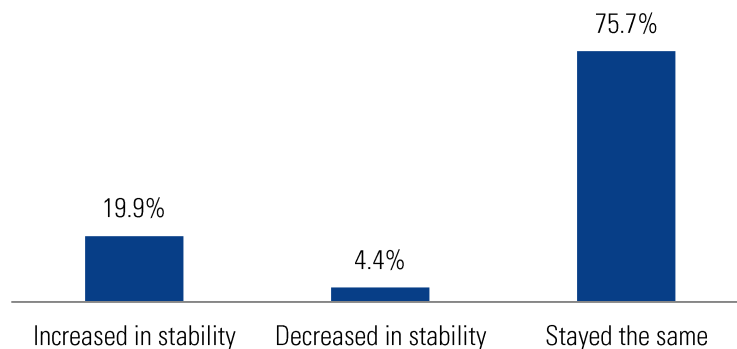
Overall, the number of clients reporting being homeless decreased, but not significantly, from 8.1% at prenatal intake, to 5.9% while pregnant and in KIDS NOW Plus, to 2.2% of clients at follow-up.

There were no significant changes in the type of situation clients reported living with the majority of clients (well over 90% at each point) living in a private residence (i.e., their own or someone else's home or apartment) before the birth of their baby and after.

At follow-up clients were asked about the stability of their living situation during their pregnancy while in KIDS NOW Plus case management services (see Figure 2.12). Overall, less than one-quarter of clients (19.9%) felt they experienced increased stability in their living situation, 75.7% indicated their living situation stayed the same, and only 4.4% of clients reported they experienced a decrease in stability.



FIGURE 2.12. LIVING SITUATION STABILITY WHILE PREGNANT AND IN KIDS NOW PLUS PROGRAM (N = 136)



SUMMARY

Clients who completed a prenatal intake between January 2013 and June 2014, gave birth to their baby and completed a six month postnatal follow-up assessment were included in this outcome report. Based upon these criteria, 136 pregnant women at high risk for substance use completed a prenatal intake and a six month postnatal follow-up assessment between August 2013 and August 2014. These clients were mostly White with an average age of about 25 years old. About one-quarter of clients were married and less than one-third were never married.

While the percentage of clients who reported employment did not increase at postnatal follow-up, the majority were caring for their children at home and the majority of clients were able to receive public assistance (mainly SNAP) while pregnant and in KIDS NOW Plus and after the birth of the baby. The number of clients who reported not having any medical insurance increased at postnatal follow-up with over one-quarter reporting no medical insurance. The number of clients who reported having difficulty meeting basic needs or health care needs decreased while pregnant and involved in KIDS NOW plus, but increased slightly at postnatal follow-up. About 2 in 10 clients also reported the stability of their living situation increased while they were pregnant and in the case management program while the majority of client reported their living situation stayed the same.

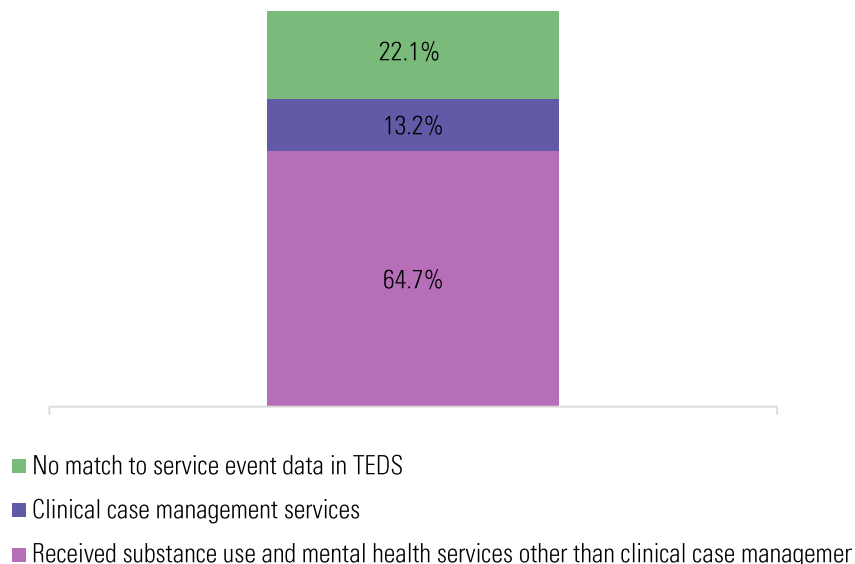
SECTION 3: CLINICAL SERVICES

This section examines case management services received by KIDS NOW Plus clients while in the program as well as mental health diagnosis. In addition, it compares services received by KIDS NOW Plus clients to those received by women with similar socioeconomic characteristics who gave birth during the same time period but who were not part of the program.

Information on clinical service events for KIDS NOW Plus clients receiving case management at community mental health centers (CMHCs) is submitted into the Treatment Event Dataset (TEDS) and is managed by the University of Kentucky Institute for Pharmaceutical Outcomes and Policy (IPOP). Clinical services include outpatient counseling, residential treatment and other services as reported monthly by the CMHCs to the Department of Behavioral Health, Development and Intellectual Disabilities as service event data in TEDS. Service events were matched to clients in the KIDS NOW Plus postnatal follow-up sample using encrypted social security numbers. In order to collect service events during the time the client was active in KIDS NOW Plus, service events were requested for the date the client was admitted to the KIDS NOW Plus case management program to two months after the date the baby was born. The timeframe varied for each client (average days 187; Minimum = 91, Maximum = 303 days) but could range from November 2012 (the earliest date which a client in the follow-up sample entered the program) to March 2014 (two months after the latest date a baby in the follow-up sample was born).

Out of the 136 KIDS NOW Plus clients in the postnatal follow-up sample, 22.1% were not found in the clinical services database. There are many reasons that an individual may not be found in the database including mistakes in identifying information, classification errors, and potentially no clinical services were rendered during this time period.²⁶ Further, as Figure 3.1 shows, 88 (64.7%) received clinical services other than clinical case management services during the timeframe analyzed.

FIGURE 3.1. PERCENTAGE OF CLIENTS IN EACH SERVICE CATEGORY BETWEEN DATE THE CLIENT ENTERED THE KIDS NOW PLUS CASE MANAGEMENT PROGRAM AND TWO MONTHS AFTER THE DATE THE BABY WAS BORN (N = 136)

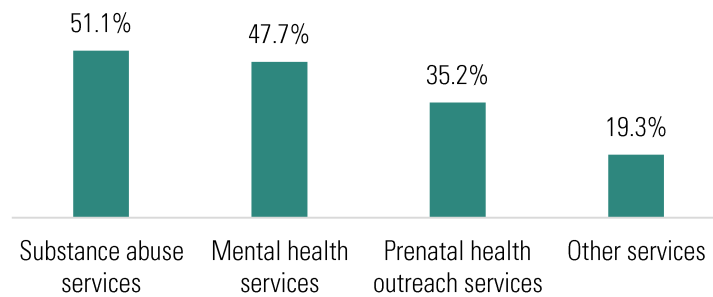


According to the clinical services database, among clients receiving clinical services other than clinical case management (n = 88), 51.1% of these clients received substance abuse treatment services including DUI assessment,

²⁶ Across all of the outcome studies at UK CDAR conducted on publicly funded treatment programs there is a similar proportion of individuals that are not found in the clinical services database.

individual substance abuse therapy, day hospital programs, residential substance abuse treatment, family residential, and intensive outpatient (see Figure 3.2). In addition, 47.7% of these clients received mental health treatment services such as individual mental health therapy, group therapy, and psychosocial and other assessment/evaluation services, and residential crisis stabilization. Also, 35.2% of these clients received prenatal health outreach services and 19.3% of these clients received other services such as medical evaluations, respite care, and outreach and education.

FIGURE 3.2. OF THOSE WHO RECEIVED CLINICAL SERVICES OTHER THAN CASE MANAGEMENT (N = 88), PERCENTAGE OF CLIENTS RECEIVING SUBSTANCE ABUSE TREATMENT SERVICES AND OTHER SERVICES



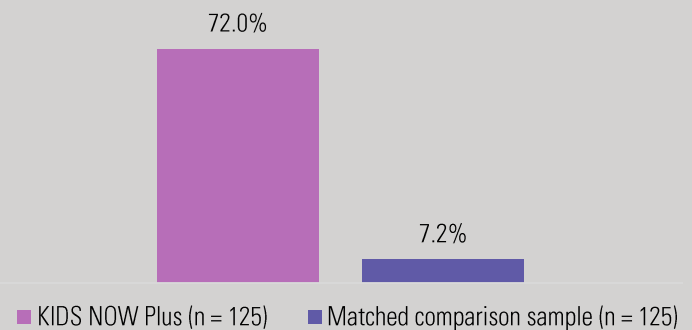
Among the clients who received clinical services other than case management (n = 88), clients received an average of 32.7 services (Min. = 2, Max. = 489 services).

KIDS NOW PLUS SERVICES COMPARED TO SERVICES FOR OTHER MOTHERS FROM THE BIRTH OF THE CHILD TO ONE YEAR PRIOR

In order to evaluate if pregnant women in KIDS NOW Plus receive more services than pregnant women who are not in the program, service utilization for KIDS NOW Plus clients was compared with other mothers who are not part of the program (see Figure 3.3). KIDS NOW Plus clients were matched to other mothers in the Kentucky Vital Statistic birth event data set who gave birth during the same period, resided in the regions served by KIDS NOW Plus, and had similar socioeconomic characteristics.^{27, 28, 29} If there were KIDS NOW Plus clients that did not have a match in the birth event data set on all characteristics for comparison, the clients were excluded from the analysis because the remaining cases would not result in a complete matched comparison. Therefore, out of the 136 KIDS NOW Plus clients who were included in the follow-up sample, a matched comparison sample was generated for 125 clients. Because the comparison sample was not in KIDS NOW Plus and, therefore, did not have a program start date, services were requested for KIDS NOW Plus clients and the comparison group during the

time between the birth of the child and one year prior. Out of the 125 clients in the KIDS NOW Plus sample and the 125³⁰ matched comparison sample, significantly more KIDS NOW Plus clients (72.0%) received clinical services other than case management than the matched comparison sample (7.2%) one year prior to the birth of the child.³¹ More information about the matched comparison sample and other comparisons with KIDS NOW Plus clients can be found in Appendix D.

FIGURE 3.3. PERCENTAGE OF MOTHERS WHO RECEIVED CLINICAL SERVICES OTHER THAN CASE MANAGEMENT DURING THE TIME BETWEEN THE BIRTH OF THE CHILD AND ONE YEAR PRIOR***



***p < .001

²⁷ KIDS NOW Plus regions include Lifeskills, Communicare, Seven Counties, NorthKey, Pathways, Kentucky River, Cumberland River, and Adanta.

²⁸ Clients were matched on age, race, education, marital status, smoking status and metropolitan/non-metropolitan status.

²⁹ More detailed information about the study method can be found in Appendix B.

³⁰ Ten cases in the comparison group had an invalid social security number and therefore, could not be matched to services.

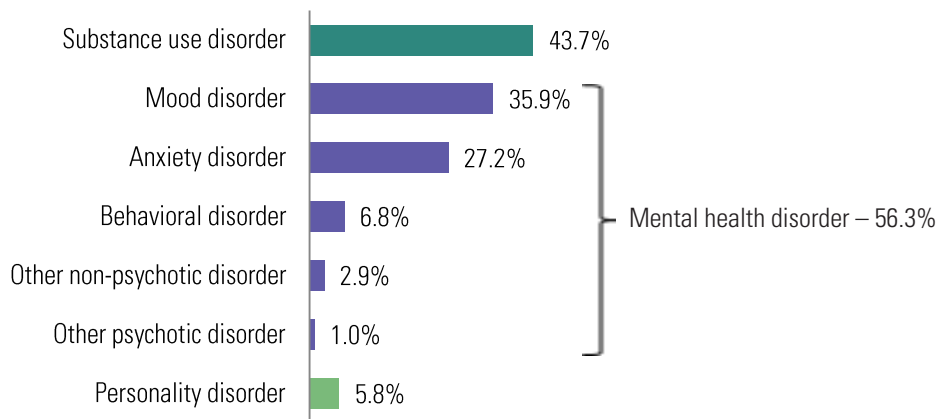
³¹ 12 additional KIDS NOW Plus clients received only additional case management services (substance abuse or mental health) but were not included in this analysis.

DSM-IV DIAGNOSIS

Using mental health diagnosis codes reported by Community Mental Health Center (CMHC) providers to the Department for Behavioral Health, Developmental and Intellectual Disabilities, DSM-IV diagnoses were obtained for KIDS NOW Plus case management services clients between the date the client was admitted to the KIDS NOW Plus case management program and two months after the date the baby was born. Out of 136 clients who were included in the postnatal follow-up sample, 75.7% had a mental health diagnosis (n = 103).

Figure 3.4 shows of those clients who received a DSM-IV mental health diagnosis, 43.7% of clients were diagnosed with a substance use disorder and 56.3% were diagnosed with a mental health disorder. Specifically, 35.9% were diagnosed with mood disorder (depression or non-psychotic bipolar disorder), 27.2% were diagnosed with anxiety disorder (generalized anxiety, panic disorder, or obsessive-compulsive disorder), and 6.8% were diagnosed with a behavioral disorder (such as attention-deficit/hyperactivity disorder). In addition, 5.8% were diagnosed with a personality disorder (such as antisocial, narcissistic, borderline). These diagnoses are not mutually exclusive, thus a person could have multiple DSM-IV diagnoses.³²

FIGURE 3.4. DSM-IV DIAGNOSES FOR CLIENTS WITH MENTAL HEALTH DIAGNOSIS (N = 103)

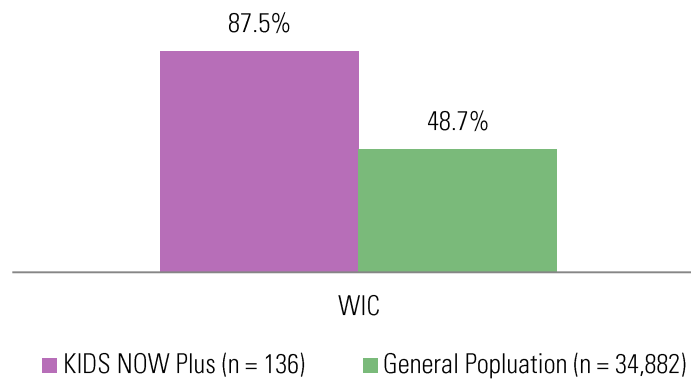


WIC

Besides the additional clinical services received from KIDS NOW Plus case management, caseworkers make an effort to connect women with support services like the Women, Infants and Children (WIC) program. WIC provides nutrition education, breastfeeding promotion and education, a monthly food allotment to use toward nutritious foods, and access to maternal, prenatal and pediatric health-care services for high-risk women. In fact, according to the vital statistics data, 87.5% of KIDS NOW Plus clients received support from WIC compared to 48.7% of mothers who were not in KIDS NOW Plus³³ which may suggest lower incomes and/or greater effort by KIDS NOW Plus caseworkers to connect women with this service (see Figure 3.5).

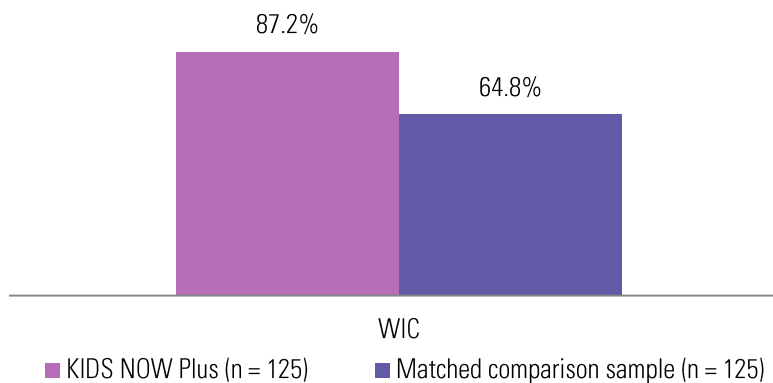
³² Clients who receive a diagnosis do not necessarily receive clinical services. Eighteen clients received a DSM-IV mental health diagnosis, but did not receive clinical services and 3 clients received services, but did not receive a DSM-IV mental health diagnosis.

³³ For more comparisons between the KIDS NOW Plus clients and mothers in the general population, see birth events and outcomes in section 5.

FIGURE 3.5. PERCENTAGE OF WOMEN ENROLLED IN WIC PROGRAM COMPARED TO THE GENERAL POPULATION OF MOTHERS IN KIDS NOW PLUS REGIONS^{a***}

a – Information on WIC was unknown for 11 mothers in the general population
Significance tested with Chi-square test; *** p < .01

When the KIDS NOW Plus mothers were compared to the matched comparison sample of women who gave birth during the same timeframe,³⁴ a significantly greater percentage of KIDS NOW Plus case management clients were enrolled in WIC at the time of the birth (87.4%) compared to the matched comparison group (65.4%; see Figure 3.6).

FIGURE 3.6. PERCENTAGE OF WOMEN ENROLLED IN WIC PROGRAM AMONG KIDS NOW PLUS CLIENTS AND A MATCHED COMPARISON SAMPLE^{***}

SUMMARY

Almost two-thirds of clients who participated in case management services and completed a postnatal follow-up assessment received clinical services other than case management. Of those clients who received clinical services other than clinical case management, 51.1% received substance abuse services such as individual therapy, and day hospital programs, residential substance abuse treatment, family residential, and intensive outpatient. Almost half (48%) of clients received mental health services such as individual mental health therapy, group therapy, and psychosocial and other assessment/evaluation services. In addition, 32.5% of clients received prenatal health outreach services. Compared to mothers of similar socioeconomic status who also gave birth during the same timeframe but were not part of the KIDS NOW Plus program, KIDS NOW Plus clients were significantly more likely to receive services in the year prior to the birth of their child. Additionally, KIDS NOW Plus mothers were more likely to receive support services such as WIC.

³⁴ More detailed information about service methods can be found in Appendix B, and other comparisons with the matched sample can be found in Appendix D.

SECTION 4: PREGNANCY STATUS

This section describes the clients' pregnancy status at prenatal intake as well general feelings and attitudes towards their pregnancies including: (1) expectations and feelings about the baby; (2) general information regarding the pregnancy/baby; and (3) planned method of birth control. Comparisons are made from prenatal intake to postnatal follow-up where applicable.

PREGNANCY STATUS

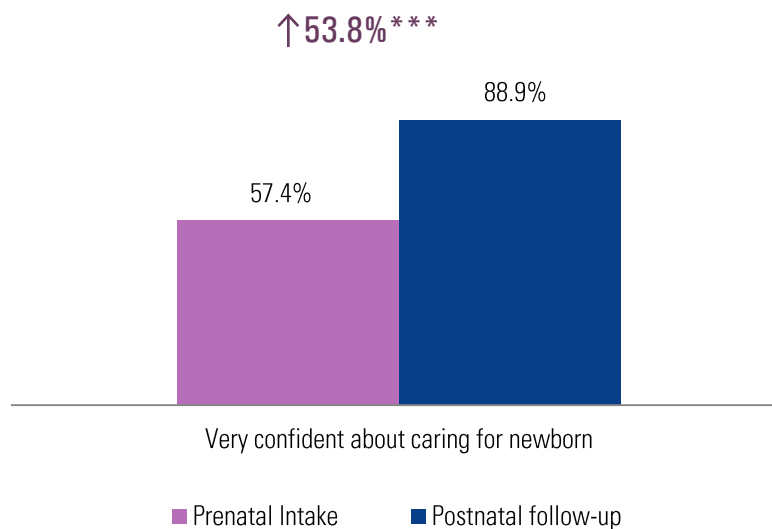
When clients completed a prenatal intake they were an average of 23.7 weeks pregnant (Min. = 7 weeks, Max. = 41 weeks) and were in the program an average of 18 weeks (Min. = 4 weeks, Max. = 35 weeks). After the baby was born, clients reported remaining in KIDS NOW Plus case management an average of 7.8 weeks (Min. = 0 weeks, Max. = 28 weeks).

EXPECTATIONS AND FEELINGS ABOUT THE BABY

At prenatal intake and postnatal follow-up, clients were asked, on a scale of 1 being 'not confident at all' to 5 being 'very confident about it', how confident they were in taking care of a newborn baby (see Figure 4.1). At prenatal intake, 57.4% of clients reported they felt very confident (an average score of 4.3) and at postnatal follow-up, 88.9% felt confident (an average score of 4.9), which is a 53.8% increase in the number of clients reporting they felt very confident in taking care of a newborn.

89% OF CLIENTS FELT CONFIDENT ABOUT THEIR ABILITY TO CARE FOR A NEWBORN BABY AT POSTNATAL FOLLOW-UP

FIGURE 4.1. LEVEL OF CONFIDENCE WITH TAKING CARE OF NEWBORN BABY AT PRENATAL INTAKE AND POSTNATAL FOLLOW-UP (N = 136)^a

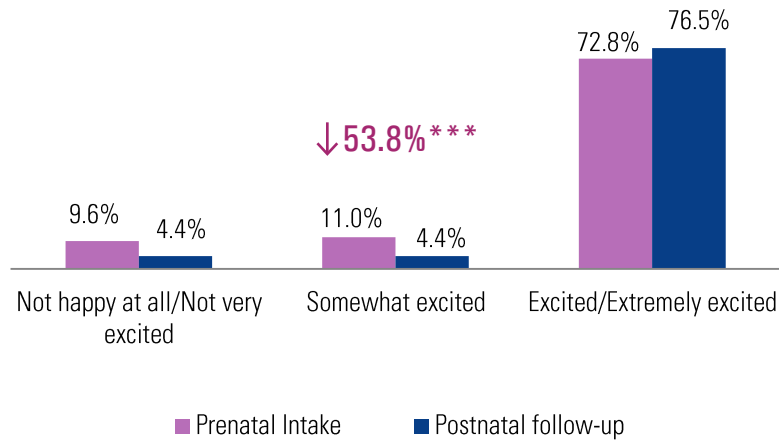


***p < .001.

a—Question skipped for one client at follow-up

The majority of clients reported the baby’s father was excited or extremely excited about the pregnancy at prenatal intake (72.8%) as well as at postnatal follow-up (76.5%).

FIGURE 4.2. FATHER’S FEELINGS ABOUT THE PREGNANCY AT PRENATAL INTAKE AND THE BABY AT POSTNATAL FOLLOW-UP (N = 136)^a

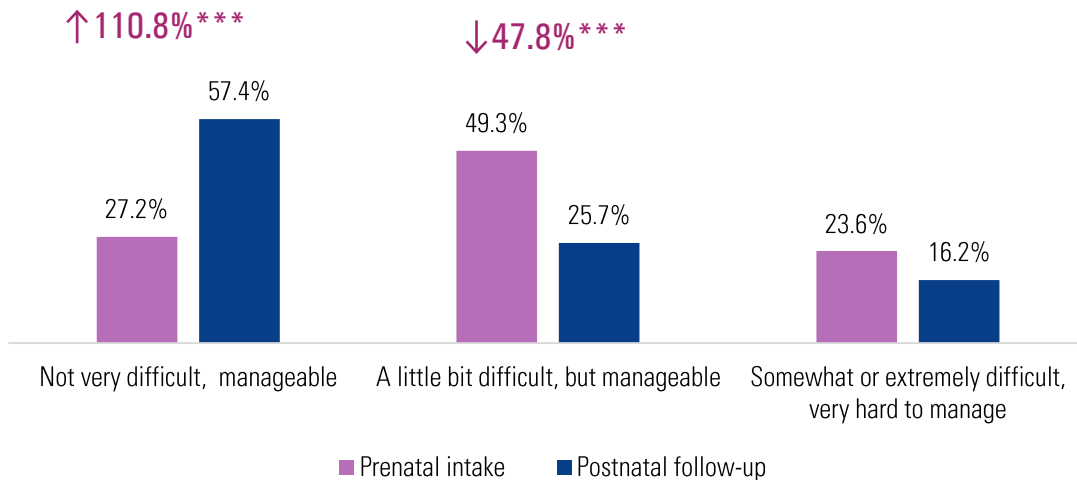


* p < .05.

a—9 clients at prenatal intake and 1 client at postnatal follow-up reported that the father of the pregnancy/baby did not know about the child and 18 clients reported at follow-up that they didn’t know what the father thought about the baby.

Perceptions about how difficult life would be/is with the baby also changed from prenatal intake to postnatal follow-up (see Figure 4.3). In general, at prenatal intake, clients felt life with a new baby would be more difficult: 23.6% reporting things would be somewhat difficult to extremely difficult and almost half of clients feeling that life would be a little bit difficult, but manageable. At postnatal follow-up, over half of clients (57.4%) reported that life with the baby was not very difficult and very/fairly manageable (a significant increase of 110.8% compared to prenatal intake).

FIGURE 4.3. CLIENT PERCEPTIONS OF LIFE WITH THE BABY AT PRENATAL INTAKE AND POSTNATAL FOLLOW-UP (N = 136)^a



*** p < .001

Significance tested with z-test for proportions

a—Question skipped for one client at follow-up

GENERAL INFORMATION REGARDING THE PREGNANCY/BABY

Clients reported they were in labor an average of 11 hours with the majority of clients reporting between a half an hour and 14 hours.

Clients were asked how their baby was doing at postnatal follow-up and all the mothers indicated the baby was “great” or “good.”

At prenatal intake, clients reported an average of 6.5 doctor visits about the pregnancy and at postnatal follow-up clients reported an average of 7.1 visits to the pediatrician or nurse since giving birth. About one-quarter of clients (24.4%) indicated they had been told by a doctor at prenatal intake that their baby had special health care needs and at postnatal follow-up, 20.6% (28 clients) reported their doctor has told them their baby has special health care needs. More specifically, 22 clients reported their babies had minor health care needs such as allergies, acid reflux, or a heart murmur. However, 16 mothers³⁵ (or 11.8%) reported various and potentially serious problems such as developmental issues, bilateral cleft foot and blindness in one eye. In comparison, for all babies born in the United States, approximately 3.0% of babies are born with a birth defect (such as cleft palate, spina bifida, or neural tube defects)³⁶ and about 1.0% of babies will be born with a congenital heart defect.³⁷ In addition, 20% of children in the United States and 26% of children in Kentucky are considered to have special health care needs as defined by the federal Maternal and Child Health Bureau’s definition.³⁸



Almost half of clients (49.3%) reported at prenatal intake that they planned on breastfeeding their baby. At postnatal follow-up, 44.1% of clients reported having breastfed their baby and, of those clients (n = 60), 18.3% were still breastfeeding.

PLANNED METHOD OF BIRTH CONTROL

At prenatal intake, clients were asked what method of birth control they planned on using and at postnatal follow-up were asked what birth control they actually had been using in the past 6 months (see Figure 5.4). At prenatal intake, a little over one-quarter of clients reported they were planning on getting a tubal ligation while at postnatal follow-up, 8.8% reported tubal ligation was the birth control they used in the past 6 months. About 13% of clients at prenatal intake reported they planned on using the patch (Ortho Evra), shot (Depo-Provera) or implant (Implanon, Nexplanon). At postnatal, however, 29.3% reported they had been using the patch, shot or implant in the past 6 months. In addition, at prenatal intake, only 8.8% of clients were not planning on using any type of form of birth control; however, at postnatal follow-up, 33.1% of client reported they were not using any form of birth control in the past 6 months.³⁹

³⁵ Mothers could report more than one special health care need.

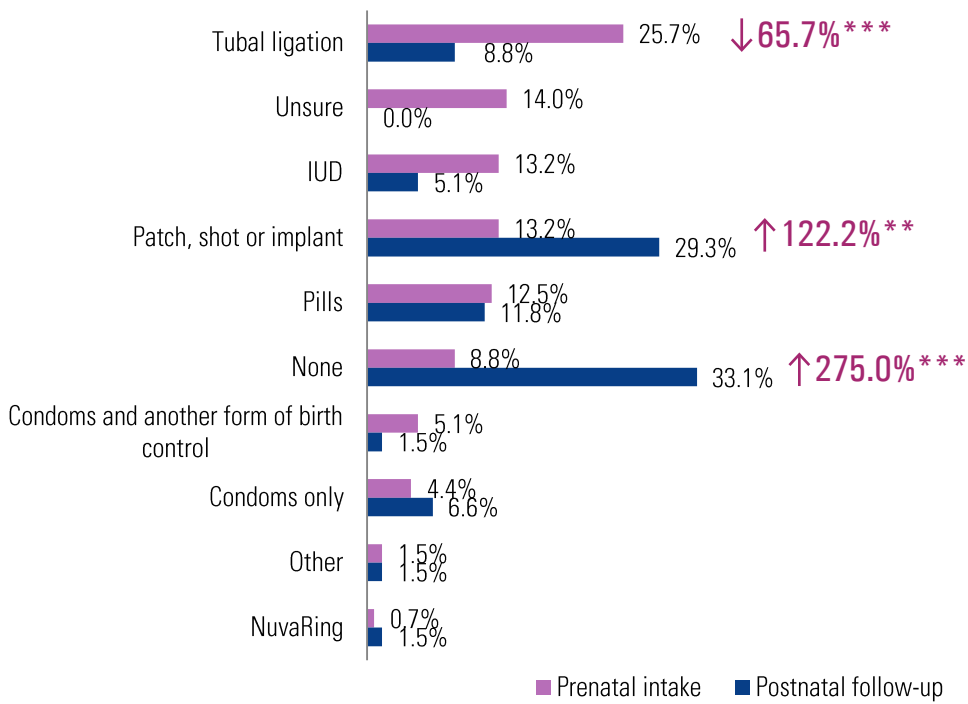
³⁶ Centers for Disease Control and Prevention. Update on Overall Prevalence of Major Birth Defects --- Atlanta, Georgia, 1978--2005]. *MMWR* 2008; 62(57):1-5.

³⁷ <http://www.marchofdimes.com/baby/congenital-heart-defects.aspx#>

³⁸ KIDS COUNT Data Center (2013). Children with special health care needs 2011-2012. Retrieved from <http://datacenter.kidscount.org/data/tables/29-children-with-special-health-care-needs?loc=19&loct=2#detailed/2/19/false/1021,18,19,12/any/298,299> and <http://datacenter.kidscount.org/data/tables/29-children-with-special-health-care-needs?loc=1&loct=1#detailed/1/any/false/1021,18,19,12/any/298,299> on September 8, 2014.

³⁹ Though 57.4% of clients at intake and 61.8% of clients at follow-up were either married or cohabiting, we do not have information on the number of clients who were sexually active at each point; therefore, not all women were necessarily sexually active.

FIGURE 4.4. PLANNED METHOD OF BIRTH CONTROL AT PRENATAL INTAKE COMPARED TO ACTUAL BIRTH CONTROL METHOD AT POSTNATAL FOLLOW-UP (N = 136)



** p < .01, *** p .001.

SUMMARY

Clients’ perceptions of how life was going to be with the baby increased from prenatal intake to postnatal follow-up as well. Specifically, at prenatal intake, over one-quarter of clients reported having a new baby would not be very difficult and would be manageable. After the birth of the baby, however, 57.4% of clients reported life was manageable and not very difficult with the baby. In fact, all the mothers in the follow-up sample reported their babies were doing “great” or “good” and the majority felt confident about being the mother of an infant.

SECTION 5. BIRTH EVENTS AND OUTCOMES: KIDS NOW PLUS CASE MANAGEMENT CLIENTS COMPARED TO THE GENERAL POPULATION OF MOTHERS WITHIN THE REGIONS SERVED BY KIDS NOW PLUS

This section uses the Kentucky Vital Statistics birth data⁴⁰ to examine (1) general risk factors; (2) targeted risk factors available from the Vital Statistics data set; and (3) birth events and outcomes of 136 KIDS NOW Plus case management clients and their babies compared to others in the state who had babies during the same period (between January 2013 and January 2014) but who did not participate in the KIDS NOW Plus Case Management study (n = 34,888).^{41,42}

One KIDS NOW Plus client and 652 mothers from the general population had more than one baby in the data set. This means there were 137 babies in the KIDS NOW Plus sample and 35,550 babies in the general population sample.⁴³ The information in this section is limited to data in the Kentucky Vital Statistics data set. This section describes demographic information (age, race, and area), socio-economic status indicators (education and source of payment for birth of the baby), physical health status (average weight gained during pregnancy and maternal health problems), patterns of cigarette smoking, and birth outcomes.

GENERAL RISK FACTORS

DEMOGRAPHICS

Table 5.1 shows the demographic differences between KIDS NOW Plus mothers and mothers from the general population in regions served by KIDS NOW Plus at the time of the birth of the baby.

Compared to the general population of women who gave birth, KIDS NOW Plus clients were younger, more likely to be White, and were less likely to live in metropolitan communities.

In addition, significantly more mothers in the general population were married (56.4%) compared to the KIDS NOW Plus mothers (29.4%).

TABLE 5.1. DEMOGRAPHIC INFORMATION OF BIRTH DATA GROUPS

	KIDS NOW Plus (n = 136)	General Population (n = 34,888)
Average age**	25.2	26.7
Race**		
White	92.6%	82.1%
Non-white	7.4%	17.9%
Type of community***		
Metropolitan	43.4%	64.8%
Non-metropolitan	44.9%	25.0%
Very rural	11.8%	10.2%
Married***a	29.4%	56.4%

*** p < .01, ** p < .01.; a—Marital status was missing for 21 women in the general population.

⁴⁰ In the Kentucky Vital Statistics birth event data set, each case is one baby paired with the mother's information collected at the time of the birth. There could potentially be multiple babies (cases) attached to one mother in the instance of multiple births or multiparous births in the same year. For that reason, the number of cases in the file does not equal the number of mothers in the file.

⁴¹ Currently 8 CMHC regions provide KIDS NOW Plus case management: LifeSkills, Communicare, Seven Counties, NorthKey, Pathways, Kentucky River, Cumberland River, and Adanta. Out of the 59,813 cases in the Vital Statistics data set that remained after cleaning, 2,338 cases had the mother's residence as out-of-state or not entered and 21,788 cases had the mother's residence in a county outside a CMHC region that provides KIDS NOW Plus. A total of 35,687 cases, therefore, remained in the analysis.

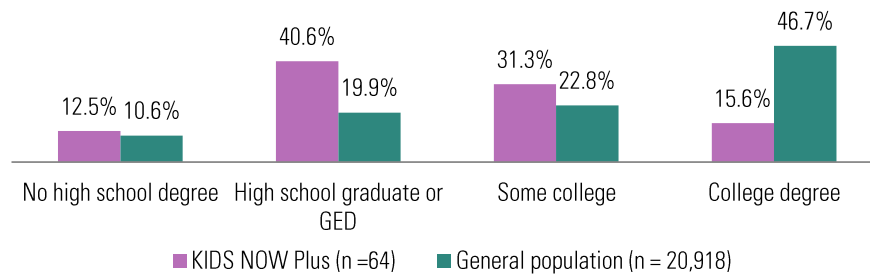
⁴² See Appendix D for further birth data comparisons between KIDS NOW Plus clients and a sample of mothers with matching characteristics.

⁴³ More detailed description of the birth data methods can be found in Appendix B.

SOCIOECONOMIC STATUS INDICATORS

Because the KIDS NOW Plus mothers were younger than the general population it is important to compare education rates only for those who had sufficient time to finish high school or GED. The 2010 census indicates that of Kentucky women ages 25 and older, 81% had high school degrees. When both groups of women ages 25 and older are compared, 87.5% of KIDS NOW Plus mothers and 89.4% of mothers in the general population have at least a high school diploma or GED (see Figure 5.1). Therefore, among women 25 years of age and older, 12.5% of KIDS NOW Plus mothers and 10.6% of mothers in the general population had less than a high school degree. In addition, 46.7% of mothers in the general population, which was significantly older than the KIDS NOW Plus mothers, received a college degree compared to 15.6% of mothers in KIDS NOW Plus.

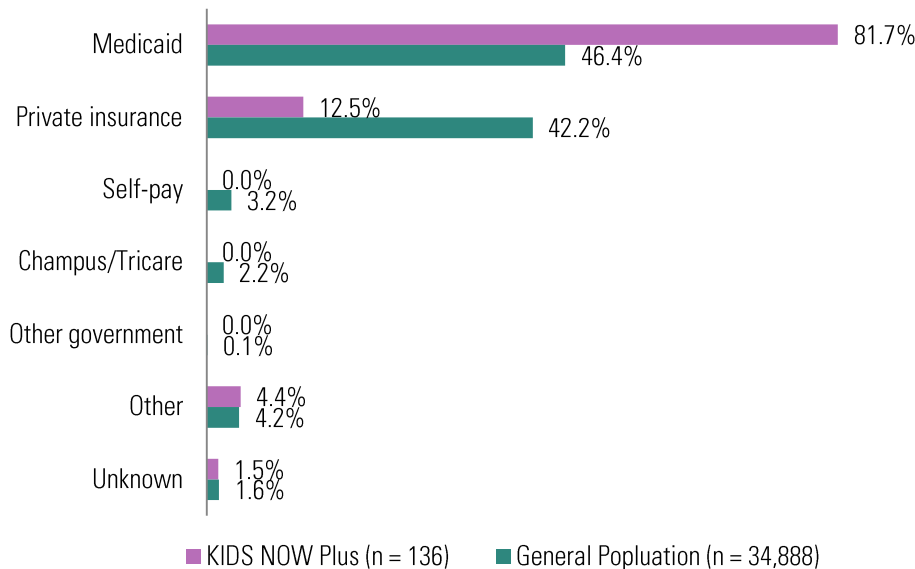
FIGURE 5.1. LEVEL OF EDUCATION ACROSS GROUPS, AMONG WOMEN 25 YEARS OLD OR OLDER***



***p < .001

Figure 5.2 shows that KIDS NOW Plus clients were significantly more likely to have Medicaid as their source of payment for the birth of the baby (81.7%)⁴⁴ whereas the general population was more likely to have private insurance (42.2%) compared to the KIDS NOW Plus clients (12.5%).

FIGURE 5.2. SOURCE OF PAYMENT FOR DELIVERY COSTS ACROSS GROUPS***



Significance tested with Chi-square test;***p < .001

⁴⁴ Percent of KIDS NOW Plus clients with Medicaid is different from section 2 because this data is from the birth event data set as opposed to self-reported at postnatal follow-up.

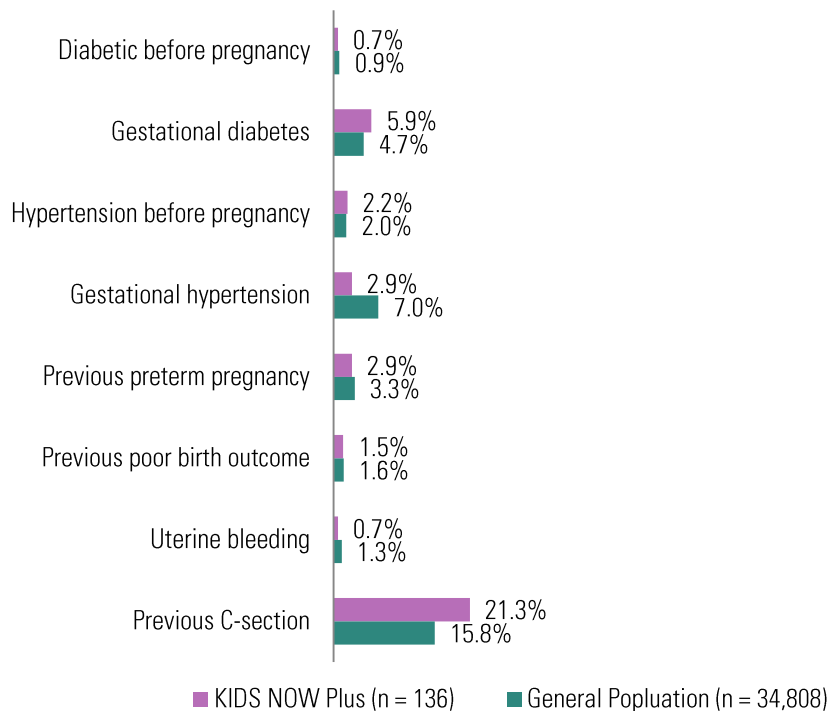
PHYSICAL HEALTH STATUS

General health conditions of pregnancy that could cause harm to the baby or the mother were collected from the state vital statistics data set and shown in Figure 5.3. KIDS NOW Plus mothers were not significantly more or less likely than the general population of mothers in the same regions to experience these maternal health conditions.



KIDS NOW PLUS MOTHERS DID NOT HAVE ANY MORE MATERNAL HEALTH PROBLEMS THAN THE GENERAL POPULATION OF MOTHERS

FIGURE 5.3. OTHER MATERNAL HEALTH FACTORS ACROSS GROUPS^a



a—85 mothers in the general population had missing information on maternal health questions.

KIDS NOW Plus clients were significantly more likely (9.6%) to have sexually transmitted infections such as gonorrhea, syphilis, herpes, or chlamydia compared to the general population (3.9%).⁴⁵ They were also significantly more likely to have hepatitis B or C (7.4%) compared to the general population of mothers (1.3%).

TARGETED RISK FACTORS

SMOKING PATTERNS

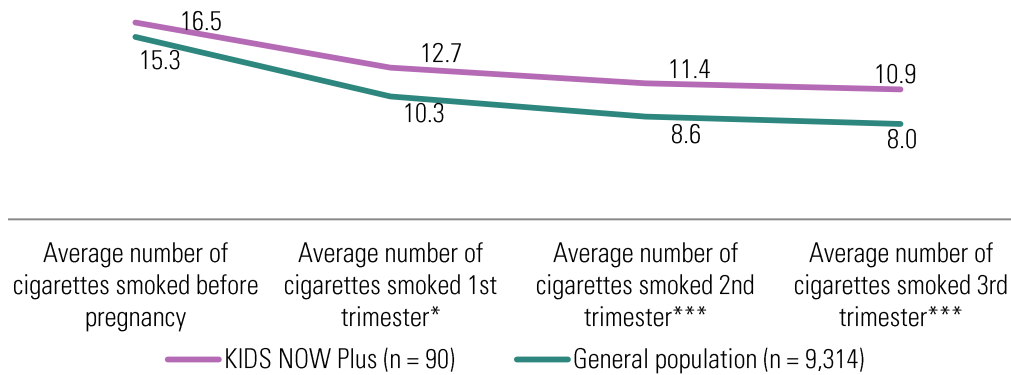
A significantly greater percentage of KIDS NOW Plus mothers (66.9%) were smokers compared to the general population of mothers (26.8%). In addition, among mothers who smoked, KIDS NOW Plus mothers reported smoking more cigarettes in each trimester compared the women in the general population (see Figure 5.4).



KIDS NOW PLUS MOTHERS SMOKED SIGNIFICANTLY MORE CIGARETTES DURING PREGNANCY COMPARED TO WOMEN IN THE GENERAL POPULATION

⁴⁵ Percentage of clients with STI is different from section 2 because this data is from the birth event data set as opposed to self-reported at intake.

FIGURE 5.4. AVERAGE NUMBER OF CIGARETTES SMOKED PER TRIMESTER



* p < .05, *** p < .01.

a— One KIDS NOW Plus client was missing information on the number of cigarettes per trimester. In the general population, 4 mothers were missing information on the number of cigarettes before pregnancy, 2 were missing the number of cigarettes in the first trimester, 3 were missing the number of cigarettes in the second trimester and 1 mother was missing the number of cigarettes in the last trimester.

BIRTH EVENTS AND OUTCOMES

MULTIVARIATE ANALYSIS OF BIRTH OUTCOMES

Using the Kentucky Vital Statistics data, the birth outcomes of children born to mothers who participated in KIDS NOW Plus case management (n = 137) were compared to the outcomes of children born to mothers who did not participate in KIDS NOW Plus and who lived in the CMHC regions that provide KIDS NOW Plus (n = 35,550). Logistic regression models were used to examine the association between KIDS NOW Plus participation and birth outcomes while adjusting for key factors. The alpha level was set at p < .01.

Each birth outcome in Table 5.2 was entered as the dependent variable in a separate binary logistic regression model with KIDS NOW Plus participation as the predictor variable and the covariates of mother’s age, education (i.e., less than high school diploma/high school diploma or higher), area of residence (metropolitan vs. non-metropolitan county), and smoking at the time of the birth (Yes/No).⁴⁶

Results of the analysis show that KIDS NOW Plus clients were not significantly more or less likely than mothers in the general population to give birth to a baby prematurely (the adjusted average mean⁴⁷ weeks gestation was 38.5 to 38.4), to have a child with low birth weight (7.2 to 7.3 lbs), to have birthing problems (between 10.0% and 10.2%), to have their baby taken to the neonatal intensive care unit (NICU; 7.3% and 7.4%), or to breastfeed (between 48.9% and 64.7%).



⁴⁶ Because race was highly associated with metropolitan vs. non-metropolitan residence for KIDS NOW Plus clients, such that only 4 non-White KIDS NOW Plus clients lived in a non-metropolitan community, to avoid the problem of multicollinearity in the models, race was excluded as a covariate while mother’s residence in a metropolitan vs. non-metropolitan community was included.

⁴⁷ An ANCOVA was used to estimate adjusted means using the same covariates used in the multivariate models and included mother’s age, education (i.e., high school diploma or higher), area of residence (metropolitan vs. non-metropolitan county), and smoking at the time of the birth.

TABLE 5.2. EFFECT OF KIDS NOW PLUS PARTICIPATION ON BIRTH OUTCOMES (N = 35,687)^a

	<i>b</i>	Adj. Odds ratio	99% Confidence Intervals
Premature	.104	1.109	.576-2.136
Low birth weight	.004	1.004	.494-2.044
Any birthing problems (other than the baby being taken to the NICU)	-.068	.935	.451-1.938
Baby taken to NICU	-.112	.894	.382-2.092
Breastfeeding	-.094	.910	.571-1.449

Note: Categorical variables were coded in the following ways: KIDS NOW Plus participation (0 = General population, 1 = KIDS NOW Plus client); Type of community in which mother resided (0=Non-metropolitan, 1=Metropolitan); Mother's education (0=Less than a high school diploma/GED, 1 = High school diploma/GED or higher); Mother reported being a smoker (0=No, 1=Yes); Premature (0 = Fullterm, 1 = Premature); Any birthing problems other than the baby being taken to the NICU (0 = No, 1 = Yes); Baby taken to NICU (0 = No, 1 = Yes); Breastfeeding (0= No, 1 = Yes).

a—The number of cases with missing values on at least one of the covariates or dependent variable for the 5 logistic models were: premature (n = 28), low birth weight (n = 8), any birth problems (n = 19), baby taken to NICU (n = 57), and breastfeeding (n = 398).

The highest APGAR score⁴⁸ was entered as the dependent variable in a linear regression model with KIDS NOW Plus participation as the predictor variable and the covariates of mother's age, education, area of residence, and smoking status at birth. As shown in Table 5.3, there was no difference in APGAR score (adjusted average score of 8.8) for babies born to KIDS Now Plus mothers versus mothers in the general population, after adjusting for the selected covariates.

TABLE 5.3. EFFECT OF PARTICIPATION IN KIDS NOW PLUS ON BABY'S HIGHEST APGAR SCORE (N = 35,335)^a

	β	t	df	p
Highest APGAR score	-.008	-1.540	5	.124

R² = .003, R²adj. = .003, F(5, 35,329) = 22.049, p < .001.

Note: Categorical variables were coded in the following ways: KIDS NOW Plus participation (0 = General population, 1 = KIDS NOW Plus client); Type of community in which mother resided (0=Non-metropolitan, 1=Metropolitan); Mother's education (0=Less than a high school diploma/GED, 1=High school diploma or higher); Mother reported being a smoker (0=No, 1=Yes).

a--Of the 35,687 cases with residence in a CMHC region that provides KNP case management, 89 cases had missing values for the highest APGAR score, 15 cases had scores outside the range of permissible values (negative values), and 248 cases had missing values on at least one of the covariates.

Specifically, there were no significant differences for the average number of gestational weeks, the percentage of babies who were born premature, highest APGAR score, birth weight, the percentage of babies with birthing problems, the percentage of babies being taken to the neonatal intensive care unit, or the decision to breastfeed. In addition, there was no significant difference for the average number of prenatal care visits with a health care provider. Further analysis of birth data outcomes can be found in Appendix B in which KIDS NOW Plus clients were compared to a sample of mothers on selected factors (i.e., age, race, education, marital status, metropolitan/non-metropolitan residence, and smoking status) along with a randomly selected comparison group from the general population. Overall, results of the comparison analysis parallel the results of the multivariate analysis with birth events and outcomes being very similar across the three groups.

⁴⁸ Most babies had one APGAR (5-minute) recorded in the file, but for a smaller number of babies a 10-minute APGAR was recorded. A new variable was computed that took the highest value APGAR (if 2 scores were recorded) or the only score.

NO SIGNIFICANT DIFFERENCES BETWEEN KIDS NOW PLUS MOTHERS COMPARED TO THE GENERAL POPULATION OF MOTHERS ON:

Gestational age



The adjusted average mean weeks gestation was 38.5 to 38.4

Low birth weight



Having a child with low birth weight (7.2 to 7.3 lbs)

Birthing problems



Between 10.0% and 10.2%

Baby taken to NICU



Between 7.3% and 7.4%

Average APGAR



Adjusted average score of 8.8

Breastfeeding



Between 48.9% and 64.7%

SUMMARY

In addition to the targeted risk factors of substance use, mental health symptoms, and partner abuse and violence, clients in KIDS NOW Plus had more risk factors compared to the general population of mothers giving birth in the same time frame. Compared to the general population of mothers giving birth in the regions served by KIDS NOW Plus case management, KIDS NOW Plus clients were younger, more lived in non-metropolitan areas, were less likely to be married, and had less education. In addition, KIDS NOW Plus mothers were more likely to have Medicaid as their source of payment for the birth of the baby. While they were not more likely to have maternal health problems such as gestational diabetes, hypertension and previous poor outcomes, they were more likely to have sexually transmitted infections as well as Hepatitis B and/or C. More KIDS NOW Plus mothers also smoked cigarettes before becoming pregnant and they smoked significantly more cigarettes in each trimester compared to the general population of mothers. Despite these characteristics, a multivariate analysis showed that birth events and outcomes were very similar between groups.

Specifically, KIDS NOW Plus clients were not significantly more or less likely to give birth prematurely, to have a child with low birth weight, to have birthing problems (such as fetal intolerance to labor, seizures or birth injury), to have a baby taken to the neonatal intensive care unit, or to breastfeed. In addition, there was no difference between KIDS NOW Plus mothers and the general population of mothers on average APGAR scores at birth.

SECTION 6. SUBSTANCE USE

This section of targeted risk factors examines change in: (1) overall substance use (illegal drug and alcohol use); (2) use of illegal drugs, alcohol, and cigarettes; (3) problems experienced with substance use; (4) readiness for substance abuse treatment; and (5) substance abuse treatment and self-help meetings. Past 30-day and past-6-month substance use are examined separately where applicable.

Change in targeted risk factors were examined for two different trends over time:⁴⁹

1. 30 day trends
 - a. 30 days before pregnancy. Information collected from the client at prenatal intake regarding the 30 days before she found out she was pregnant.
 - b. 30 days at prenatal intake. Information collected from the client at prenatal intake regarding past 30 days she has been pregnant.
 - c. 30 days before the baby was born. Information collected from the client at postnatal follow-up regarding the 30 days before giving birth while she was involved in KIDS NOW Plus case management services.
 - d. 30 days at postnatal follow-up. Information collected at postnatal follow-up regarding the past 30 days.
2. Six month trends
 - a. 6 months before pregnancy. Information collected from the client at prenatal intake regarding the six months before she found out she was pregnant.
 - b. 6 months since the birth of the baby. Information collected at postnatal follow-up regarding the past 6 months since the baby was born.

OVERALL SUBSTANCE USE (ILLEGAL DRUG AND ALCOHOL USE)

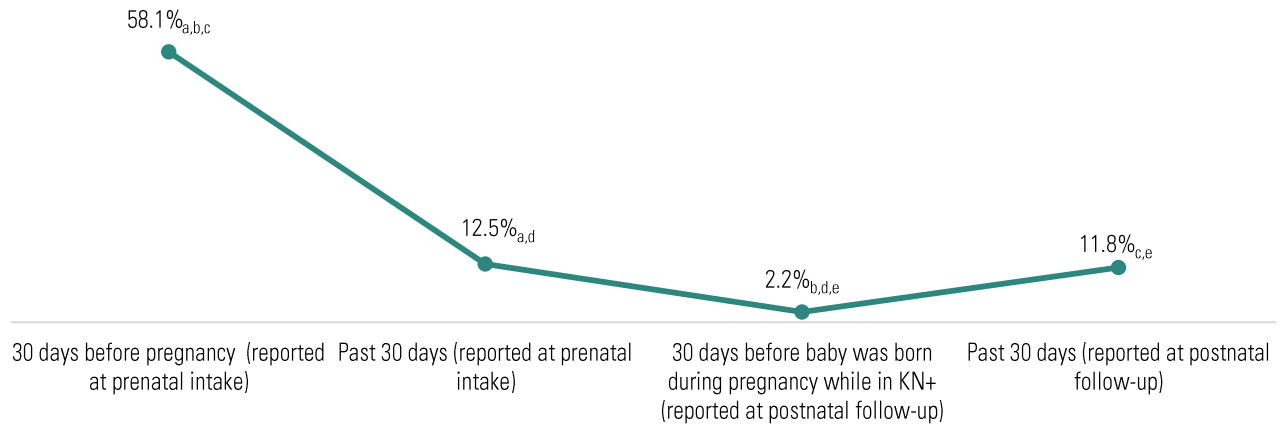
PAST-30-DAY ILLEGAL DRUGS AND/OR ALCOHOL USE

Figure 6.1 shows the results for overall illegal drug and/or alcohol use across all four past 30-day periods. In the 30 days before pregnancy, 58.1% of clients reported using illegal drugs and/or alcohol. In the past 30 days at intake, 12.5% of clients reporting using illegal drugs and/or alcohol (a significant decrease of 78.5% from the 30 days before pregnancy).

At postnatal follow-up, 2.2% of clients reported using illegal drugs and/or alcohol in the 30 days before the baby was born compared to 58.1% of clients in the 30 days before pregnancy (a 96.2% significant decrease) and 12.5% in the past 30 days at prenatal intake (a significant decrease of 84.2%). Finally, 11.8% of clients reported illegal drug and/or alcohol use in the past 30 days at postnatal follow-up. This is a significant decrease of 79.7% compared to the 30 days before pregnancy, but a significant increase of 433.3% compared to the 30 days before the baby was born.

⁴⁹ z-test for proportion was used for significance testing of substance use, mental health problems and intimate partner violence unless otherwise indicated.

FIGURE 6.1. PAST-30-DAY SUBSTANCE USE FROM PRENATAL INTAKE TO POSTNATAL FOLLOW-UP (N = 136)

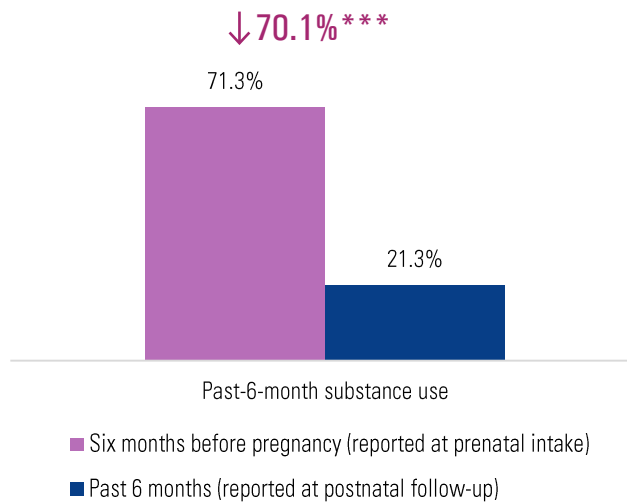


a, b, c, d, e— Values sharing the same subscript differ at $p < .01$

PAST-6-MONTH ILLEGAL DRUGS AND/OR ALCOHOL USE

In the 6 months before pregnancy, almost three-quarters of clients (71.3%) reported using illegal drugs and/or alcohol. In the past 6 months at follow-up, less than one-quarter (21.3%) of clients reported using illegal drugs and/or alcohol (a significant decrease of 70.1%).

FIGURE 6.2. PAST-6-MONTH SUBSTANCE USE FROM PRENATAL INTAKE TO POSTNATAL FOLLOW-UP (N = 136)



*** $p < .001$

ILLEGAL DRUG USE

PAST-30-DAY ILLEGAL DRUG USE

Less than one-half (44.1%) of clients reported illegal drug use⁵⁰ in the 30 days prior to becoming pregnant (see Figure 6.3). **A national survey of women indicated that 11.4% of non-pregnant women age 15-44 reported using illegal drugs in the past month.**⁵¹ A little less than 10% of clients reported using illegal drugs in the past 30 days

⁵⁰ Illegal drug use includes marijuana, sedatives, barbiturates, prescription opiates, cocaine, heroin, hallucinogens, inhalants, methadone, and non-prescribed buprenorphine.

⁵¹ Substance Abuse and Mental Health Services Administration. *Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863*. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

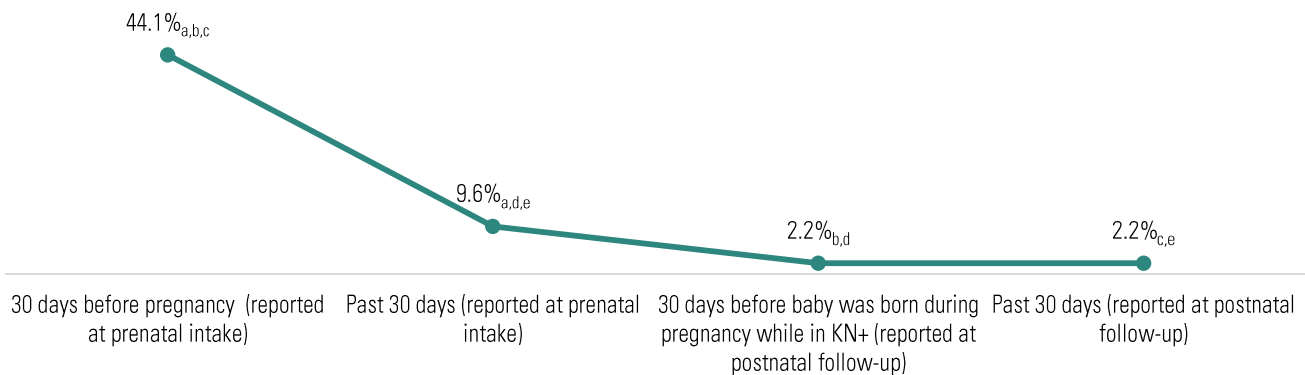
at intake (a significant decrease of 78.3% compared to the 30 days before pregnancy). **In comparison, nationally, 5.4% of pregnant women aged 15-44 reported using illegal drugs in the past month.**

At postnatal follow-up, 2.2% of clients (n = 3) reported using illegal drugs in the 30 days before the baby was born (a significant decrease of 95.0% from 30 days before pregnancy and 76.9% from the past 30 days at prenatal intake). This decrease was sustained in the past 30 days at postnatal follow-up.



95.0% fewer clients
REPORTED ILLEGAL DRUG USE IN THE 30 DAYS BEFORE THE BABY WAS BORN COMPARED TO THE 30 DAYS BEFORE PREGNANCY

FIGURE 6.3. PAST-30-DAY ILLEGAL DRUG USE FROM PRENATAL INTAKE TO POSTNATAL FOLLOW-UP (N = 136)

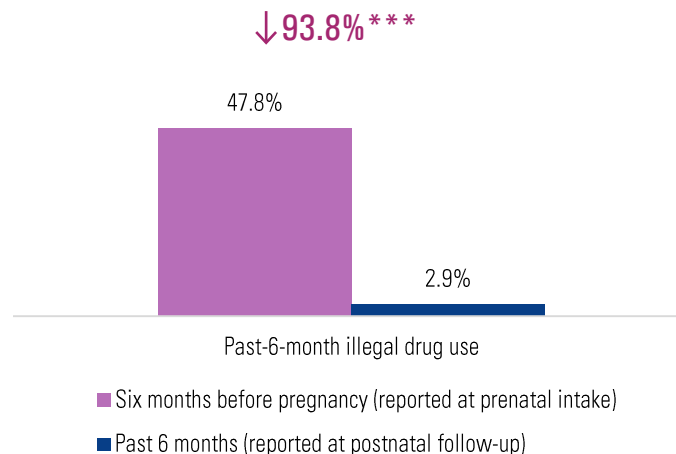


a, b, c, d, e— Values sharing the same subscript differ at $p < .01$

PAST-6-MONTH ILLEGAL DRUG USE

In the 6 months before pregnancy, 47.8% of clients reported using illegal drugs and in the past 6 months at follow-up 2.9% of clients reported illegal drug use (a significant decrease of 93.8%).

FIGURE 6.4. PAST-6-MONTH ILLEGAL DRUG USE FROM PRENATAL INTAKE TO POSTNATAL FOLLOW-UP (N = 136)



*** $p < .001$

INJECTION DRUG USE

At prenatal intake, 20.6% of clients reported ever injecting any drug and one client reported injecting a drug in the past 30 days. No client reported injecting drugs at postnatal follow-up.

ALCOHOL USE

PAST-30-DAY ALCOHOL USE

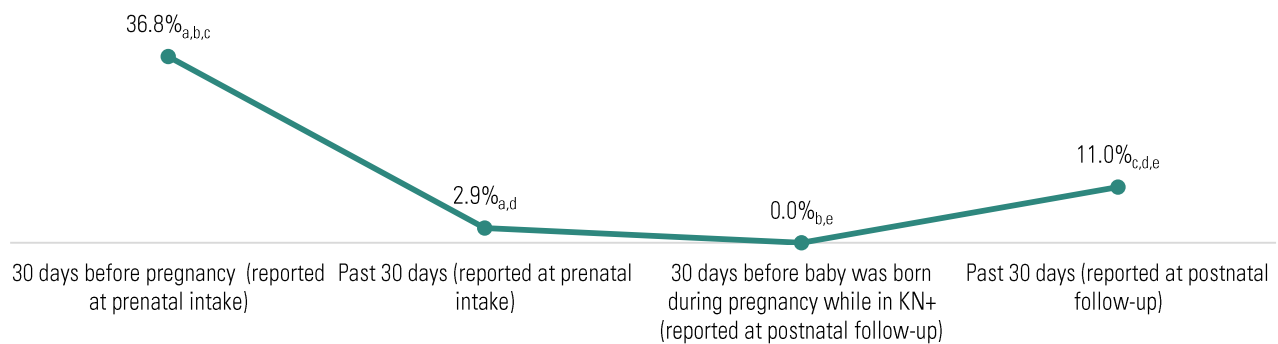
Figure 6.5 shows that 36.8% of clients reported alcohol use in the 30 days prior to becoming pregnant. **At the national level, 55.4% of non-pregnant women aged 15-44 reported drinking alcohol in the past 30 days.** In the past 30 days at prenatal intake, 2.9% of clients reported using alcohol (a significant decrease of 92.0% compared to the 30 days prior to pregnancy). **Nationally, 9.4% of women aged 15-44 reported using alcohol during pregnancy.**

At postnatal follow-up, no client reported using alcohol in the 30 days before the baby was born while they were involved in KIDS NOW Plus. After the baby was born, 11.0% clients reported alcohol use in the past 30 days (a significant increase of 275.0% from the 30 days prior at prenatal intake, but a significant decrease of 70.0% from the 30 days before pregnancy).



0 KIDS NOW Plus clients
REPORTED ALCOHOL USE IN THE 30 DAYS BEFORE THE BABY WAS BORN

FIGURE 6.5. PAST-30-DAY ALCOHOL USE FROM PRENATAL INTAKE TO POSTNATAL FOLLOW-UP (N = 136)

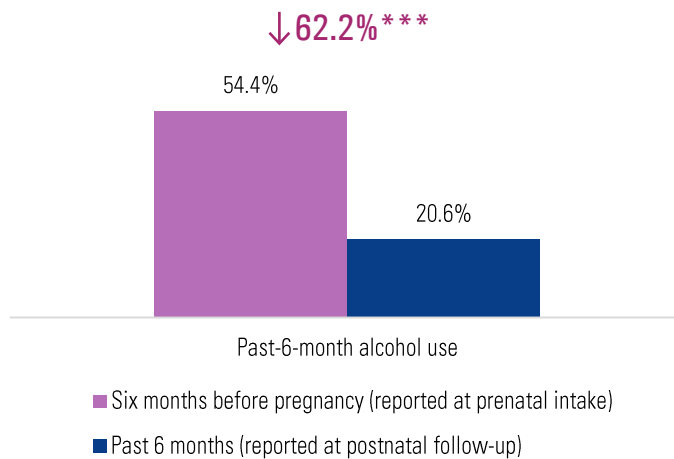


a, b, c, d— Values sharing the same subscript differ at $p < .01$

PAST-6-MONTH ALCOHOL USE

Figure 6.6 shows that in the six months before pregnancy 54.4% of clients reported alcohol use and after the baby was born, 20.6% clients reported alcohol use in the past 6 months (a significant decrease of 62.2% from the six months before pregnancy).

FIGURE 6.6. PAST-6-MONTH ALCOHOL USE FROM PRENATAL INTAKE TO POSTNATAL FOLLOW-UP (N = 136)



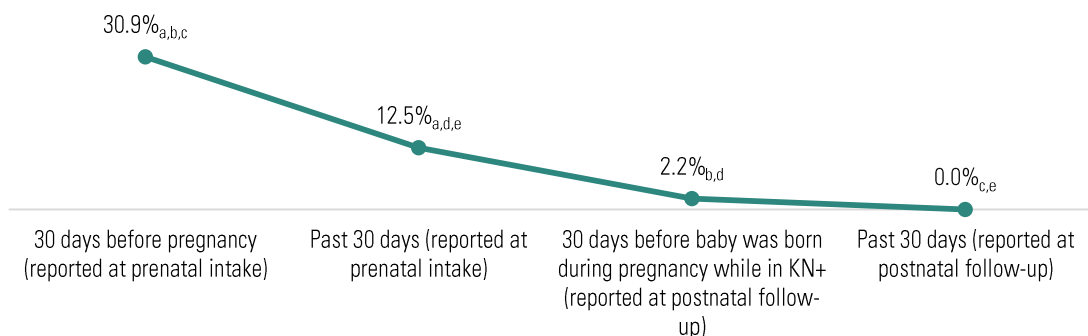
*** $p < .01$

PROBLEMS EXPERIENCED WITH SUBSTANCE USE

ILLEGAL DRUGS

In the 30 days before pregnancy, 30.9% of clients reported they experienced problems with drugs such as craving, withdrawal, wanting to quit but being unable, or worrying about relapse (see Figure 6.7). In the past 30 days at prenatal intake, 12.5% of clients reported experiencing problems with drugs (a significant decrease of 59.5% from the 30 days before pregnancy). At follow-up, 2.2% of clients (n = 3) reported experiencing problems with drugs in the 30 days before the baby was born (a significant decrease of 92.9% from before pregnancy and a significant decrease of 82.4% from the past 30 days at prenatal intake). In the past 30 days at postnatal follow-up, no clients reported any problems with drugs (a significant decrease of 100% from before pregnancy and from the past 30 days at prenatal intake).

FIGURE 6.7. CLIENTS EXPERIENCING PROBLEMS WITH ILLEGAL DRUGS AT PRENATAL INTAKE AND POSTNATAL FOLLOW-UP (N = 136)

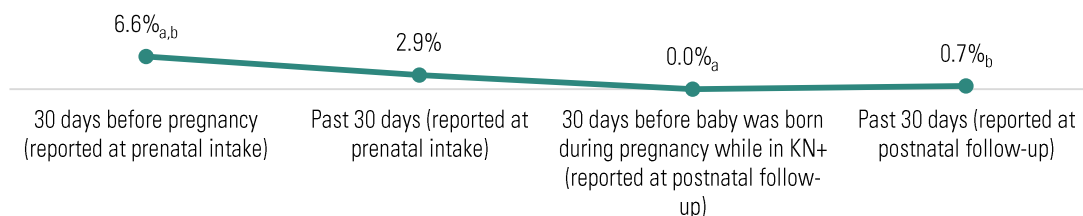


a, b, c, d, e— Values sharing the same subscript differ at $p < .01$

ALCOHOL

In the 30 days before pregnancy, 6.6% of clients reported they experienced problems with alcohol such as craving, withdrawal, wanting to quit but being unable, or worrying about relapse (see Figure 6.8). In the past 30 days at prenatal intake, 2.9% of clients reported experiencing problems with alcohol. At follow-up, none of the KIDS NOW Plus clients reported experiencing problems with alcohol in the 30 days before the baby was born (a significant decrease of 100% from before pregnancy). In the past 30 days at postnatal follow-up, only one client reported any problems with alcohol (a significant decrease of 88.9% from before pregnancy).

FIGURE 6.8. CLIENTS EXPERIENCING PROBLEMS WITH ALCOHOL AT PRENATAL INTAKE AND POSTNATAL FOLLOW-UP (N = 136)



a, b— Values sharing the same subscript differ at $p < .01$

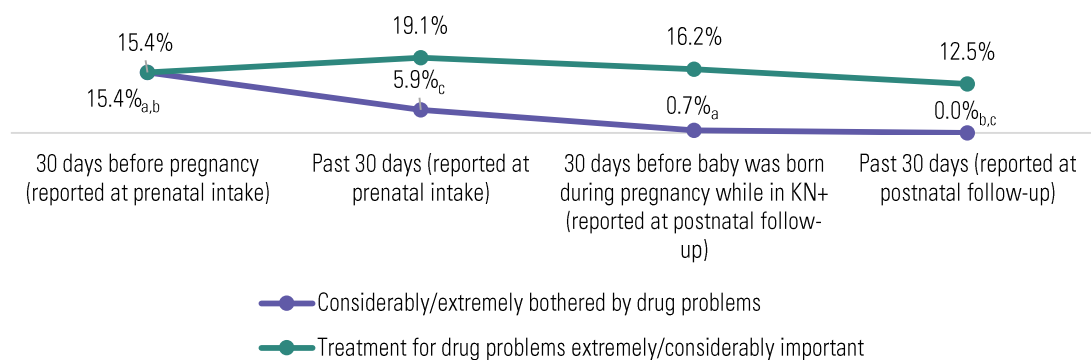
READINESS FOR SUBSTANCE ABUSE TREATMENT

READINESS FOR TREATMENT OF ILLEGAL DRUG USE

In the 30 days before pregnancy, 15.4% of clients reported they were considerably or extremely troubled or bothered by drug problems (see Figure 6.9). In the past 30 days at prenatal intake, 5.9% of clients were considerably or extremely troubled or bothered by drug problems. At follow-up, 0.7% of clients (n = 1) reported being considerably or extremely troubled or bothered by drug problems in the 30 days before the baby was born (a significant decrease of 95.2% from before pregnancy). In the past 30 days at postnatal follow-up, no clients reported being considerably or extremely troubled by drug problems (a significant decrease of 100% from before pregnancy and from the past 30 days at prenatal intake).

At prenatal intake, 15.4% of clients reported that treatment for drug problems was considerably or extremely important in the 30 days before pregnancy. In the past 30 days at prenatal intake, 19.1% of clients reported that treatment for drug problems was considerably or extremely important in the past 30 days. In the 30 days before the baby was born, 16.2% of clients felt that treatment for drug problems was considerably or extremely important and in the past 30 days at follow-up, 12.5% of clients reported treatment for drug problems was considerably or extremely important.

FIGURE 6.9. READINESS FOR TREATMENT FOR ILLEGAL DRUG USE AT PRENATAL INTAKE AND POSTNATAL FOLLOW-UP (N = 136)



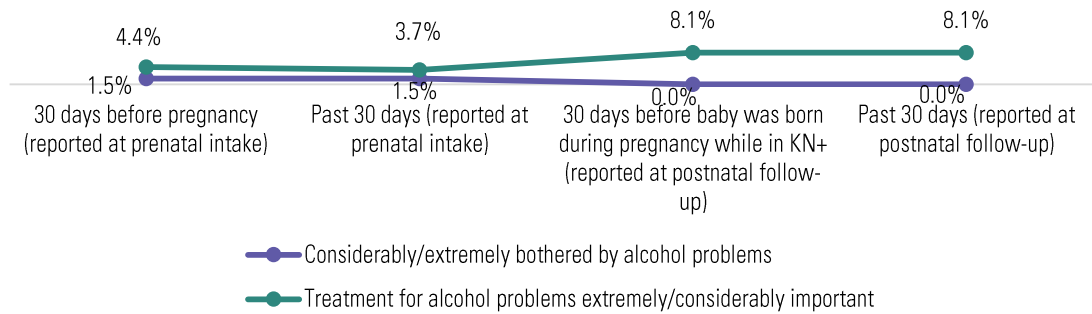
a, b, c– Values sharing the same subscript differ at $p < .01$

READINESS FOR ALCOHOL TREATMENT

Very few clients were considerably or extremely bothered by alcohol problems. In both the 30 days before pregnancy and the past 30 days at prenatal intake, 1.5% of clients reported they were considerably or extremely troubled or bothered by alcohol problems (see Figure 6.10). At follow-up, no client reported being considerably or extremely troubled or bothered by alcohol problems either in the 30 days before the baby was due or in the past 30 days.

In the 30 days before pregnancy, 4.4% of clients reported that treatment for alcohol problems was considerably or extremely important. In the past 30 days at prenatal intake, 3.7% of clients reported that treatment for alcohol problems was considerably or extremely important in the past 30 days. In both the 30 days before the baby was born and the past 30 days at postnatal follow-up, 8.1% of clients felt that treatment for alcohol problems was considerably or extremely important.

FIGURE 6.10. READINESS FOR TREATMENT FOR ALCOHOL USE AT PRENATAL INTAKE AND POSTNATAL FOLLOW-UP (N = 136)

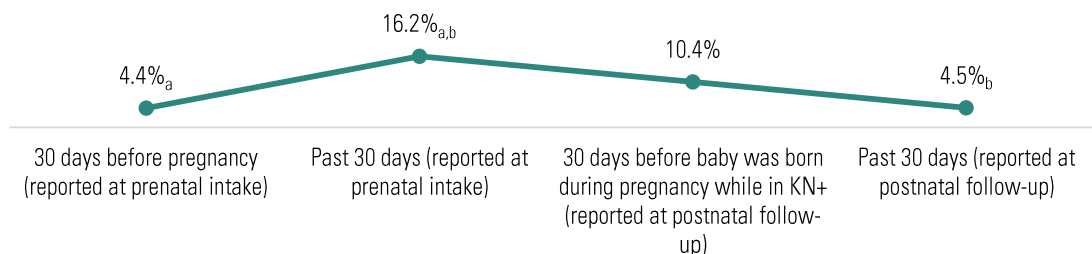


a, b, c– Values sharing the same subscript differ at $p < .01$

SUBSTANCE ABUSE TREATMENT

Figure 6.11 shows that in the 30 days before pregnancy, 4.4% of clients reported being treated for substance abuse (including detox) and in the past 30 days at intake, 16.2% of clients reported being treated for substance abuse (a significant increase of 72.7%). At postnatal follow-up, 10.4% of clients reported being treated for substance abuse (including detox) in the 30 days before the baby was born and 4.5% of clients reported being treated for substance abuse in the past 30 days (a significant decrease of 72.7% from the past 30 days at prenatal intake).

FIGURE 6.11. CLIENTS REPORTING SUBSTANCE ABUSE TREATMENT AT PRENATAL INTAKE AND POSTNATAL FOLLOW-UP (N = 136)



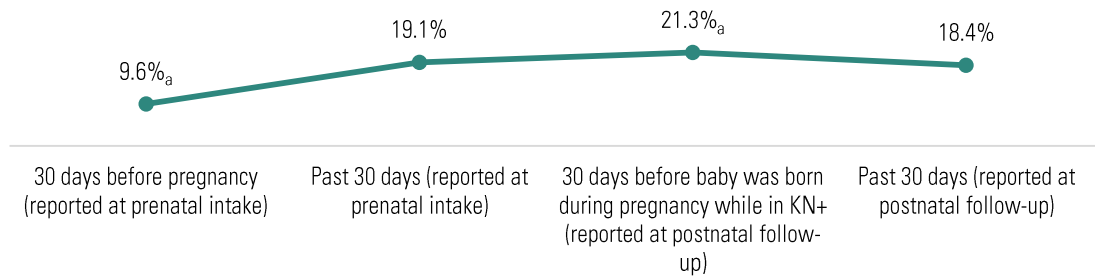
a, b– Values sharing the same subscript differ at $p < .01$

Note: Interviewer skipped question regarding substance abuse treatment for one client in the 30 days before the baby was born and two clients in the past 30 days at postnatal follow-up.

SELF-HELP MEETINGS

The number of clients who reported attending a self-help recovery meeting (such as AA, NA, or MA) increased from the 30 days before pregnancy to the past 30 days at follow-up. In the 30 days prior to pregnancy, 9.6% of clients reported attending a self-help meeting compared to 19.1% in the past 30 days at prenatal intake (see Figure 6.12). At follow-up, 21.3% of clients reported attending a self-help meeting in the 30 days before the baby was born (a significant increase of 123.1% compared to the 30 days before pregnancy). A little over 18% of clients reported attending a self-help meeting in the past 30 days at follow-up which, while not a significant increase, shows a sustained increase from prior to pregnancy.

FIGURE 6.12. CLIENTS REPORTING ATTENDING A SELF-HELP GROUP AT PRENATAL INTAKE AND POSTNATAL FOLLOW-UP (N = 136)



a— Values sharing the same subscript differ at $p < .01$

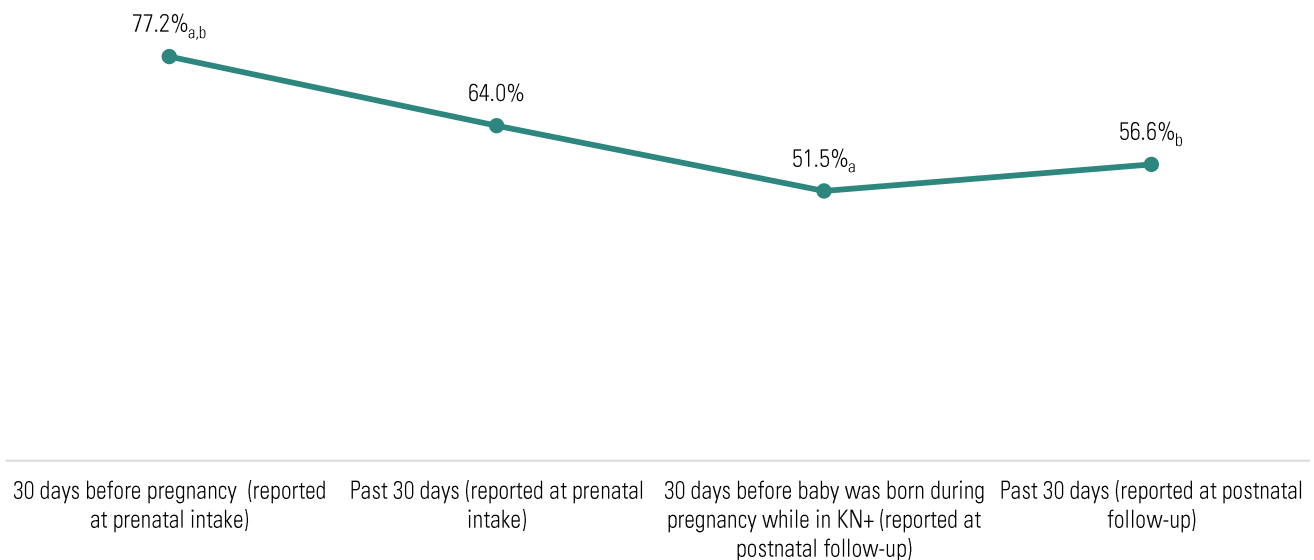
TOBACCO USE

PAST-30-DAY TOBACCO USE

At prenatal intake, 77.2% of clients reported smoking tobacco products in the 30 days prior to pregnancy (Figure 6.13). **This percentage is considerably higher than the national estimate of 24.0% of non-pregnant women aged 15-44 who reported cigarette use.** Sixty-four percent of clients reported smoking tobacco in the past 30 days at prenatal intake **compared to a little over 15% of pregnant women, nationally, reported smoking cigarettes.**

At postnatal follow-up, in the 30 days before the baby was born, 51.5% of clients reported smoking tobacco products (a significant decrease of 33.3% compared to the 30 days prior to pregnancy). The percentage of women who reported cigarette use in the past 30 days at postnatal follow-up remained stable (still a significant decrease from prior to pregnancy).


FIGURE 6.13. SMOKING TOBACCO USE IN THE PAST 30 DAYS FROM PRENATAL INTAKE TO POSTNATAL FOLLOW-UP (N = 136)



a,b— Values sharing the same subscript differ at $p < .01$

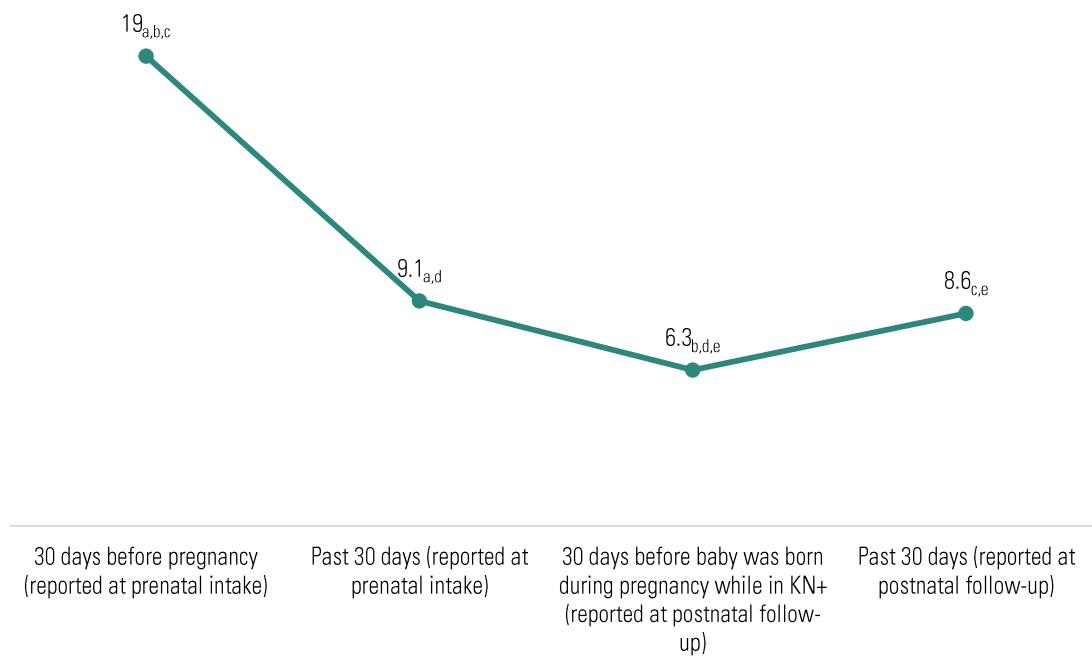
AVERAGE NUMBER OF CIGARETTES SMOKED IN THE PAST 30 DAYS

Figure 6.14 shows that for women who reported smoking tobacco in the 30 days prior to pregnancy (n = 105), the average number of cigarettes smoked declined from prior to pregnancy to after the client became involved in KIDS NOW Plus and remained low after the birth of the baby. At prenatal intake, women who smoked reported that in the 30 days before they found out they were pregnant they smoked an average of 19.0 cigarettes per day (nearly one pack) and an average of 9.1 cigarettes per day in the past 30 days at prenatal intake (a 52.1% significant decrease). At postnatal, in the 30 days before the baby was born and the client was in the KIDS NOW Plus case management program, the average number of cigarettes decreased further to 6.3 (a 66.8% significant decrease from the 30 days prior to pregnancy and a 30.8% significant decrease from the past 30 days at prenatal intake). While there was a significant increase in the number of cigarettes smoked after the baby was born compared to the 30 days before the baby was born (a 36.5% increase), they still smoked significantly fewer cigarettes than before pregnancy (a significant decrease of 54.7%) suggesting positive changes in smoking.



55% decrease
IN THE NUMBER OF CIGARETTES
SMOKED AFTER THE BABY WAS BORN
COMPARED TO BEFORE PREGNANCY

FIGURE 6.14. AVERAGE NUMBER OF CIGARETTES SMOKED AMONG WOMEN REPORTING CIGARETTE USE IN THE 30 DAYS PRIOR TO PREGNANCY (N = 105)

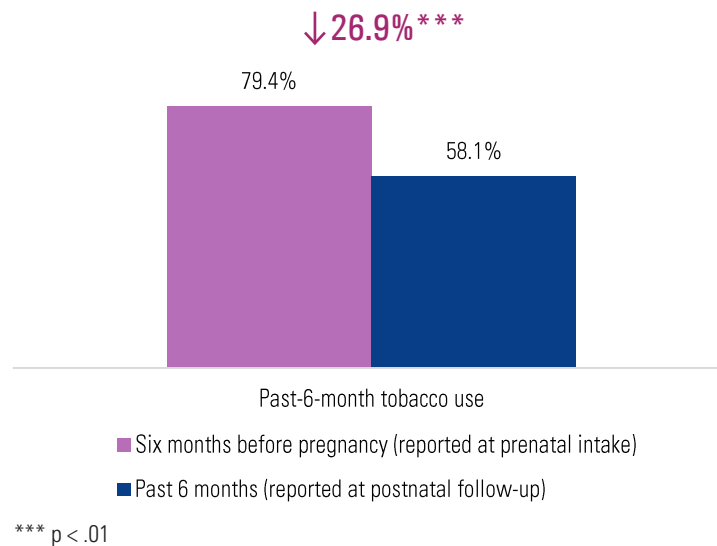


a, b, c, d, e – Values sharing the same subscript differ at p < .01

PAST-6-MONTH TOBACCO USE

At prenatal intake, 79.4% of clients reported smoking tobacco use in the six months prior to pregnancy (Figure 6.15). At postnatal follow-up, 58.1% of clients reported tobacco use in the past 6 months (a significant decrease of 26.9%).

FIGURE 6.15. SMOKING TOBACCO USE IN THE PAST 6 MONTHS FROM PRENATAL INTAKE TO POSTNATAL FOLLOW-UP (N = 136)



SUMMARY

These new mothers reported significant reductions in substance use in the past 30 days of pregnancy at prenatal intake and further reductions after the baby was born. Specifically, 95.0% fewer clients reported illegal drug use in the 30 days before the baby was born compared to the 30 days before pregnancy and no clients reported alcohol use in the 30 days before the baby was born. In addition, after becoming involved in KIDS NOW Plus, fewer clients reported experiencing or being bothered by substance use problems (such as craving, withdrawal, wanting to quit but being unable, or worrying about relapse) while more clients reported attending self-help meetings (such as AA, NA, or MA) in the past 30 days at prenatal intake compared to before pregnancy. The number of women who reported smoking cigarettes in the 30 days before the baby was born decreased 33% from the 30 days prior to pregnancy as did the average number of cigarettes clients reported smoking. These decreases in smoking, compared to before pregnancy, were sustained even after the baby was born.

Furthermore, clients reported experiencing fewer problems with drugs (such as craving, withdrawal, wanting to quit but being unable, or worrying about relapse) from the 30 days before becoming pregnant to during the time they were pregnant and in KIDS NOW Plus. This decrease was sustained in the past 30 days at follow-up. More clients also reported receiving substance abuse treatment and attending self-help meetings while pregnant and involved in KIDS NOW Plus.

SECTION 7. MENTAL HEALTH

This section examines changes in self-reported mental health for following factors: (1) depression; (2) generalized anxiety; (3) exposure to traumatic events; and, (4) number of days physical and mental health were poor. Past 30-day and past-6-month mental health symptoms are examined separately where applicable.

DEPRESSION SYMPTOMS

To assess depression, clients were first asked two screening questions:

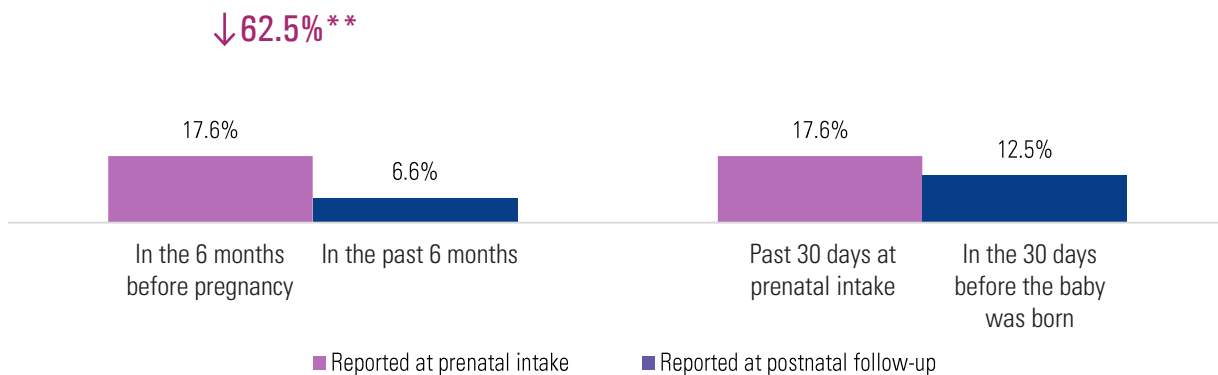
1. "Did you have a two-week period when you were consistently depressed or down, most of the day, nearly every day?" and
2. "Did you have a two-week period when you were much less interested in most things or much less able to enjoy the things you used to enjoy most of the time?"

If participants answered "yes" to at least one of these two screening questions, they were then asked seven additional questions about symptoms of depression (e.g., sleep problems, weight loss or gain, feelings of hopelessness or worthlessness). To meet study criteria for depression, clients had to say "yes" to at least one of the two screening questions and at least 4 of the other symptoms.

In the 6 months before they became pregnant, 17.6% of the women met study criteria for depression. In the past 6 months at postnatal follow-up, 6.6% of KIDS NOW Plus clients met study criteria for depression (a significant decrease of 62.5% from the 6 months before pregnancy). In the past 30 days at prenatal intake, 17.6% of the women met study criteria for depression (see Figure 7.1). At postnatal follow-up, 12.5% of clients met study criteria for depression in the 30 days before the baby was born.

63% DECREASE IN THE NUMBER OF WOMEN WHO MET STUDY CRITERIA FOR DEPRESSION IN PAST 6 MONTHS AT FOLLOW-UP COMPARED TO PRENATAL INTAKE

FIGURE 7.1. MEETING STUDY CRITERIA FOR DEPRESSION AT PRENATAL INTAKE AND POSTNATAL FOLLOW-UP (N = 136)

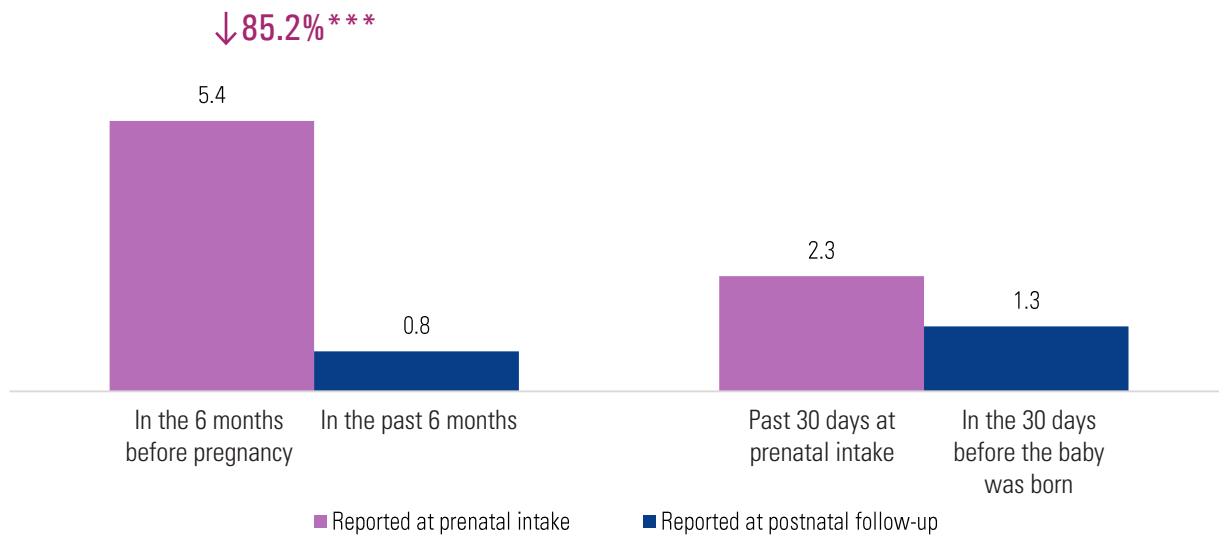


AVERAGE NUMBER OF DEPRESSION SYMPTOMS

Clients who reported experiencing feelings of depression in the 6 months before pregnancy at prenatal intake (n = 24) were asked about 7 symptoms they may have, such as a decrease in appetite, trouble sleeping, feeling worthless or considering hurting themselves (see Figure 7.2). Of the clients who reported experiencing feelings of depression in the 6 months before pregnancy, they reported an average of 5.4 symptoms. In the past 6 months at postnatal follow-up clients reported an average of 0.8 symptoms (a significant decrease of 85.2% compared to before pregnancy), indicating that reduction in depressive symptoms was sustained after KIDS NOW Plus participation.

Clients who reported feelings of depression in the 6 months before pregnancy reported an average of 2.3 symptoms in the past 30 days at prenatal intake and an average of 1.3 symptoms in the 30 days before the baby was born.

FIGURE 7.2. AVERAGE NUMBER OF SYMPTOMS OF DEPRESSION AMONG THOSE CLIENTS WHO MET STUDY CRITERIA FOR DEPRESSION IN THE 6 MONTHS BEFORE PREGNANCY AT PRENATAL INTAKE (N = 24)



*** p < .001
Significance tested with paired sample t-test

ANXIETY SYMPTOMS

To assess for generalized anxiety symptoms, participants were first asked:

1. "In the 12 months before you entered this program, did you have a period lasting 6 months or longer where you worried excessively or were anxious about multiple things on more days than not (like family, health, finances, school, or work difficulties)?"

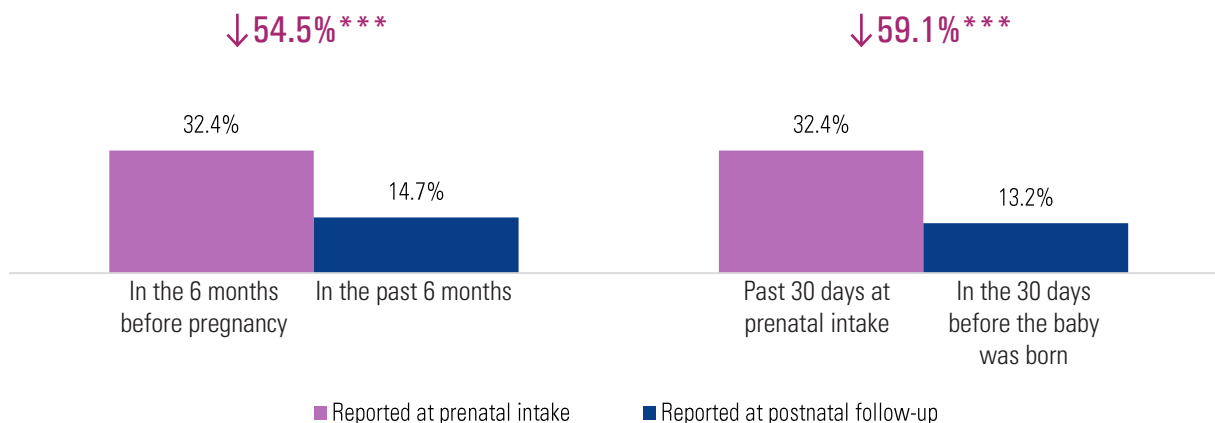
Participants who answered "yes" were then asked 6 additional questions about anxiety symptoms (e.g., felt restless, keyed up or on edge, have difficulty concentrating, feel irritable). To meet study criteria for generalized anxiety, clients had to answer "yes" to the screening question and to at least 3 of the symptom items.

In the 6 months before pregnancy, 32.4% of clients reported symptoms that met study criteria for generalized anxiety (see Figure 7.3). In the past 6 months at postnatal follow-up, 14.7% of clients met study criteria for generalized anxiety, which is a significant decrease of 54.5% from the 6 months before pregnancy.

In the past 30 days at prenatal intake, 32.4% of clients reported symptoms that met study criteria for generalized anxiety (see Figure 7.3). In the 30 days before the baby was born, 13.2% of KIDS NOW Plus clients met criteria for generalized anxiety, which is a significant decrease of 59.1% from the past 30 days at prenatal intake.

55% DECREASE IN THE NUMBER OF WOMEN WHO MET STUDY CRITERIA FOR GENERALIZED ANXIETY IN PAST 6 MONTHS AT FOLLOW-UP COMPARED TO PRENATAL INTAKE

FIGURE 7.3. MEETING STUDY CRITERIA FOR GENERALIZED ANXIETY AT PRENATAL INTAKE AND POSTNATAL FOLLOW-UP (N = 136)

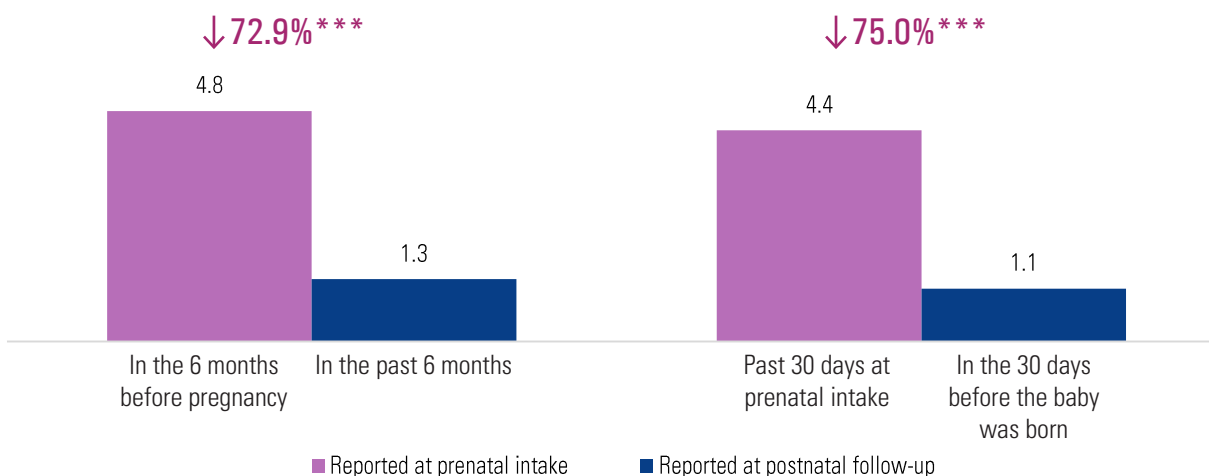


AVERAGE NUMBER OF ANXIETY SYMPTOMS

Clients who reported experiencing feelings of anxiety in the 6 months before pregnancy (n = 44) were asked about 6 symptoms they may have, such as a feeling restless, keyed up or on edge, having difficulty concentrating, or feeling irritable (see Figure 7.4). Of the clients who reported experiencing feelings of anxiety in the 6 months before pregnancy, they reported an average of 4.8 symptoms. In the past 6 months at postnatal follow-up, clients reported an average of 1.3 symptoms which is a significant decrease of 72.9% compared to before pregnancy.

At prenatal intake, clients who reported feelings of anxiety in the 6 months before pregnancy reported an average of 4.4 symptoms in the past 30 days at prenatal intake. At postnatal follow-up, those who reported anxiety prior to pregnancy reported an average of 1.1 symptoms in the 30 days before the baby was born (a significant decrease of 75.0% significant decrease compared to the past 30 days at prenatal intake).

FIGURE 7.4. AVERAGE NUMBER OF SYMPTOMS OF ANXIETY AMONG THOSE CLIENTS WHO REPORTED FEELINGS OF ANXIETY IN THE 6 MONTHS BEFORE PREGNANCY AT PRENATAL INTAKE (N = 44)



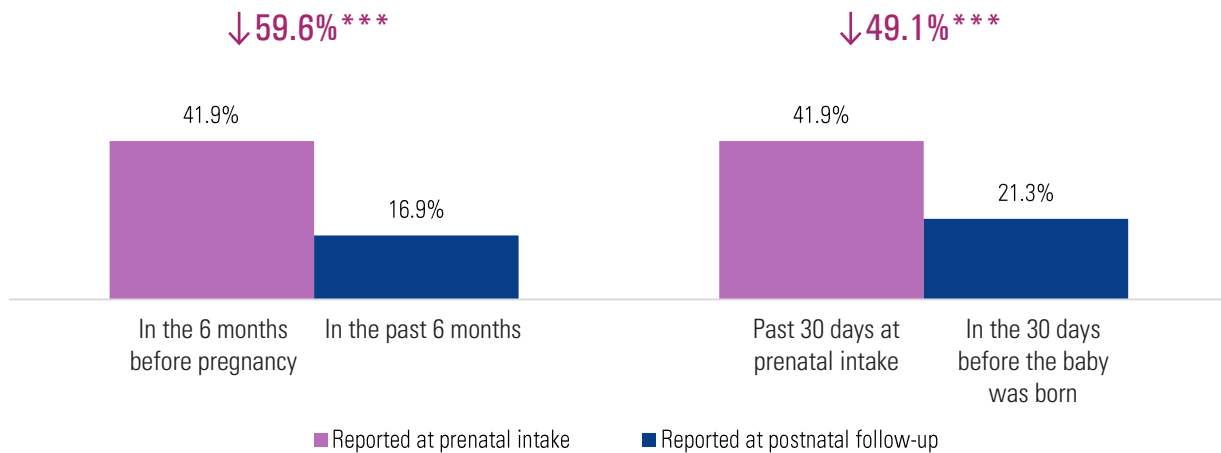
*** p < .001
Significance tested with paired sample t-test

DEPRESSION AND ANXIETY SYMPTOMS

Figure 7.5 shows that 41.9% met study criteria for depression and/or anxiety in the 6 months before pregnancy. In the past 6 months at postnatal follow-up, 16.9% of clients met criteria for depression and/or anxiety which is a 59.6% significant decrease from the 6 months before pregnancy. In the past 30 days at prenatal intake, 41.9% of clients met study criteria for depression and/or anxiety and in the 30 days before the baby was born, 21.3% of the women met study criteria for depression and/or anxiety (a significant decrease of 49.1% from the past 30 days at prenatal intake).

60% DECREASE IN THE NUMBER OF WOMEN MEETING STUDY CRITERIA FOR DEPRESSION AND/OR ANXIETY IN THE 6 MONTHS AFTER THE BABY WAS BORN COMPARED TO PRENATAL INTAKE

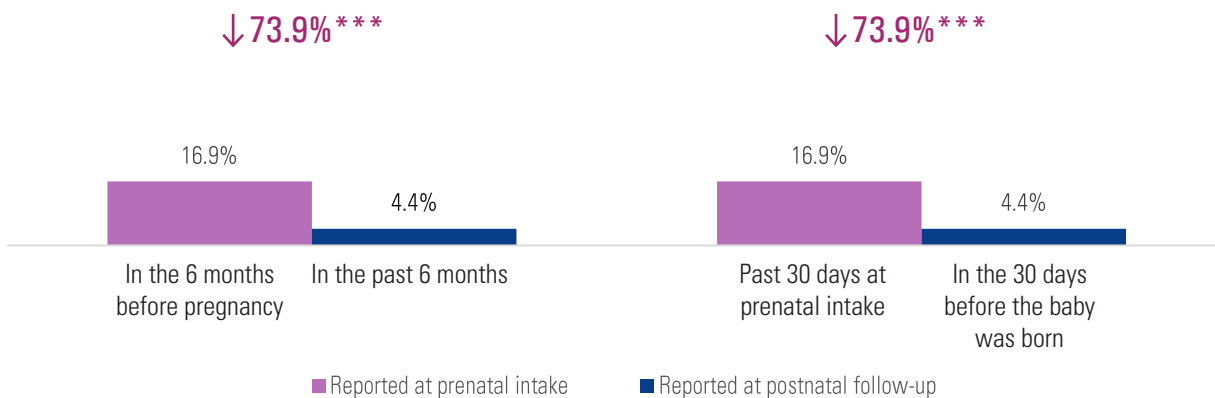
FIGURE 7.5. MET STUDY CRITERIA FOR DEPRESSION AND/OR ANXIETY AT PRENATAL INTAKE AND POSTNATAL FOLLOW-UP (N = 136)



*** p < .01

About 17% of clients met criteria for both anxiety and depression in the past 6 months before they became pregnant as well as in the past 30 days at prenatal intake (see Figure 7.6). At postnatal follow-up, 4.4% of clients reported both anxiety and depression in the 30 days before the baby was born and in the past 6 months (a significant decrease of 73.9% from prenatal intake).

FIGURE 7.6. CLIENTS MEETING CRITERIA FOR COMORBID DEPRESSION AND GENERALIZED ANXIETY AT PRENATAL INTAKE AND POSTNATAL FOLLOW-UP (N = 136)



*** p < .01

EXPOSURE TO TRAUMATIC EVENTS

In addition to depression and anxiety, at prenatal intake, 32.4% of clients indicated they had, in the past 12 months, experienced or witnessed an extremely traumatic event. At postnatal follow-up, 7.4% of clients reported having experienced or witnessed a new extremely traumatic event in the past 12 months.

PERCEPTIONS OF POOR PHYSICAL OR MENTAL HEALTH LIMITING ACTIVITIES

Clients were asked how many days in the past 30 days their physical and mental health were not good, at prenatal intake and postnatal follow-up (see Figure 7.7). There was a 68.2% significant decrease from intake to follow-up in the number of days clients reported their physical health was not good (from 4.4 days to 1.4 days). In comparison, America’s Health Rankings indicate people in Kentucky report an average of 4.9 days of poor physical health in the past 30 days.⁵² KIDS NOW Plus clients report fewer days of poor physical health at both prenatal intake and postnatal follow-up compared to the general population surveyed in Kentucky.

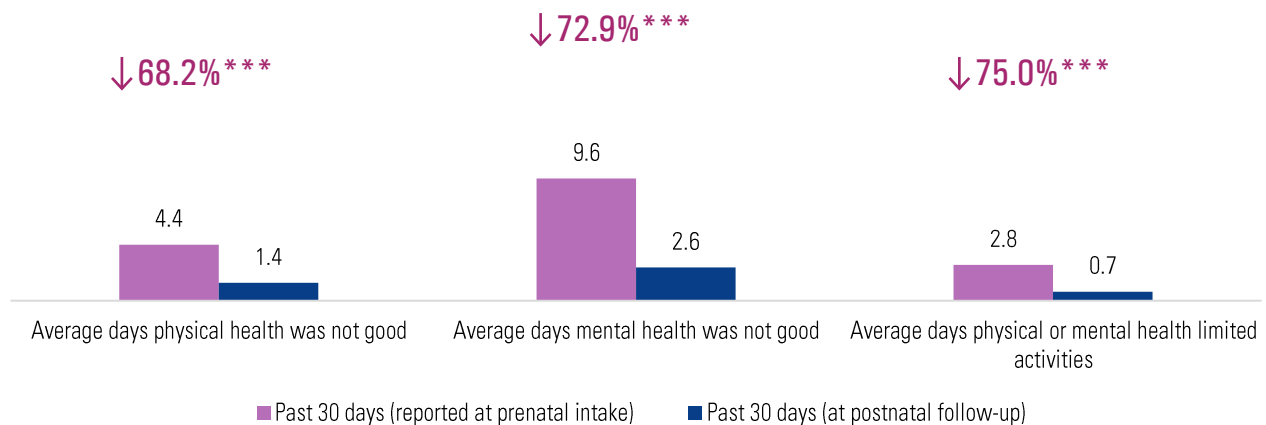
The number of days clients’ mental health was not good decreased significantly by 72.9% from 9.6 days at prenatal intake to 2.6 days at postnatal follow-up. America’s Health Rankings indicate people in Kentucky report an average of 4.5 days of poor mental health in the past 30 days.

The number of days clients reported their physical or mental health kept them from doing their usual activities decreased significantly by 75.0% from 2.8 days at intake to 0.7 days at follow-up



75% DECREASE IN THE NUMBER DAYS CLIENTS REPORTED THEIR PHYSICAL OR MENTAL HEALTH KEPT THEM FROM DOING THEIR USUAL ACTIVITIES

FIGURE 7.7. PERCEPTIONS OF POOR PHYSICAL HEALTH AND MENTAL HEALTH LIMITING ACTIVITIES IN THE PAST 30 DAYS AT INTAKE AND FOLLOW-UP (N = 135)^a



*** p > .01

Significance tested with paired sample t-test

a— One client did not have question on survey at follow-up.

⁵² America’s Health Rankings: A Call to Action for Individuals and Their Communities. Retrieved from <http://www.americashealthrankings.org/KY>.

SUMMARY

The number of clients who met study criteria for depression and/or anxiety decreased significantly from prenatal intake to postnatal follow-up. In addition, of those clients who met criteria for depression and/or anxiety in the 6 months before they were pregnant, the average number of depression and anxiety symptoms decreased significantly from before pregnancy to while they were and involved in KIDS NOW Plus case management services. Furthermore, the average number of symptoms remained lower 6 months after the birth of the baby.

Clients also reported a significant decrease in the average number of days their physical and mental health were not good and the average number of days their physical or mental health limited their activities.

SECTION 8. PARTNER ABUSE AND SEXUAL ASSAULT

This section examines changes in intimate partner abuse and violence such as: (1) any abuse, (2) psychological abuse, (3) coercive control, (4) physical abuse, and (5) sexual violence by any type of perpetrator, from prenatal intake to postnatal follow-up. Past 6-month and past 30-day partner abuse measures are examined separately where applicable.

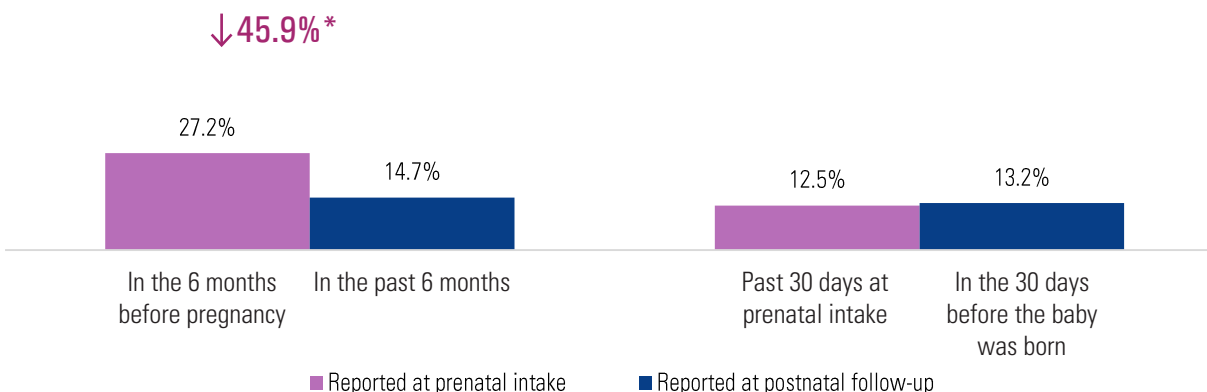
Including fear of a current or ex-partner, 4.4% of clients reported they felt unsafe at intake, and 2.9% reported feeling unsafe at the follow-up.

ANY ABUSE

Figure 8.1 shows that in the 6 months before pregnancy, 27.2% of clients reported experiencing any type of abuse⁵³ (including psychological abuse, control, physical abuse, and sexual abuse) perpetrated by a current or ex-partner and 14.7% of clients reported experiencing abuse in the past 6 months at postnatal follow-up (significant decrease of 45.9%). In the past 30 days at prenatal intake, 12.5% of KIDS NOW Plus clients reported experiencing any type of abuse. In the 30 days before the baby was born, 13.2% of clients reported any type of partner abuse.

46% DECREASE IN THE NUMBER OF CLIENTS WHO REPORTED **ANY INTIMATE PARTNER ABUSE** AT POSTNATAL FOLLOW-UP

FIGURE 8.1. ANY TYPE OF ABUSE AT PRENATAL INTAKE AND POSTNATAL FOLLOW-UP (N = 136)



*p < .05

PSYCHOLOGICAL ABUSE

Almost one-quarter of clients reported at prenatal intake that a partner psychologically abused them in the 6 months before pregnancy (e.g., insulted the client, shouted, criticized them, criticized them in front of others, treated them like an inferior, tried to make them feel crazy, or told them their feelings were irrational or crazy) and 7.4% of clients reported

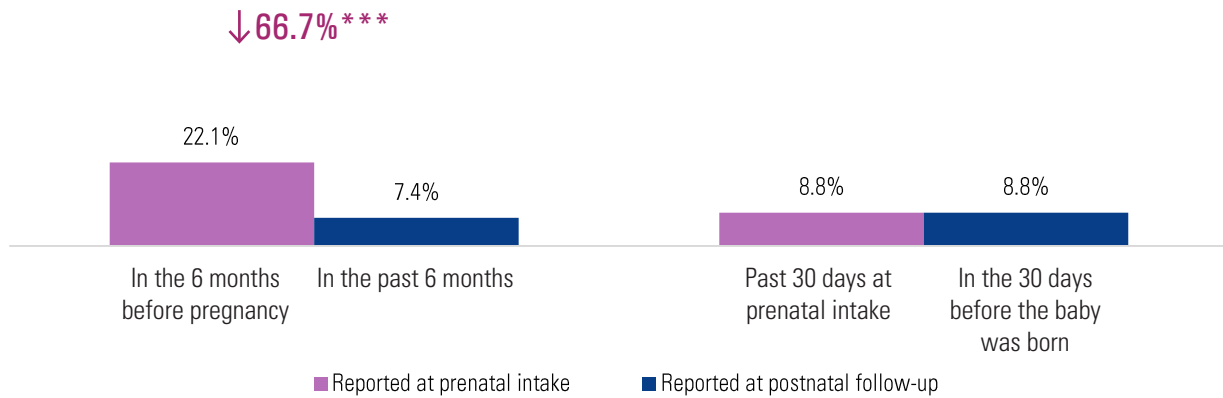
67% DECREASE IN THE PERCENTAGE OF CLIENTS REPORTING BEING A **VICTIM OF PSYCHOLOGICAL ABUSE** IN THE 6 MONTHS AFTER THE BABY WAS BORN

⁵³ Any abuse was defined in this study as a client indicating “yes” to any of the partner abuse questions asked in the survey (e.g., verbal and psychological abuse, extreme jealousy and control, threats of violence towards client and others close to them, physical violence, stalking, partner purposely damaging or destroying property, sexual assault/threats of assault) at each period.

psychological abuse in the past 6 months at postnatal. Compared to the 6 months before they were pregnant, there was a significant 66.7% decrease in reports of psychological abuse in the 6 months after clients had their baby (see Figure 8.2).

In the past 30 days at prenatal intake, 8.8% of clients reported psychological abuse by a partner. This percentage remained unchanged with 8.8% of clients reporting psychological abuse in the 30 days before the baby was born.

FIGURE 8.2. PSYCHOLOGICAL ABUSE AT PRENATAL INTAKE AND POSTNATAL FOLLOW-UP (N = 136)



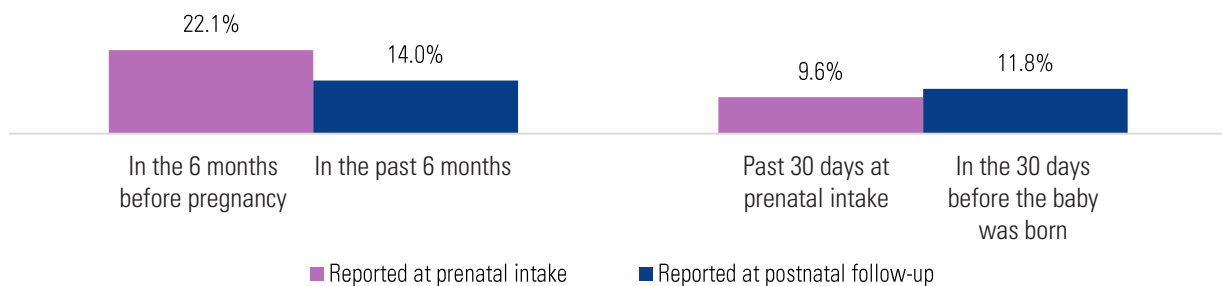
*** p < .01

COERCIVE CONTROL

For this study, coercive control is described as abuse by a partner wherein the partner threatened the client or a family member in order to frighten her, was extremely jealous and controlling, interfered with other relationships, stalked her, or purposely destroyed property that belonged to the client or a close friend/family member. In the 6 months before becoming pregnant, 22.1% of clients reported being a victim of coercive control and 14.0% of clients in the past 6 months at postnatal follow-up reported experiencing coercive control from their partner (see Figure 8.3).

In the past 30 days at prenatal intake, 9.6% reported coercive control occurred while they were pregnant and involved in KIDS NOW Plus. Almost 12% reported experiencing coercive control from their partner in the 30 days before the baby was born.

FIGURE 8.3. COERCIVE CONTROL BY A PARTNER AT PRENATAL INTAKE AND POSTNATAL FOLLOW-UP (N = 136)



PHYSICAL ABUSE

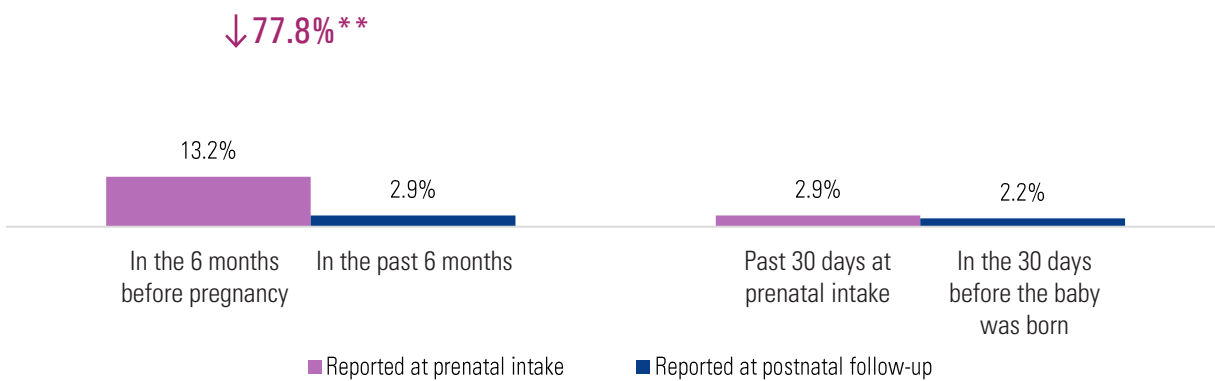
A little over 13% of women reported that a partner physically abused them (e.g., pushing, shoving, kicking, beating up, choking, burning, attacking with a weapon) in the 6 months before they became pregnant (see Figure 8.4). In the past 6 months at postnatal follow-up, 2.9% of clients reported physical abuse by a partner (a significant decrease of 77.8% compared to the 6 months before pregnancy).



78% DECREASE IN THE PERCENTAGE OF CLIENTS REPORTING BEING A **VICTIM OF PHYSICAL ABUSE** IN THE 6 MONTHS AFTER THE BABY WAS BORN

Less than 3% of clients reported a partner physically abused them in the past 30 days at prenatal intake. In the 30 days before the birth of the baby, 2.2% reported a partner physically abused them.

FIGURE 8.4. PHYSICAL ABUSE AT PRENATAL INTAKE AND POSTNATAL FOLLOW-UP (N = 136)^a



** p < .01

a—Question skipped for one client at follow-up.

SEXUAL ASSAULT

Very few clients (3.7%, n = 5) reported at prenatal intake that they had been sexually assaulted by a partner (e.g., partner made them do sexually degrading things, caused them to have sex because they were afraid of what would happen if they didn't, made the client have sex by threatening to harm them or someone close to them, or physically forcing them to have sex) in the 6 months before pregnancy. In the past six months at postnatal follow-up, one client indicated she had been sexually assaulted by a partner (see Figure 8.5).

In the past 30 days at prenatal intake, only 1 client reported being a victim of sexual assault and in the 30 days before the baby was born, 2 clients reported sexual assault.

FIGURE 8.5. PARTNER SEXUALLY ASSAULTED CLIENT AT PRENATAL INTAKE AND POSTNATAL FOLLOW-UP (N = 136)



Only a handful of clients reported being forced to have sex by someone other than a partner at any point (2.9% of clients in the 6 months before pregnancy, 1.5% in the past 6 months at postnatal follow-up, 0.7% clients in the past 30 days at prenatal intake, and 0.7% in the 30 days before the baby was born).

SUMMARY

Several forms of partner violence were examined from prenatal intake to postnatal follow-up. Approximately one-quarter of KIDS NOW Plus clients reported experiencing at least one of the types of abuse asked about on the survey in the 6 months before pregnancy. At postnatal follow-up, about 15% of clients reported experiencing some type of abuse in the past 6 months. The number of clients reporting psychological abuse and reporting physical abuse decreased significantly from before pregnancy to the past 6 months at postnatal follow-up. Very few clients reported experiencing a sexual assault by a partner or other type of perpetrator at any period.

SECTION 9. PHYSICAL HEALTH

Section 9 describes chronic health problems reported at prenatal intake and change in physical health status of clients from prenatal intake to postnatal follow-up including: (1) current health; (2) chronic pain; and (3) emergency room usage.

CHRONIC HEALTH PROBLEMS REPORTED AT PRENATAL INTAKE

At prenatal intake, 39.0% reported no health problems, 36.8% reported having one chronic health problem and 24.3% of clients had two or more chronic health problems.

As Figure 9.1 shows, among the clients who reported at least one physical health problem at prenatal intake (n = 83), 38.6% of KIDS NOW Plus clients reported asthma, 18.1% reported arthritis and another 18.1% reported dental problems.

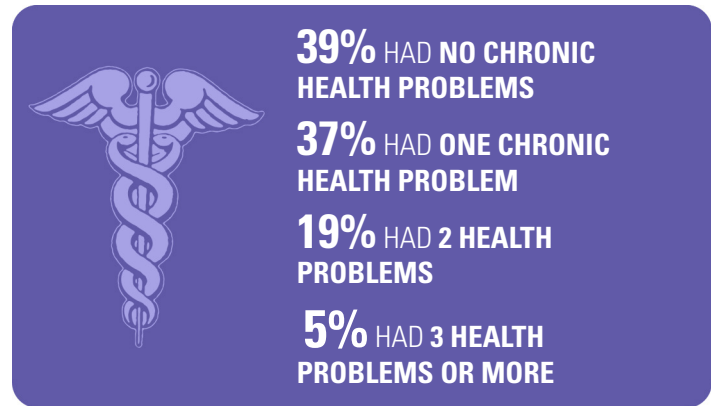
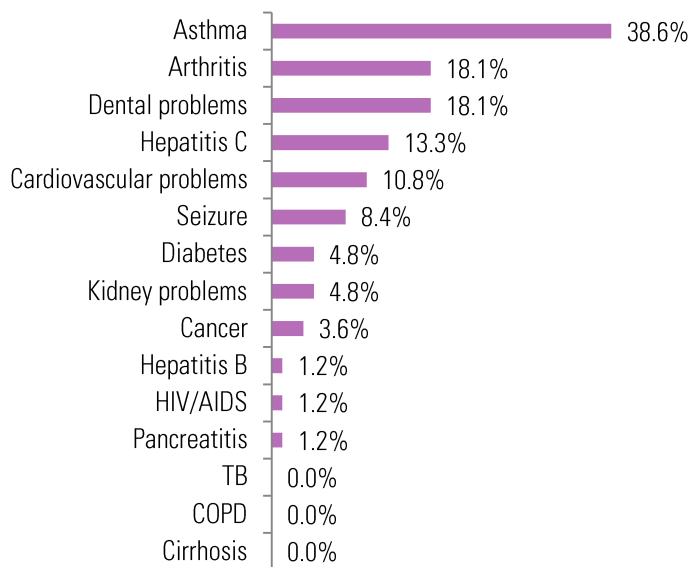


FIGURE 9.1. CHRONIC HEALTH PROBLEMS REPORTED BY CLIENTS AT PRENATAL INTAKE (N= 83)



Overall, at prenatal intake, 9.6% reported they had health problems that were not currently being treated. These problems included hepatitis C, depression and anxiety, and urinary tract infections.

In addition, at prenatal intake, 11.8% of clients reported currently having a sexually transmitted infection (STI). Of those with an STI (n = 16), the most common STIs were chlamydia, trichomoniasis, and genital herpes.

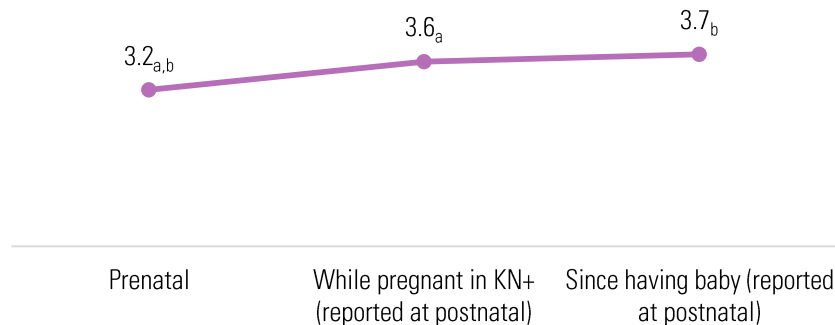
Eleven percent of clients reported having a serious fall or accident during pregnancy that caused bodily injury. In addition, 31.6% of clients reported they had a virus or serious infection while pregnant at prenatal intake. Of these clients (n = 43), 90.7% received medical treatment.

CURRENT HEALTH STATUS

At prenatal intake, clients reported their current health at an average of 3.2 on a scale of 1 being “poor” and 5 being “excellent”. At postnatal follow-up, clients reported that, while pregnant and in KIDS NOW Plus case management services, their health was an average of 3.6, which is significantly higher compared to prenatal intake.

Also at postnatal follow-up, clients were asked about their current health (about 6 months after having the baby) and reported an average current health rating of 3.7, which is significantly higher than it was at prenatal intake (3.2). Figure 9.2 shows the average health ratings at all three points.

FIGURE 9.2. AVERAGE OVERALL HEALTH RATING FROM PRENATAL INTAKE TO POSTNATAL FOLLOW-UP (N = 136)



a, b, – Values sharing the same subscript differ at $p < .01$
 Note. Significance tested with paired sample t-tests

The majority of clients (95.5%) gained weight during their pregnancies (an average of 37 pounds). At prenatal intake, clients reported an average weight of 157.3lbs before they became pregnant and at postnatal follow-up, clients weighed significantly more with an average of 167.1lbs.⁵⁴ As a result, the average body mass index of clients increased significantly from 26.8 before pregnancy to 28.4 in the six months after the baby was born. The number of clients who, according to the Center for Disease Control⁵⁵, are considered overweight or obese did not change significantly from prenatal intake (47.0%) to postnatal follow-up (58.3%).

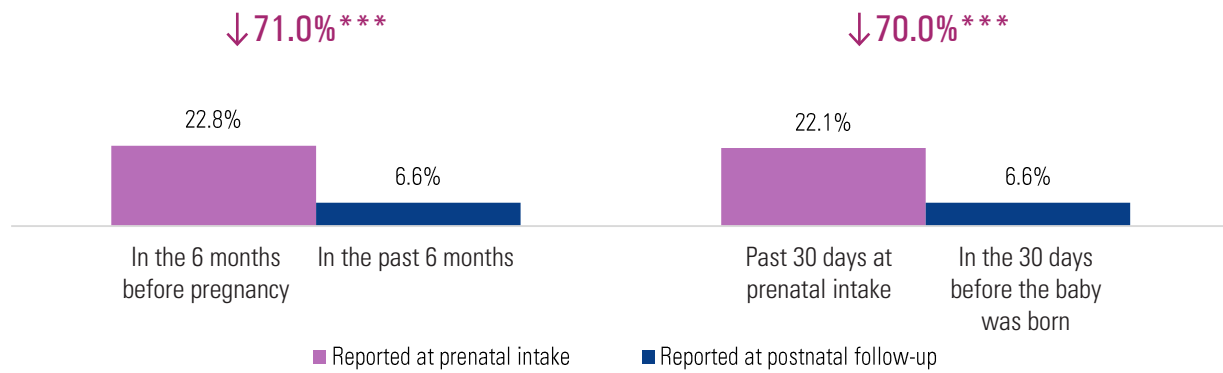
CHRONIC PAIN

At prenatal intake, 22.8% of women reported experiencing chronic pain in the 6 months before pregnancy and 6.6% of clients reported experiencing chronic pain in the past 6 months at postnatal follow-up (a significant decrease of 71.0%). In the past 30 days at prenatal intake, 22.1% of clients reported chronic pain in the past 30 days and in the 30 days before the baby was born 6.6% of clients reported experiencing chronic pain (a significant decrease of 70.0% compared to the past 30 days at intake).

⁵⁴ Four clients did not reveal their weight at follow-up.

⁵⁵ http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/index.html.

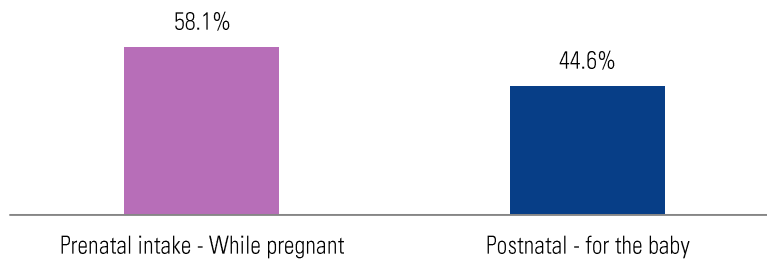
FIGURE 9.3. PERCENTAGE OF KIDS NOW PLUS CLIENTS IN CHRONIC PAIN GROUPS (N = 136)



EMERGENCY ROOM VISITS DURING PREGNANCY AND POSTNATAL

At both prenatal intake and postnatal follow-up, clients were asked if they had been to the emergency room (see Figure 9.4). At prenatal intake, 58.1% of clients reported they had been to the emergency room while pregnant. At postnatal follow-up, 44.6% of clients reported they had taken their baby to the emergency room.

FIGURE 9.4. CLIENTS REPORTING VISITING THE EMERGENCY ROOM (N = 136)



SUMMARY

At prenatal intake, over one-third of clients reported having at least one chronic health problem such as asthma, arthritis, dental problems and Hepatitis C. Almost 1 in 10 clients reported they had health problems that were not currently being treated. Almost 12% of clients reported at prenatal intake that they currently had a sexually transmitted infection and 11% had experienced a serious fall or accident while pregnant.

Clients' overall current health status rating increased significantly from prenatal intake to while they were pregnant and in KIDS NOW Plus. The average health rating increased even further at after the birth of the baby. Slightly less than one-quarter of clients reported experiencing chronic pain in the 6 months before pregnancy and this decreased significantly to 6.6% in the past 6 months at postnatal follow-up. Furthermore, the number of clients reporting chronic pain during pregnancy significantly decreased while in KIDS NOW Plus with 22.1% of clients reporting chronic pain in the past 30 days at prenatal intake and 6.6% reporting chronic pain in the 30 days before the baby was born.

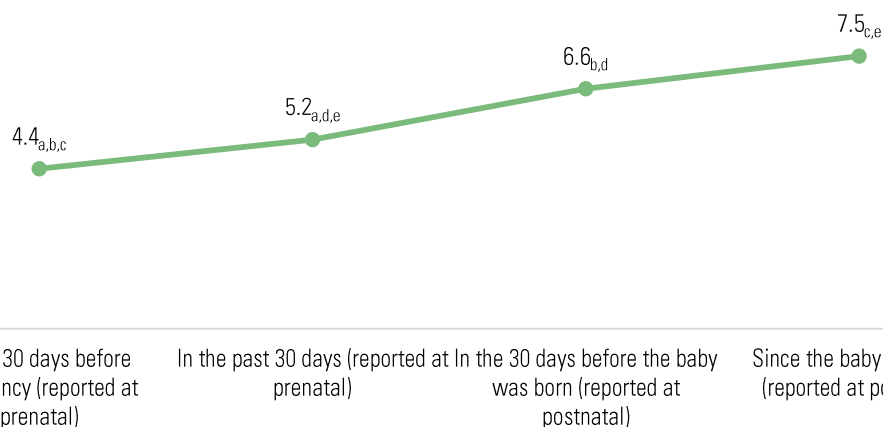
SECTION 10: EMOTIONAL SUPPORT

This section focuses on the number of people the individual said they could count on for emotional support and client satisfaction with the level of emotional support from others.

EMOTIONAL SUPPORT

There was a significant increase in the average number of people clients reported they could count on for support when needed. In the 30 days before pregnancy, clients reported they could count on an average of 4.4 people and an average of 5.2 people in the past 30 days at prenatal intake, which is a significant increase from before pregnancy. In the 30 days before the baby was born, clients reported an average of 6.6 people they could count on for support (a significant increase from both the 30 days before pregnancy and in the past 30 days at prenatal intake). Since the baby was born, clients reported that they could count on an average of 7.5 people for emotional support (a significant increase from both the 30 days before pregnancy and in the past 30 days at prenatal intake).

FIGURE 10.1. AVERAGE NUMBER OF PEOPLE CLIENT COULD COUNT ON FOR EMOTIONAL SUPPORT AT PRENATAL INTAKE AND POSTNATAL FOLLOW-UP (N = 135)



a,b,c,d,e – Values sharing the same subscript differ at $p < .01$
Significance tested with paired sample t-test

Note: One client was missing data on the number of people the client could count on for emotional support at follow-up.

In general, the majority of clients were satisfied with the level of emotional support they received from others. In the 30 days before pregnancy, 70.6% of KIDS NOW Plus clients were extremely or fairly satisfied with the level of support they received from others (see Figure 10.2). In the past 30 days at prenatal intake, 80.9% were extremely or fairly satisfied with the level of support they received from others. About 85% of clients were extremely or fairly satisfied with the level of emotional support they received from others in the 30 days before the baby was born (a significant increase of 19.8% compared to the 30 days before the pregnancy).

FIGURE 10.2. SATISFACTION WITH THE OVERALL LEVEL OF SUPPORT IN LIFE (N = 136)



In the 30 days before pregnancy (reported at prenatal)	In the past 30 days (reported at prenatal)	In the 30 days before the baby was born (reported at postnatal)	Since the baby was born (reported at postnatal)
--------------------------------------------------------	--------------------------------------------	-----------------------------------------------------------------	-------------------------------------------------

a, b – Values sharing the same subscript differ at $p < .01$
 Significance tested with z-test for proportions

SUMMARY

Almost 84% of KIDS NOW Plus clients at postnatal follow-up were satisfied with the level of support they received from others, a 19.8% significant increase from before pregnancy. In addition, the average number of people clients felt they could count on for support increased significantly from before pregnancy to postnatal follow-up.

SECTION 11: STRESS AND QUALITY OF LIFE

This section examines changes in stress and quality of life including the following factors: (1) health consequences of stress; (2) quality of life ratings; (3) positive and negative experiences; and (4) satisfaction with life.

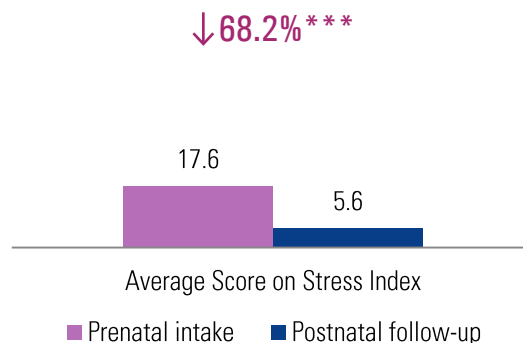
HEALTH CONSEQUENCES ASSOCIATED WITH STRESS

Clients were asked about physiological symptoms often associated with higher stress called the Stress Index.⁵⁶ The index contains 15 symptoms and clients indicate how often they have experienced these symptoms in the past 7 days (e.g., experienced unexplained aches and pains, slept poorly, experienced an increased heart rate). Higher scores on the scale indicate higher stress and greater health consequences of stress. The minimum score is 0 and the maximum score is 75. For the overall sample, Stress Index scores decreased significantly from 17.6 at prenatal intake to 5.6 at postnatal follow-up, representing a significant decrease of 68.2% (see Figure 11.1).



CLIENTS REPORTED A SIGNIFICANT DECREASE IN HEALTH CONSEQUENCES ASSOCIATED WITH STRESS AT POSTNATAL FOLLOW-UP

FIGURE 11.1. AVERAGE SCORES ON THE STRESS INDEX AT PRENATAL INTAKE AND POSTNATAL FOLLOW-UP (N = 136)



*** $p > .01$
Significance tested with paired sample t-test

QUALITY OF LIFE AND SATISFACTION WITH LIFE

There were three quality of life and satisfaction with life indexes used including: (1) quality of life rating, (2) positive and negative feelings, and (3) satisfaction with life.

QUALITY OF LIFE

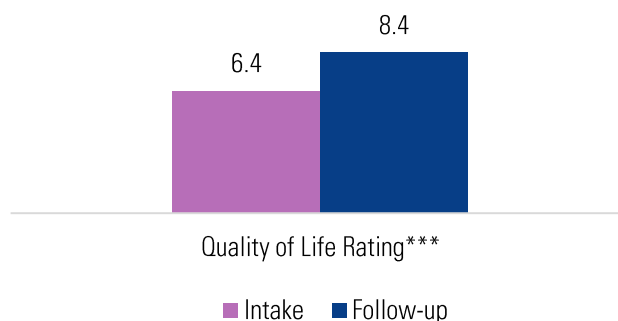
At both prenatal intake and postnatal follow-up, clients were asked to rate their current quality of life using ratings ranging from 1 = 'Worst imaginable' to 10 = 'Best imaginable'. Clients rated their quality of life before entering the KIDS NOW Plus case management program as on average 6.4 (see Figure 11.2). The average rating of quality of life at postnatal follow-up significantly increased to 8.4.



CLIENTS REPORTED A SIGNIFICANT INCREASE IN QUALITY OF LIFE AT POSTNATAL FOLLOW-UP (6.4 VS. 8.4 ON A 10-POINT SCALE)

⁵⁶ Stress Index measure created by Logan, TK and Walker, R. Stress and Allostatic Load.

FIGURE 11.2. PERCEPTION OF QUALITY OF LIFE AT PRENATAL INTAKE AND POSTNATAL FOLLOW-UP (N = 134)



1, worst imaginable; 10, best imaginable

*** $p < .01$

a—Question was missing from one client's survey and interviewer skipped this question at follow-up for one client.

POSITIVE AND NEGATIVE EXPERIENCES

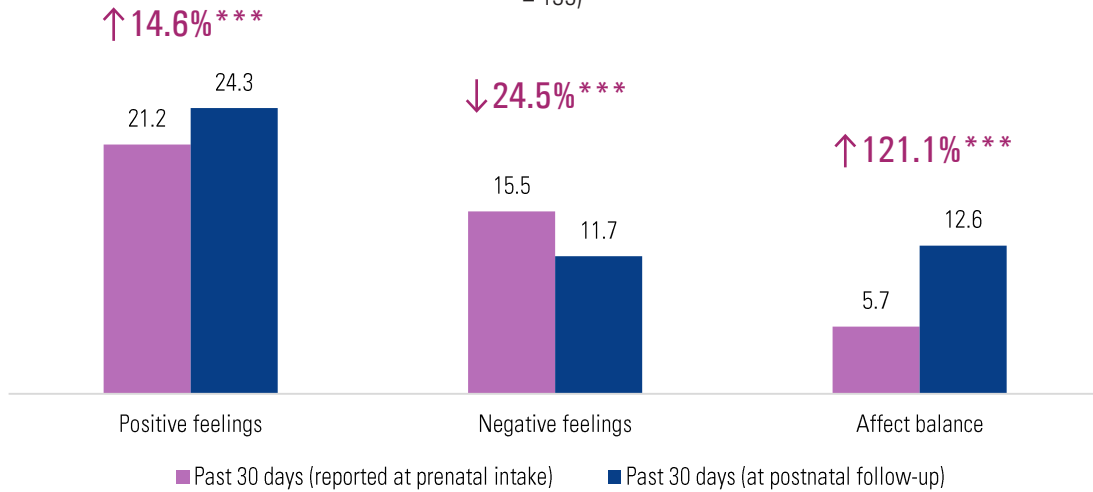
Clients were also asked about their positive or negative experiences on the Scale of Positive and Negative Experience (SPANE).⁵⁷ The index contains 12 feelings/experiences and clients indicate how often they have felt this way in the past 30 days (e.g., positive, negative, good, bad, pleasant, unpleasant, happy, sad). Clients answered using a scale with 1 representing "Very rarely or never" to 5 "Very often or always." The responses are then added for the 6 positive items, yielding a Positive Feelings Score, and the same scoring method is used for the Negative Feelings Score. The minimum score on each scale is 6 and the maximum score is 30. Low scores on the Positive Feelings Scale indicate the client rarely or infrequently experienced the six positive emotions/states. A high score on the Positive Feelings Scale indicates the client very often or frequently experienced the six positive emotions/states. To determine the overall affect balance (or the balance of negative and positive feelings about their life), the score derived from the negative feelings score is subtracted from the positive feelings score (with -24 being the minimum and unhappiest to 24 being the happiest). For example, a client with a high score reports that she rarely experiences negative feelings and very often has positive feelings.

Figure 11.3 shows that clients' average positive feelings score increased significantly from 21.2 at prenatal intake to 24.3 at postnatal follow-up, representing a significant increase of 14.6%. Average scores on the negative feelings decreased significantly by 24.5% from 15.5 at prenatal intake to 11.7 at postnatal follow-up. The significantly higher affect score at postnatal follow-up indicates that clients' positive feelings were more frequent than their negative feelings compared to prenatal intake.



⁵⁷ Diener, E., Wirtz, D. Tov, W., Kim-Prieto, C., Choi, D., Oishi, S., & Biswas-Diener, R. (2009). New measures of well-being: Flourishing and positive and negative feelings. *Social Indicators Research*, 39, 247-266.

FIGURE 11.3. CLIENT'S POSITIVE AND NEGATIVE FEELINGS IN THE PAST 30 DAYS AT PRENATAL INTAKE AND POSTNATAL FOLLOW-UP (N = 135)^a

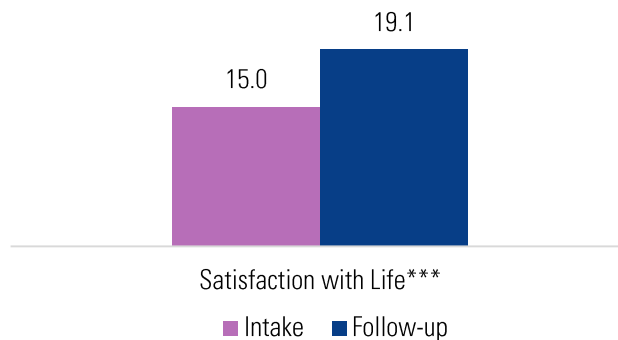


*** p > .001
 Significance tested with paired sample t-test
 a—Question not on survey for one client at follow-up.

SATISFACTION WITH LIFE

In order to measure the clients' overall satisfaction with their life, clients were asked 5 questions on the Satisfaction With Life Scale (SWLS)⁵⁸ at both prenatal intake and postnatal follow-up, and clients responded to each item with 1 'Extremely dissatisfied' to 5 'Extremely satisfied' (see Figure 11.4). Scale scores were a sum of the five items and ranged from 5 which indicates the client is extremely dissatisfied with her current life to 25 which indicates the client is highly satisfied with her life. At prenatal intake, clients reported an average well-being score of 15.0 and this significantly increased to 19.1 at postnatal follow-up, indicating a high score and that clients are generally happy with their lives.

FIGURE 11.4. AVERAGE RANKING OF SATISFACTION WITH LIFE AT PRENATAL INTAKE AND POSTNATAL FOLLOW-UP (N = 135)



***p < .01
 a—Question was skipped for one client at postnatal follow-up.

⁵⁸ A modified version of the Satisfaction With Life Scale. Diener, E., Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The Satisfaction with Life Scale. *Journal of Personality Assessment*, 49, 71-75.

SUMMARY

Clients reported significantly fewer physiological consequences associated with higher stress at postnatal follow-up compared to prenatal intake. In addition, clients reported a significantly greater quality of life at postnatal follow-up (8.4) compared to prenatal intake. There were also significant improvements in the clients' feelings and experiences with clients reporting feeling significantly more positive at postnatal follow-up compared to prenatal intake. Furthermore, clients reported significantly greater satisfaction with their lives at postnatal follow-up.

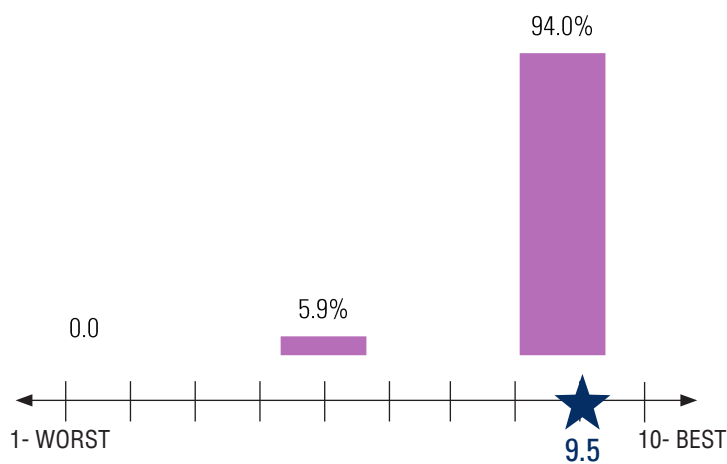
SECTION 12. CLIENT SATISFACTION WITH KIDS NOW PLUS CASE MANAGEMENT

This section describes four aspects of client satisfaction assessed for clients who completed a postnatal follow-up: (1) overall program satisfaction; (2) ratings of program experiences; (3) if the client would recommend the program to a friend; and (4) what clients found most useful from the program.

KIDS NOW PLUS CASE MANAGEMENT SERVICES SATISFACTION RATING

At the beginning of the follow-up interview, interviewers asked clients questions about their satisfaction with the treatment programs where 1 represented the worst experience and 10 represented the best experience. Clients rated their KIDS NOW Plus experience, on average, as 9.5 (see Figure 12.1). Overall, 94.0% gave a rating between 8 and 10 and 76.1% of clients gave the highest possible rating, 10.

FIGURE 12.1. RATING OF EXPERIENCE WITH KIDS NOW PLUS (N = 134)



Note. Two clients indicated they were not sure about a rating.

SATISFACTION WITH EXPERIENCE

Figure 12.2 shows that the majority of clients were very positive about every aspect of their KIDS NOW Plus experience. Most of the pregnant mothers (99.3%) indicated they learned about how drugs and alcohol affect pregnancy and baby outcomes and 99.0% reported that they learned about how tobacco use affects pregnancy and baby outcomes. In addition, 95.5% believed their mental health during pregnancy was better due to KIDS NOW Plus and 92.4% felt safer from partner violence. All clients reported their case manager was polite and respectful, 99.2% indicated the services were helpful, 97.0% reported they had a healthier pregnancy, and 97.8% felt better about themselves as a result of KIDS NOW Plus case management services.



AS A RESULT OF THEIR KIDS NOW PLUS CASE MANAGEMENT EXPERIENCE, THE MAJORITY OF CLIENTS INDICATED THEY **LEARNED ABOUT THE RISKS OF TOBACCO, ALCOHOL AND DRUGS DURING PREGNANCY** AND:

- 97.8% INDICATED THEY **FELT BETTER ABOUT THEMSELVES** AFTER PARTICIPATION
- 97.0% BELIEVED THEY HAD A **HEALTHIER PREGNANCY**
- 95.5% REPORTED THEIR **MENTAL HEALTH WAS IMPROVED**
- 92.4% FELT **SAFER FROM INTIMATE PARTNER VIOLENCE**

FIGURE 12.2. SATISFACTION OF KIDS NOW PLUS EXPERIENCE (N = 135)^a

a- One client indicated she could not remember how satisfied she was with each aspect of treatment.

RECOMMEND KIDS NOW PLUS TO A FRIEND

The majority of clients (98.5%) in the postnatal follow-up sample indicated they would recommend KIDS NOW Plus to a friend. The following are some quotes from clients about why they would recommend Kids NOW Plus to a friend:

"Because [my counselor] gives me really good information and helped me stay calm."

"It helped me out. Before I was pregnant, I didn't know what kind of programs there were."

"The resources and information were very helpful as a new mom."

"This should be recommended to anyone who is on drugs."

MOST USEFUL PARTS OF PROGRAM

When clients were asked what they found most helpful about KIDS NOW Plus, most responses fell into one of three main categories:

1 Information about risks and a healthy baby (56%)

"They helped me get ready for the baby."

"I mainly joined because I wanted to stop smoking cigarettes during my pregnancy and I have only had 1 in the last year."

"The most helpful thing was the substance abuse information."

2 Emotional support (53%)

"They cared and listened."

"My caseworker went out of her way to help me. She still helps me today."

"My case manager was always there when I needed something."

3 Resources (29%)

"The gift cards, resources and classes were very helpful for me as a new mom."

"They bought me a lot of things I needed for the baby."

"They gave me rides to appointments and stores for diapers. She got me a brand new crib and mattress."

SECTION 13: CONCLUSION

OVERVIEW

KIDS NOW Plus is part of the overall KIDS NOW initiative in Kentucky (Kentucky Invests in Developing Success NOW), coordinated and funded by the Governor's Office of Early Childhood, which provides numerous health and educational services for young children. The program is administered by the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities and its Division of Behavioral Health. Services are provided by eight of the Commonwealth's fourteen Community Mental Health Centers and are free for pregnant women living in those regions.

The overall goal of KIDS NOW Plus is to increase positive birth outcomes for high risk pregnant women in Kentucky by reducing maternal substance use as well as mental health symptoms and partner abuse and violence. These three interrelated risk factors all impact the health of the pregnant mother, fetal development, and birth outcomes. Clearly alcohol, tobacco, and illicit drug use during pregnancy have been shown to negatively influence fetal development and women's health.^{59, 60, 61, 62, 63} Risks of negative birth outcomes are doubly increased when women using alcohol and illegal drugs avoid obtaining prenatal care due to fear of losing custody of their babies or fear of being arrested.^{64, 65} Further, substance use is related to poor mental health as well as interpersonal victimization such as partner abuse and violence.^{66, 67} Thus, it is critical to target all three of these risk factors to have the best success in reducing substance abuse and the related negative pregnancy outcomes.

KIDS NOW Plus case management clients received both traditional case management assistance to meet basic needs such as safe housing, food, and childcare, as well as referrals to treatment services. Referrals to clinical services are facilitated using the evidence-based practice of Motivational Interviewing aimed at increasing readiness to follow through on referrals, linkage with peer support groups, support to maintain abstinence throughout pregnancy, and finally, support and transportation to attend prenatal appointments. Clients also receive information and support to facilitate a healthy pregnancy and fetus as well as to meet needs after the baby is born. Services provided by KIDS NOW Plus case managers are client centered and do not follow a specific manualized intervention. Client centered services are based on individual needs which change over time with risk, situation, and pregnancy development.

The KIDS NOW Plus outcome evaluation includes a face-to-face intake interview by program staff upon entering the program and approximately 6 months after the birth of their baby, consenting clients are contacted for a follow-up assessment. The follow-up assessment includes their satisfaction with the program, the health and well-being of their baby, the impact KIDS NOW Plus case management services had on them during pregnancy, as well as the

⁵⁹ Chiriboga, CA. (2003). Fetal alcohol and drug effects. *Neurologist*, 9(6), 267-279.

⁶⁰ Bandstra, E. S., Morrow, C. E., Mansoor, E., & Accornero, V. H. (2010). Prenatal drug exposure: infant and toddler outcomes. *Journal of Addictive Diseases*, 29(2), 245-258.

⁶¹ Agrawal, A., Scherrer, J. F., Grant, J. D., Sartor, C. E., Pergadia, M. L., Duncan, A. E., et al. (2010). The effects of maternal smoking during pregnancy on offspring outcomes. *Preventive Medicine*, 50(1), 13-18.

⁶² Salisbury, A. L., Ponder, K. L., Padbury, J. F., & Lester, B. M. (2009). Fetal effects of psychoactive drugs. *Clinics in perinatology*, 36(3), 595-619.

⁶³ Stroud, L. R., Paster, R. L., Goodwin, M. S., Shenassa, E., Buka, S., Niaura, R., et al. (2009). Maternal smoking during pregnancy and neonatal behavior: a large-scale community study. *Pediatrics*, 123(5), e842-e848.

⁶⁴ Poland, M. L., Dombrowski, M. P., Ager, J. W., & Sokol, R. J. (1993). Punishing pregnant drug users: enhancing the flight from care. *Drug and Alcohol Dependence*, 31(3), 199-203.

⁶⁵ Roberts, S., & Nuru-Jeter, A. (2010). Women's perspectives on screening for alcohol and drug use in prenatal care. *Women's Health Issues*, 20(3), 193-200.

⁶⁶ Logan, T., Walker, R., Jordan, C. & Leukefeld, C. (2006). *Women and victimization: contributing factors, interventions, and implications*. Washington, DC: American Psychological Association Press.

⁶⁷ Shah, P. S., & Shah, J. (2010). Maternal exposure to domestic violence and pregnancy and birth outcomes: a systematic review and meta-analyses. *Journal of Women's Health*, 19(11), 2017-2031.

extent to which risk factors decreased during pregnancy and were sustained after the baby's birth.

The pregnant women involved with KIDS NOW Plus case management services are high risk across a number of general and targeted risk factors. The majority of clients who enter the program are about halfway through their pregnancies, are young (in her mid 20s), do not have a college education, and are unemployed. Additionally, many of these young women used cigarettes, alcohol and/or drugs before knowing about their pregnancy. A sizable number of these pregnant women also experience depression, anxiety, and intimate partner abuse and violence.

However, in spite of these significant risk factors, the KIDS NOW Plus mothers had very positive birth outcomes that were similar to the general population of mothers in Kentucky who resided in the same regions served by KIDS NOW Plus and who had babies during the same period. Specifically, the two groups of mothers had similar birth outcomes, such as babies' birth weight, babies' highest APGAR score, premature births, birthing problems, babies taken to NICU, and breastfeeding.

Reported illegal drug use was higher for the KIDS NOW Plus clients when compared to a national sample of pregnant women. Specifically, almost half of clients reported illegal drug use in the 30 days before becoming pregnant, compared to 11.4% of non-pregnant women reporting illegal drug use in the past month in a national survey. In the past 30 days at prenatal intake, 9.6% of clients reported illegal drug use and in the 30 days before the baby was born only 2.2% of clients reported illegal drug use. In comparison, a national survey of women reported 5.4% of pregnant women aged 15-44 used illegal drugs in the past month. Illegal drug use decreased significantly at postnatal follow-up compared to the period before clients found out about the pregnancy.

A similar pattern was seen with reduction in alcohol use with clients reporting significantly less use while pregnant and in KIDS NOW Plus with a sustained decrease after the birth of the baby. A little over one-third of clients reported using alcohol in the 30 days before pregnancy compared to 55.4% of non-pregnant women aged 15-44 in a national sample reporting drinking alcohol in the past 30 days. Further, only 2.9% of KIDS NOW Plus clients reported alcohol use in the past 30 days at prenatal intake compared to 9.4% of pregnant women nationally. Although there was an increase in the number of clients who reported alcohol use at postnatal follow-up (in the six months after the birth of the baby) compared to during pregnancy, there were still significantly fewer clients reporting alcohol use compared to the 6 months before pregnancy.

In addition, the number of clients who reported smoking decreased significantly from the 30 days before the client became pregnant to the 30 days before the baby was born. This decrease was sustained in the past 30 days at postnatal follow-up. In addition, the average number of cigarettes clients smoked decreased over 50% from before the client found out about their pregnancy to the past 30 days at prenatal intake. The number of cigarettes decreased further in the 30 days before the baby was born and remained low in the past 30 days at postnatal follow-up.

Clients' mental health also showed significant improvements. Specifically, significant reductions in depression and anxiety symptoms were found in the past 6 months at postnatal follow-up compared to before pregnancy. Moreover, individuals reported significantly fewer days in the past 30 days their mental health was not good at follow-up compared to intake. Clients also reported more positive feelings and fewer physiological symptoms associated with stress at postnatal follow-up. In addition, clients reported their quality of life significantly increased at postnatal follow-up.

Reported incidences of intimate partner abuse such as psychological abuse, physical abuse, and coercive control all decreased from the period before they found out they were pregnant to postnatal follow-up.

In addition to these risk factors, there were improvements in other general areas of the mothers' lives after becoming involved in the KIDS NOW Plus program including a reduction in chronic pain and improved overall health. Women also reported improved economic conditions with significantly fewer clients reporting having difficulty meeting basic living or health care needs as a result of financial problems.

Clients also reported significantly higher quality of life after the program, having significantly more positive feelings and significantly less negative feelings, and an overall greater satisfaction with life at postnatal follow-up compared to prenatal intake. The vast majority of clients were satisfied with KIDS NOW Plus case management services and believed they and their baby were better off due to their participation.

There are several limitations to this outcome study including the lack of random assignment to the KIDS NOW Plus program. Although it would be ethically and procedurally difficult to conduct a random assignment of pregnant women at risk for substance use to a program such as KIDS NOW Plus, random assignment can provide more confidence that the birth outcomes of these mothers are directly due to interventions provided by KIDS NOW Plus. Also, this study has no control group with which to compare KIDS NOW Plus clients. While the matched comparison group matches mothers on several key factors (age, race, education, marital status and smoking status), there is no information on drug use, mental health problems or intimate partner violence for the comparison group. However, given the small number of cases that had negative birth outcomes against significant odds (i.e., multiple risk factors), it is reasonable to assume that the services provided by KIDS NOW Plus play a critical role in the health and safety of these mothers and their children. Further, in order to better understand the results of the KIDS NOW Plus case management program, the analysis was done in several ways. As presented in this report, a multivariate analysis of birth outcomes was conducted to control for several key factors that may be associated with birth outcomes. Additionally, a group of mothers matched on selected factors⁶⁸ along with a randomly selected comparison group from the general population were compared to the KIDS NOW Plus case management group on birth outcomes (see Appendix B). Results paralleled the findings of the multivariate analysis on birth outcomes. Specifically, there were no significant differences for the average number of prenatal care visits, average number of gestational weeks, highest APGAR score, birth weight, the percentage of babies who were born premature, or the percentage of babies with birthing problems.

Second, most of the data for this report is self-reported by KIDS NOW Plus clients. Recent research has supported findings about the reliability and accuracy of individuals' reports of their substance use.^{69, 70, 71, 72} Earlier studies found that the context of the interview influences reliability.⁷³ During the informed consent process at the beginning of the follow-up survey, interviewers tell participants that the research team operates independently from the KIDS NOW Plus program and individuals' responses will be reported in group format and will not be identifiable at the individual level. These assurances of confidentiality and lack of affiliation with the data collectors may minimize individuals' concern about reporting stigmatizing behavior or conditions. In addition, studies of pregnant women and substance use indicate that self-report is as good as urine tests in identifying use.^{74, 75}

Third, clients are self-selected and voluntarily agree to participate in KIDS NOW Plus case management rather than being randomly or mandated to participate. While these women report high risk factors such as substance use, mental health and interpersonal violence victimization, there is likely a segment of the pregnant population who are

⁶⁸ Mothers were matched on age, education, metropolitan/non-metropolitan residence, marital status and smoking status.

⁶⁹ Del Boca, F.K., & Noll, J.A. (2000). Truth or consequences: The validity of self-report data in health services research on addictions. *Addiction*, 95, 347-360.

⁷⁰ Harrison, L. D., Martin, S. S., Enev, T., & Harrington, D. (2007). *Comparing drug testing and self-report of drug use among youths and young adults in the general population (DHHS Publication No. SMA 07-4249, Methodology Series M-7)*. Rockville, MD: Substance abuse and Mental Health Services Administration, Office of Applied Studies.

⁷¹ Rutherford, M.J., Cacciola, J.S., Alterman, A.I., McKay, J.R., & Cook, T.G. (2000). Contrasts between admitters and deniers of drug use. *Journal of Substance Abuse Treatment*, 18, 343-348.

⁷² Shannon, E.E., Mathias, C.W., Marsh, D.M., Dougherty, D.M., & Liguori, A. (2007). Teenagers do not always lie: Characteristics and correspondence of telephone and in-person reports of adolescent drug use. *Drug and Alcohol Dependence*, 8(90), 288-291.

⁷³ Babor, T.F., Stephens, R.S., & Marlatt, A. (1987). Verbal report methods in clinical research on alcoholism: Response bias and its minimization. *Journal of Studies on Alcoholism*, 48, 410-424.

⁷⁴ Christmas, J., Nislely, J., Dawson, K., Dinsmoor, M., Weber, S., Schnoll, S. (1992). Comparison of questionnaire screening and urine toxicology for detection of pregnancy complicated by substance use. *Obstetrics & Gynecology*, 80, 750-754.

⁷⁵ Yonkers, K. A., Howell, H. B., Gotman, N., & Rounsaville, B. J. (2011). Self-report of illicit substance use versus urine toxicology results from at-risk pregnant women. *Journal of Substance Use*, 16(5), 372-380.

heavier drug users, have more severe mental health problems, or are at an even greater risk for safety compared to the women who voluntarily enter KIDS NOW Plus. Women with more severe use may be more hesitant to seek or accept treatment because they either do not accept they have a problem, fear having the child removed, or fear being prosecuted.⁷⁶ On the other hand, the fact that this program is voluntary, but recruits and retains high risk women, is a strength of the program. High risk pregnant mothers in other state-funded substance abuse programs in the state are referred by the courts or the child protective service agency, the Department for Community Based Services. Recruiting and retaining clients who have no external motivating factor poses challenges to service providers who must rely on their interpersonal skills to engage clients in services.

This study provides support of the efforts by the Kentucky Division of Behavioral Health to address the rising statewide and national problem of drug-exposed pregnancies, given the positive changes in the women's substance-using behavior once interventions were initiated. Given these positive outcomes, there is every reason to see a rationale for maintaining and expanding these services in the eight participating regions as well as to the remaining six regions of the state. This is especially critical when comparing the level of tobacco and drug use in the pregnant women served by the KIDS NOW Plus program to the national level data which shows significantly higher rates of substance use at prenatal intake for Kentucky women.

One of the most important policy questions implicit in this study is about the months and early years of the child's life after the mother has given birth. The KIDS NOW Plus program ends 60 days after the end of the month in which the child is born, due to Medicaid eligibility limits⁷⁷ and two months postpartum is far too early to fully secure changes toward abstinence or reduced substance use among these women. Those mothers who persist in or return to drug-using lifestyles are at great risk for child neglect and other forms of child maltreatment,^{78, 79} as well as for setting the stage for these children to grow into alcohol and illegal drug users as adolescents and adults.^{80, 81} Thus, reducing risk during the early development of the child is in large part contingent on continued services and engagement with recovery and parenting supports. As Kentucky continues to work toward more integrated service provisions under the umbrella of behavioral health, the utilization of all possible resources will be important both for these mothers and their newborns. The KIDS NOW Plus program plays a critical role toward this end.

Overall, pregnant women participating in KIDS NOW Plus services significantly improved on all three targeted areas of behavioral health and had birth outcomes similar to the general population of mothers. Further, clients were overwhelmingly positive about the program. They indicated they would refer their friends or others to the program, and felt like what they gained from the program helped them have a healthier pregnancy, improved their birth outcomes, and provided valuable information about the risk of substance use during pregnancy. The study demonstrates positive changes in the inter-related targeted risk factors after involvement in KIDS NOW Plus suggesting significant benefit of this program especially if it were expanded to serve high-risk pregnant women across the state.

⁷⁶ Tuchman, E. (2010). Women and addiction: The importance of gender issues in substance abuse research. *Journal of Addictive Diseases, 29*(2), 127-138.

⁷⁷ Data for the postnatal follow-up was completed prior to Kentucky's Medicaid coverage expansion which was effective January 1, 2014. As of this date, these eligibility limits are no longer in effect.

⁷⁸ McKeganey, N., Barnard, M. & McIntosh, J. (2002) Paying the price for their parent's addiction: meeting the needs of the children of drug using parents. *Drugs: Education, Prevention and Policy, 9*, 233-246.

⁷⁹ Barnard, M., & McKeganey, N. (2004). The impact of parental problem drug use on children: what is the problem and what can be done to help? *Addiction, 99*(5), 552-559.

⁸⁰ Ireland, T. O., Smith, C. A., & Thornberry, T. P. (2002). Developmental issues in the impact of child maltreatment on later delinquency and drug use. *Criminology, 40*(2), 359-400.

⁸¹ Biederman, J., Faraone, S. V., Monuteaux, M. C., & Feighner, J. A. (2000). Patterns of alcohol and drug use in adolescents can be predicted by parental substance use disorders. *Pediatrics, 106*(4), 792-797.

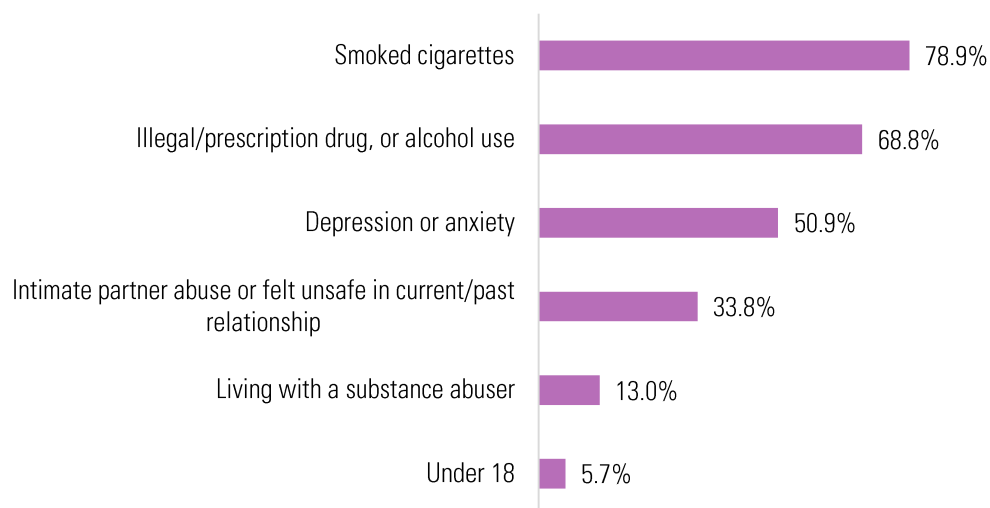
APPENDIX A: DESCRIPTION OF KIDS NOW PLUS CASE MANAGEMENT CLIENTS AT PRENATAL INTAKE

The KIDS NOW Plus outcome evaluation includes a face-to-face intake interview by program staff to assess targeted factors such as substance use, mental health symptoms, intimate partner violence, and other factors such as education, employment status, and living situation prior to pregnancy and while involved in the program. Between January 2013 and June 2014, 564 pregnant women completed a prenatal intake interview.^{82, 83} For 4 clients, however, the date between when the intake assessment was completed and when it was submitted to UK CDAR was greater than 90 days and, therefore, these clients were not included in this analysis. As a result, the analysis below is for 560 pregnant women who completed a prenatal intake assessment and whose assessment was submitted within 90 days of completion.

RISK STATUS

Figure AA.1 shows that of the 560 clients who completed a KIDS NOW Plus prenatal intake, 95.9% (n = 537 clients), fit into at least one of the major risk factor categories assessed in the intake interview. Overall, 78.9% of clients reported cigarette use, 68.8% reported drug or alcohol use at intake, 50.9% reported depression or anxiety, 33.8% reported intimate partner abuse and/or feeling unsafe in either their current relationship or because of a partner from a previous relationship, 13.0% of clients reported currently living with someone who has drug or alcohol problems, and 5.7% were under the age of 18.

FIGURE AA.1. PERCENTAGE OF CLIENTS FALLING INTO AT LEAST ONE TARGETED RISK FACTORS (N = 560)



PREGNANCY STATUS

Eighteen percent of KIDS NOW Plus clients were referred to the case management program by the local health department. Fifteen percent of clients were referred by a counselor and 15.2% were referred by HANDS. Over one-third of clients (35.9%) reported that receiving information about pregnancy and fetal development from KIDS NOW Plus was important, 16.4% wanted information services for after the baby was born. About 11% wanted help with stress or for mental health issues and 10.5% wanted information about substance use and the effects on pregnancy. Overall, at the time clients completed the prenatal intake, they were an average of 22 weeks pregnant (ranging from women who were 5 weeks pregnant to women who were 42 weeks pregnant). Although 81.6% of the clients

⁸² The intake and postnatal assessment were changed in January 2013; therefore, this analysis includes clients who completed the latest version of the assessment to the end of fiscal year 2014.

⁸³ Clients who completed a prenatal intake (n = 564) entered the KIDS NOW Plus case management program between August 2012 and June 2014.

indicated their pregnancy was unplanned, only 1.6% reported they were not sure about keeping the baby or were definitely not keeping their baby.

At the time of prenatal intake, clients had been to an average of 6.1 visits (range of 0-50 visits) with their prenatal health care provider and 45.4% reported they were planning on breastfeeding.

Overall, 72.9% of clients reported they been pregnant before. The majority of clients who entered the KIDS NOW Plus case management program were confident (27.9%) or very confident (57.3%) about caring for a new baby.

Only 3.6% of the women reported the father did not know about the baby. Of those who indicated the father knew about the baby (n = 540), 75.9% indicated the father was excited (16.1%) or extremely excited (59.8%) about the baby.

SOCIOECONOMIC STATUS

- On average, clients were 25 years old (ranging from 14 years old to 43 years old).⁸⁴
- The majority of women who entered KIDS NOW Plus case management were unemployed (73.0%) at the time of the intake interview. Less than 10% were employed full-time and 14.6% either worked part-time or had occasional/seasonal work.
- About 58% of clients were either married (23.9%) or cohabiting with a partner (33.8%) at prenatal intake. Of those clients who were married or cohabiting (n = 323), 93.2% reported that their partner was the father of the baby with whom they were pregnant.
- Eleven percent of the KIDS NOW Plus mothers reported at prenatal intake they were currently homeless. Of those that indicated they were homeless (n = 63), 11.1% were staying in a shelter, 71.4% were staying temporarily with friends/family, and 3.2% were staying on the street or in their car. About 14% reported they perceived themselves to be homeless for other reasons (i.e., living in a residential treatment center or living in poor conditions).

CASE MANAGEMENT ACTIVITY

From January 2013 to June 2014, 576 clients completed a new intake survey for the KIDS NOW Plus program (see Table 1.1) and 891 clients were active in the program at any point during that period for those that had information reported in the KIDS NOW Plus Client Information System.⁸⁵ There are several ways that case managers maintain contact with active clients. For the 891 active clients in the KIDS NOW Plus case management program that had information recorded, there were 13,226 case manager contacts (or about 15 contacts on average per active client). Specifically, there were 6,155 face-to-face contacts with clients (or about 7 face-to-face contacts with each active client, on average) and 5,416 phone contacts (or about 6 phone calls per active client, on average). In addition, case managers had a total of 94 email contacts with clients and 1,561 texts to clients (or almost 2 texts on average per active client).

⁸⁴ Three clients had incorrect birthdates entered and, therefore, age could not be calculated.

⁸⁵ The information in the client information system may not reflect all of the clients or all of the activities, or may contain duplicate clients if the clinician entered her twice. The information provided here is based on what was entered into the system.

TABLE 1.1. CASE MANAGER CASELOAD AND EFFORTS FROM JANUARY 2013 TO JUNE 2014

REGION	CLIENTS ENTERED INTO KIDS NOW PLUS	ACTIVE CLIENTS	FACE-TO-FACE CONTACTS	PHONE CONTACTS	EMAIL CONTACTS	TEXT CONTACTS	TOTAL CASE MANAGER CONTACTS
Adanta	51	74	621	407	0	17	1,045
Communicare	124	234	1,075	388	14	542	2,019
Cumberland River	39	58	348	119	5	331	803
Kentucky River	45	56	262	347	0	361	970
Lifeskills	109	164	1,397	1,504	43	205	3,149
Seven Counties	58	82	778	670	0	0	1,448
NorthKey	19	44	366	337	0	0	703
Pathways	131	179	1,308	1,644	32	105	3,089
TOTAL	576	891	6,155	5,416	94	1,561	13,226

APPENDIX B: METHODS

This evaluation project collects data from pregnant women in Kentucky who are at high risk for substance abuse and participate in KIDS NOW Plus case management services. Eight community mental health centers participate in the program and collect intake data on each client entering the KIDS NOW Plus case management services program. Data analysis has three main phases: (1) examination of service utilization and change in behavior and risks over time, using the prenatal intake information and the postnatal follow-up interviews among clients who gave birth; (2) comparisons of KIDS NOW Plus clients and general population birth outcome information from the Vital Statistics birth outcome data set; and (3) comparison of KIDS NOW Plus clients matched to mothers in the general population who did not receive KIDS NOW Plus case management services based upon age, race, education, marital status, smoking status and metropolitan/non-metropolitan residence.

INTAKE ASSESSMENT

The intake assessment is an electronic, structured interview developed by the University of Kentucky Center on Drug and Alcohol Research (UK CDAR) in collaboration with KIDS NOW Plus program administrators. Intake information is collected during face-to-face client interviews with case managers when the client enters the program and the responses are electronically submitted to UK CDAR. At the end of the intake interview, clients are told about the opportunity to participate in a follow-up telephone interview that is conducted independently from the program by the UK CDAR Behavioral Health Outcome Studies (BHOS) staff approximately 6 months after the birth of their baby. Clients who volunteer to participate in the follow-up interview provide locator information including phone numbers of two relatives or friends who could help UK CDAR locate the client for the postnatal follow-up interview. A total of 560 intakes were completed between January 2013 and June 2014 and submitted to UK CDAR within 90 days.⁸⁶ Overall, women completed a KIDS NOW Plus case management intake when they were an average of 22 weeks pregnant (minimum = 5 weeks, maximum = 42 weeks).⁸⁷

METHOD OF DETERMINING FOLLOW-UP SAMPLE

FOLLOW-UP ASSESSMENT. KIDS NOW Plus clients are eligible for the follow-up assessment if they consent to be contacted by UK CDAR BHOS staff and provide locator information. The target month for follow-up assessment is computed by adding 6 months (180 days) to the self-reported due date the client provides at prenatal intake. In reality, there was an average of 6.4 months between the time the baby was due and the date of the follow-up assessment (with a mode of 6 months). These individuals are then included in the sample of women to be followed up.

Follow-up interviews are conducted on the telephone by the UK CDAR BHOS research team and are independent of KIDS NOW Plus case management services in order to confidentially examine changes in clients' behavior and risks. In addition, UK CDAR BHOS obtained a Federal Certificate of Confidentiality from the National Institute of Health which states that BHOS researchers cannot be forced to disclose any information which may identify the client, even by court subpoena, in any federal, state, or local civil, criminal administrative, legislative, or other proceedings.⁸⁸ The follow-up interviews examine program satisfaction, current substance use, intimate partner violence, physical and mental health status, employment, and recovery supports.

The UK CDAR BHOS team begins their efforts to locate and conduct follow-up interviews with women pulled into the

⁸⁶ The intake assessment was changed in January 2013; therefore, this analysis includes all clients who received the latest version of the assessment through the end of fiscal year 2014. Though 564 clients completed an intake during this time period, only 560 were included in the intake analysis because the time between when the intake was completed and when the intake was submitted to UK CDAR was greater than 90 days for 4 clients.

⁸⁷ The average number of days between when the client was admitted to the KIDS NOW Plus case management program and when the baseline was completed was 21.7 days with a minimum of 0 days and a maximum of 183 days.

⁸⁸ The exception to this is if harm to the client, harm to others, or child abuse is disclosed to the researchers.

follow-up sample one month before the target month for their follow-up interview and continues their efforts until the women have completed the follow-up interview or for two months after the target month, whichever comes first. For example, if a woman has a targeted follow-up interview in August, the research team will begin their attempts to locate and contact her in July (i.e., one month before the targeted month for her follow-up interview). If the team is unable to locate this woman they will continue their efforts until the end of October (i.e., two months after her target month for the follow-up interview).

When the follow-up team contacts women, they must determine additional eligibility criteria before completing the follow-up interview. First, women who have not given birth to their babies or who do not have the baby living with them are not eligible for the follow-up interview. Second, women who are living in a controlled environment (e.g., jail, prison, residential treatment) are not eligible for completing the follow-up interview. As mentioned previously, 560 intakes were completed between January 2013 and June 2014 and submitted in less than 90 days from the baseline completion date.⁸⁹ Of these, 276 clients were not yet in the time frame for the targeted follow-up date (i.e., not 6 months from the estimated due date) and, therefore, not yet eligible for the follow-up sample. Of the clients who were in the targeted window to complete a postnatal follow-up (n = 284), 46 did not consent to be contacted by follow-up staff (see Table AB.1). Of the remaining 238 women, 44 were not eligible because they were in jail or another controlled environment (n = 6), because their baby was not living with them (n = 15), or other reasons such as invalid contact data (n = 23). To maximize the number of follow-up assessments included in the FY 2015 Outcomes report, all follow-up assessments that were completed by August 2014, which was the last date the follow-up assessments were pulled, and had a targeted follow-up date in FY 2014, were included in the follow-up sample (n=162).⁹⁰

TABLE AB.1. FOLLOW-UP SAMPLE AND EFFORTS⁹¹

	Number of intakes (n = 560)
Not in the 6 month follow-up targeted window	276
Clients in the 6 month follow-up targeted window	284
Did not consent to follow-up	46
Not eligible for follow-up	44
In jail or controlled environment (i.e, residential treatment)	6
Baby not living with them	15
Other (i.e., invalid data)	23
Total number of intake surveys eligible for follow-up	194
Expired cases (i.e., never contacted, did not complete the survey during the follow-up period)	31
Expired rate ((the number of expired cases/eligible cases)*100)	16.0%
Refused	0
Refusal rate ((the number of refusal cases/eligible cases)*100)	0.0%
Follow-up interviews completed as of August 18, 2014	162
Follow-up rate	83.5%

⁸⁹ Again, 564 prenatal intakes were completed; however, 4 were not submitted within 90 days of the baseline date.

⁹⁰ As of August 18, 2014 clients who had a six month follow-up target date within the 2014 fiscal year were completed.

⁹¹ An additional survey was noted as being completed, but was missing and, therefore, could not be verified. Thus, the number of follow-up surveys completed is 162.

Because the follow-up sample is based upon the women who have had their babies, live in a KIDS NOW Plus region and had a follow-up interview, the next step in determining the follow-up sample was to match to the birth event data set.

OBTAINING THE BIRTH EVENT DATA. The Vital Statistics birth data is used to compare mothers in KIDS NOW Plus case management and their babies to mothers who had babies during the same time period but who did not participate in KIDS NOW Plus Case Management. Before any analysis of the Vital Statistics birth data is conducted, a series of steps is performed to ensure data quality and integrity. Each step is described in the following paragraphs.

Kentucky Vital Statistics automatically moves each year of updated birth index text files to UK CDAR using the CHFS MoveIT Central FTP process. The data is then opened in Microsoft Access to create variables based upon a file layout codebook provided by Kentucky Vital Statistics. From Access, the data are transferred into SPSS and given variable names, values, and labels corresponding to the codebook. Births occurring within the time frame of the annual report are then saved to a separate file where they are cleaned.

As a first step in merging Vital Statistics data with KIDS NOW Plus intake data, birth event data for 2013 and 2014 (up to the date of analysis on September 16, 2014) were combined ($n=89,240$; 55,516 for 2013 and 33,724 for 2014). Next, KIDS NOW Plus clients in the birth event data set were identified based upon social security number. Only mothers in the birth data set that had their babies during the same time period as KIDS NOW Plus clients were kept in the data set (January 2013-January 2014); thus, 29,163 cases were removed leaving a sample of $n = 60,077$. Seventeen cases were removed because they were duplicate records (the earliest record for the child was kept in the file). In addition, 167 cases were removed from the whole birth event data set because they matched mothers involved in KIDS NOW Plus but who were not involved in the current follow-up sample analysis and, therefore, should not be included in the general population of mothers. Also, because follow-up analysis years regarding the birth data often overlap, cases were removed from the birth data file if they had been analyzed in the previous year's report ($n = 78$). Finally, two cases were removed from the birth data set corresponding to two clients from KIDS NOW Plus who did not give permission to access their birth event data. This left a sample of 59,813.

The next step to preparing the data was that all cases in which the mother was not a Kentucky resident were eliminated ($n=2,338$) which was 3.9% of the birth data sample and left a sample of 57,475 cases in Kentucky.

In addition, because not all CMHC regions provide KIDS NOW Plus services, to make the general population group more comparable to the KIDS NOW Plus mothers, only cases from the regions served by KIDS NOW Plus were included in the analysis.⁹² In order to determine the region, the mother's county of residence from the birth data was matched to the counties in the selected regions. This step eliminated 21,788 cases leaving a sample of $n = 35,687$ cases from regions served by KIDS NOW Plus.

FOLLOW-UP SAMPLE. In order to be included in the analysis of this report, clients must have been engaged in KIDS NOW Plus case management services for at least 30 days before the baby's birth; thus, of the 162 follow-up interviews completed, 10 were not included in the analysis because the intake information was submitted to CDAR less than 30 days before the baby was born. Also, only clients who had data in the birth event data set and who resided in a KIDS NOW Plus region were included in the analysis. Once the follow-up clients were matched to the birth event data set, 14 clients were not included in the follow-up analysis because they did not have a match to data in the Vital Statistics data set.⁹³ In addition, 2 clients did not give permission to access their birth data. This left a follow-up sample of 136 KIDS NOW Plus mothers for the birth event analysis.

ANALYSIS. Once the data set was cleaned and internally certified according to UK CDAR BHOS quality standards,

⁹² KIDS NOW Plus regions include LifeSkills, Communicare, Seven Counties, NorthKey, Pathways, Kentucky River, Cumberland River, and Adanta.

⁹³ Of these 14, 9 did not reside in regions served by KIDS NOW Plus and 5 were not in the birth event data set at all which could be due to an incorrect social security number, name or birthdate.

data analysis began. This included using the statistical software SPSS to complete Chi-square tests of independence, one-way ANOVAS, and z-test for proportions, while percent-of-change calculations were performed in Microsoft Excel. In this analysis the alpha level was set at .01. The statistical results were then placed in tables for review by the research team.

SERVICE EVENT DATA. Information on clinical services and mental health diagnosis codes for KIDS NOW Plus intake clients receiving treatment at community mental health centers is submitted into the Treatment Event Dataset (TEDS) and is managed by the University of Kentucky Institute for Pharmaceutical Outcomes and Policy (IPOP). Clinical services include billed case management, outpatient counseling, residential treatment, and other services as reported monthly by the CMHCs to the Department for Behavioral Health, Development and Intellectual Disabilities as service event data in TEDS. Service events and mental health diagnosis codes were matched to KIDS NOW Plus client intake data using encrypted social security numbers and based upon the timeframe from the date the intake interview was submitted to two months after the date the baby was born which varied for each client (average days 187; Minimum = 91, Maximum = 303 days). Of the 136 postnatal follow-up women included in the analysis, 64.7% (n = 88) received clinical services other than clinical case management services⁹⁴ provided by the KIDS NOW Plus program staff. Services that were categorized by TEDS as “unknown/not collected” or “miscellaneous” were not included in the analysis.

ANALYSIS OF BIRTH EVENTS AND OUTCOME DATA

BIRTH DATA SAMPLE. As described in the section regarding obtaining the birth event data, based upon the range of dates that the KIDS NOW Plus clients gave birth, which were from January 2013 to January 2014, the final sample for the general population of mothers is 34,888 mothers and 35,550 babies who were not involved in KIDS NOW Plus.

The KIDS NOW Plus Case Management study focuses on two units of analysis depending on the outcome being examined: (1) some outcomes use the mother as the unit of analysis and in those cases the mother will be represented only one time in the data set to avoid violating the assumption of independence; and (2) some outcomes use the birth and baby characteristics as the unit of analysis and those outcomes can include all of the babies in the Vital Statistics data set.

While the Vital Statistics data set has a variable which identified those mothers that had multiple births at one birth event (e.g., twins, triplets or quadruplets), it does not capture mothers who may have had two pregnancies and deliveries within the period analyzed (i.e., January 2013 – January 2014).

In addition, the Vital Statistics data set counts each child as a multiple. For example, Child A will have a value indicating he or she is a twin and Child B will also have a value indicating he or she is a twin. When the unit of analysis is the baby (or births), all children should be included in the analysis. When the unit of analysis is the mother, only one child (the one with the first child identification number) will be included in the analysis to avoid violating the assumption of independence of cases. Thus, a variable is created in the data set which identifies whether the baby is a twin, triplet or quadruplet, or if there is a sibling in the file that was born in the approximate 12 months that were analyzed for this report.

Table AB.2 displays the number of children born at the same birth event as well as the number of children with a sibling in the data set. For the entire data set (35,687 babies) there were 1,114 twins, 27 triplets, 4 quadruplets (totaling 1,145 multiple births, or 3.2% of the sample) and 85 children that had siblings born during the time frame but their siblings were not twins or triplets. Thus, when analyzing outcomes of the birth and baby characteristics the total sample size is 35,687 in order to include all babies.

⁹⁴ An additional 20 clients received only clinical case management services including substance abuse, adult mental health, child mental health and intellectual disabilities, and 2 clients received “unknown/not collected” or “miscellaneous” services, but were not included in the analysis.

TABLE AB.2. MULTIPLE BIRTHS AT ONE BIRTH EVENT BETWEEN JANUARY 1, 2013 AND JANUARY 31, 2014

Out of a total of 35,687 babies:	
Twins	1,114
Triplets	27
Quadruplets	4
Total multiple births	1,145 or 3.2%
Siblings born in separate deliveries within the time frame	85

Note: 2 babies in the KIDS NOW Plus sample were twins; the remaining babies were in the general population

Using mothers' social security numbers and children's dates of birth, mothers with multiple and multiparous births were identified as shown in Table AA.3. This shows there were 35,024 mothers total because 663 events with the same mother were excluded from the analysis. The mother data that remained for analysis was based upon the first child identification number (as determined by the birth data set), or in the case of multiparous births, the child with the earlier birth date. A total of 557 mothers had twins, 9 had triplets, 1 had quadruplets and 85 had children in separate deliveries but within the selected timeframe. When analyzing characteristics of the mother the sample size will be 35,024 so that these mothers are not counted more than once.

TABLE AB.3. MOTHERS WITH MORE THAN ONE BABY IN THE BIRTH DATA SET BETWEEN JANUARY 1, 2013 AND JANUARY 31, 2014

Out of a total of 35,024 mothers:	
Mothers who had twins	557
Mothers who had triplets	9
Mothers who had quadruplets	1
Total mothers with multiple births	567
Mothers with separate deliveries within the selected timeframe (siblings)	85
Total mothers with more than one child in the data set	652 or 1.9%

Note: Of the 652 mothers, 1 mother from KIDS NOW Plus had twins and or multiparous births. Also, 3 mothers in the general population had one child and then twin siblings. These mothers are counted only once.

ANALYSIS. Using the statistical software IBM SPSS, analysis included Chi-square tests and one-way ANOVAS comparing clients that were in KIDS NOW Plus to the general population of mothers. Demographics, socio-economic indicators, physical health status, smoking, prenatal visits, and birth outcomes (i.e., average weeks gestation, prematurity, birth weight and birthing problems) were included in the analysis. All analyses were done using a $p < .01$ alpha level based on power analysis, including the multivariate analysis and the comparison group analysis. For example, with the comparison group analysis using a Chi-square test, to detect a moderate effect size (0.3) with 8 degrees of freedom (3 groups X 3 category levels) on an overall sample size of 798, the alpha would be set at .00000001 when power is 0.95 using GPower to calculate the power analysis. Thus, alpha was set at $< .01$ because having a larger alpha would increase the risk of a Type I error. And for the multivariate analysis the sample size was so large GPower could not calculate the required alpha due to extreme parameters. Even reducing the sample size by an order of magnitude to 3,400 would require an alpha of .000000001 to detect a small effect size of .15 with a power of .95 and 7 degrees of freedom. Thus, to control for Type I error alpha was set at .01.

Multivariate regression models were used to examine the association between KIDS NOW Plus participation and birth outcomes while adjusting for key factors. Each birth outcome in Table 5C.1 was entered as the dependent

variable in a separate binary logistic regression model with KIDS NOW Plus participation as the predictor variable and the covariates of mother's age, education (i.e., less than a high school diploma or GED vs. high school diploma or higher), area of residence (metropolitan vs. non-metropolitan county), and smoking at the time of the birth (No/Yes).

MATCHED COMPARISON SAMPLE. In order to create a similar sample to which the KIDS NOW Plus birth outcomes and service data can be compared, clients were matched to mothers in the general population who did not receive KIDS NOW Plus case management services based upon age, race, education, marital status, smoking status and metropolitan/non-metropolitan residence.

To create these samples, a random number was assigned to the general population of mothers in Excel. Then, the KIDS NOW Plus and general population mothers were placed in separate data files within Access. A query was created from the KIDS NOW Plus file which contained the fields upon which we wanted to base the comparison group. In addition, a count was created to determine how many clients had a certain set of characteristics that needed to be matched.

Next, a table was created in which the comparison characteristics in the above query were linked to the variables in the general population birth data set in order to create a table with only cases that had characteristics matching KIDS NOW Plus clients. A structure only copy of this table was then created and the six fields being matched were set as the primary keys.

Another query was created which included the query from KIDS NOW Plus with the data from the six fields we wanted to match and the birth data table with matching characteristics. The query and the table were linked on the six variables and appended to the table which had the six fields set to primary keys. This created the first sample in which one individual from the general birth data matched on the six characteristics to one case in the KIDS NOW Plus birth event data.

Next, a table of birth event data with characteristics matching KIDS NOW Plus was created, but without cases that were chosen for the first sample in order to pull cases for additional matches. Based upon the count that was created to determine how many clients from KIDS NOW Plus possess each of the six characteristics, the next step was to pull the remaining number of cases from the birth data set that matched KIDS NOW Plus.

If there were KIDS NOW Plus clients that did not have a match to the birth event data set on all characteristics for comparison, the clients were excluded from the analysis because the remaining cases would not result in a complete matched comparison.

Once a matched comparison sample was generated, the remaining birth event data was sorted by the random number assigned and the top cases were chosen for the general population file based upon the sample size of the KIDS NOW Plus client file. This resulted in a sample size of $n = 125$ mothers for each group. Because some mothers had multiple births, there were 126 babies born to the 125 KIDS NOW Plus mothers, 125 babies born to the 125 mothers in the matched comparison sample and 127 babies born to the 125 mothers in the general population sample.

The three groups were analyzed using Chi-square tests and one-way ANOVAs with Tukey's HSD (honestly significant difference) test in order to determine which groups in the sample differ on birth characteristics and outcomes.

MATCHED COMPARISON SAMPLE SERVICE EVENT DATA AND MENTAL HEALTH DIAGNOSIS. Because KIDS NOW Plus strives to get women into necessary services, service event data and mental health diagnoses for KIDS NOW Plus postnatal follow-up clients and the matched comparison sample were analyzed. Service event data was matched to KIDS NOW Plus clients and the matched comparison group using encrypted social security numbers from one year prior to the child's date of birth to the child's date of birth (dates range from January 2012 to January

2014). Of the 125 women in each group,⁹⁵ 90 KIDS NOW Plus clients⁹⁶ and 9 mothers in the matched comparison group had service data. Services that were categorized by TEDS as “unknown/not collected” and “miscellaneous” were not included in the analysis (a total of 4 services for 2 clients). None of the clients had only unknown/not collected services.

⁹⁵ 10 women in the matched comparison sample had invalid social security numbers and were not able to be matched up to service data.

⁹⁶ An additional 12 clients received clinical case management services including substance abuse, adult mental health, child mental health and intellectual disabilities, but were not included in the analysis.

APPENDIX C: CLIENT CHARACTERISTICS AT INTAKE FOR THOSE WITH COMPLETED FOLLOW-UP INTERVIEWS AND THOSE WITHOUT COMPLETED FOLLOW-UP INTERVIEWS

Between January 2013 and June 2014, 560 mothers completed a prenatal intake. Of those clients, 276 either had not yet had their baby or were not in their 6-month postnatal targeted assessment month in FY 2014. Individuals who completed a postnatal follow-up assessment (n = 162) are compared in this section with 122 individuals who did not complete a postnatal follow-up interview but were in their 6-month follow-up window (e.g., ineligible for follow-up [n = 23], did not consent to follow-up [n = 46], interviewers were unable to locate the client for the follow-up survey [n = 31] or other reasons including invalid contact data or more than 30 days between prenatal intake survey completion and submission [n = 22⁹⁷]).

DEMOGRAPHIC CHARACTERISTICS

There were no significant demographic differences between clients who were followed-up and clients who were not followed-up (see Table AC.1). The average client age was about 25 years old for both groups of clients. Clients in both groups came into the KIDS NOW Plus program when they were about 24 weeks pregnant. More than half of clients in both groups were either married or cohabiting at prenatal intake. Of those who were married or cohabiting, over 90% of clients in both groups reported this partner was the father of the baby.

TABLE AC.1. COMPARISON OF DEMOGRAPHICS FOR CLIENTS WHO WERE INCLUDED IN THE FOLLOW-UP SAMPLE AND CLIENTS WHO WERE NOT INCLUDED IN THE FOLLOW-UP SAMPLE

	FOLLOW-UP SAMPLE	
	NO n = 122	YES n = 162
AVERAGE AGE	25.2 years	25.2 years
AVERAGE WEEKS PREGNANT	23.5 weeks	24.2 weeks
RELATIONSHIP STATUS		
Married	16.4%	23.5%
Cohabiting	42.6%	35.8%
Separated or divorced	6.6%	11.7%
Never married	34.4%	29.0%
Of those married or cohabiting, percentage that reported the partner is the father	(n = 67) 93.1%	(n = 96) 90.6%

Of those who completed a postnatal follow-up, 70.4% were currently unemployed compared to 71.3% of the clients who did not complete a follow-up. Almost three-quarters of clients in both groups expected to be employed in the next 12 months (see Table AC.2).

⁹⁷ Category includes one client with missing follow-up survey.

TABLE AC.2. CURRENT EMPLOYMENT STATUS AT PRENATAL INTAKE

	FOLLOW-UP SAMPLE	
	NO n = 122	YES n = 162
EMPLOYMENT		
Not currently employed	71.3%	70.4%
Full-time	10.7%	8.6%
Part-time	12.3%	15.4%
Occasional, from time to time seasonal work	1.6%	2.5%
On leave from a job for pregnancy related reasons	4.1%	3.1%
Expect to be employed in the next 12 months	69.9%	73.6%

The majority of clients reported that their usual living arrangement in the 12 months before entering the KIDS NOW Plus case management program was in a private residence (i.e., their own home or apartment or someone else's home or apartment; see Table AC.3). Small numbers of individuals were living in a correctional facility (i.e., jail or prison) before entering case management services. A small number of individuals reported their usual living arrangement had been in a shelter or on the street. At the time individuals entered KIDS NOW Plus, overall, about 12% of clients considered themselves to be homeless, with many of those individuals stating that they were temporarily staying with friends or family (see Table AC.3). There were no significant differences in living situation at intake between women who completed the postnatal follow-up and women who did not.

TABLE AC.3 LIVING SITUATION OF CLIENTS BEFORE ENTERING THE KIDS NOW PLUS PROGRAM

	FOLLOW-UP SAMPLE	
	NO n = 122	YES n = 162
USUAL LIVING ARRANGEMENT IN THE 12 MONTHS BEFORE ENTERING KIDS NOW PLUS		
Own or someone else's home or apartment	91.0%	96.3%
Jail or prison	2.5%	0.0%
Residential program, hospital, recovery center, or sober living home	3.3%	0.6%
Shelter or on the street	1.6%	1.9%
Other	1.6%	1.2%
CONSIDERS SELF TO BE CURRENTLY HOMELESS		
Why the individual considers himself/herself to be homeless	(n = 19)	(n = 14)
Staying in a shelter	15.8%	7.1%
Staying temporarily with friends or family	68.4%	71.4%
Staying on the street or living in your car	0.0%	7.1%
Other	15.8%	14.3%

PHYSICAL HEALTH

Clients that were included in the follow-up sample were very similar on several physical health measures to clients who were not in the follow-up sample (see Table AC.4). On a scale of 1 - 5, clients rated their health an average of 3.2. A significantly greater number of clients who did not complete a follow-up reported they had no health problems while a little less than a quarter of clients who did complete a follow-up reported two or more health problems. There were no significant differences between the two groups on viruses or emergency room visits since the client became pregnant although more clients who were followed up reporting experiencing a serious fall. The average number of doctor visits reported by clients is very similar with 6.7 visits for clients not followed up and 6.6 visits for clients who completed a follow-up.

TABLE AC.4. PHYSICAL HEALTH ISSUES OF CLIENTS BEFORE ENTERING THE KIDS NOW PLUS PROGRAM

	FOLLOW-UP SAMPLE	
	NO n = 122	YES n = 162
NUMBER OF HEALTH PROBLEMS**		
None	55.7%	37.0%
One health problem	31.1%	39.5%
Two or more health problems	13.1%	23.5%
OVERALL HEALTH RATING (1 – Poor, 5 – Excellent)	3.3	3.2
CHRONIC PAIN IN THE PAST 12 MONTHS	18.0%	22.8%
Of those experiencing chronic pain	n = 22	n = 37
Average level of pain over the past 30 days	7.0	6.1
CURRENTLY HAVE SEXUALLY TRANSMITTED INFECTION	8.2%	11.7%
SINCE PREGNANCY		
Viruses	26.2%	27.8%
Serious falls	4.9%	11.7%
Been to the emergency room	65.6%	59.3%
AVERAGE NUMBER OF DOCTOR VISITS ABOUT PREGNANCY	6.7	6.6

* p < .05, **p < .01

TARGETED RISK FACTORS

SUBSTANCE USE

There were few significant differences for substance use at prenatal intake between clients who did and clients who did not complete a postnatal follow-up. The majority of clients reported illegal drug and/or alcohol use in the 6 months prior to pregnancy and over half of clients in both groups reported substance use in the 30 days before pregnancy. Significantly more clients who completed a follow-up interview reported using alcohol in the 6 months prior to pregnancy when compared to clients who did not complete a follow-up interview.

TABLE AC.5 SUBSTANCE USE OF CLIENTS AT PRENATAL INTAKE

	FOLLOW-UP SAMPLE	
	NO n = 122	YES n = 162
SUBSTANCE USE IN THE 6 MONTH PRIOR TO PREGNANCY		
Illegal drugs and/or alcohol	63.9%	72.2%
Illegal drugs	51.6%	50.0%
Alcohol*	38.5%	51.9%
Cigarettes	73.0%	80.9%
SUBSTANCE USE IN THE 30 DAYS PRIOR TO PREGNANCY		
Illegal drugs and/or alcohol	55.7%	58.6%
Illegal drugs	45.9%	45.7%
Alcohol	27.0%	35.8%
Cigarettes	73.0%	79.0%
Of clients who smoked	(n = 89)	(n = 128)
Average number of cigarettes per day	17.9	19.1
SUBSTANCE USE IN THE PAST 30 DAYS		
Illegal drugs and/or alcohol	17.2%	11.7%
Illegal drugs	14.8%	9.3%
Alcohol	3.3%	2.5%
Cigarettes	65.6%	66.0%
Of clients who smoked	(n = 80)	(n = 107)
Average number of cigarettes per day	12.4	11.9

* p < .05

MENTAL HEALTH

There were no significant differences between the two groups for self-reported mental health problems (see Table AC.6). Among those clients who reported depression and those clients who reported anxiety, there were no significant differences between the clients on the average number of symptoms reported for either depression or anxiety.

TABLE AC.6 SELF-REPORTED MENTAL HEALTH SYMPTOMS OF CLIENTS AT PRENATAL INTAKE

	FOLLOW-UP SAMPLE	
	NO n = 122	YES n = 162
EXPERIENCED SYMPTOMS OF DEPRESSION IN THE PAST 6 MONTHS BEFORE PREGNANCY	25.4%	23.5%
Average number of symptoms	(n = 31) 5.0	(n = 38) 5.0
EXPERIENCED SYMPTOMS OF DEPRESSION IN THE PAST 30 DAYS AT PRENATAL INTAKE	21.3%	21.0%
Average number of symptoms	(n = 27) 4.7	(n = 34) 4.6
EXPERIENCED SYMPTOMS OF ANXIETY IN THE PAST 6 MONTHS BEFORE PREGNANCY	27.9%	32.7%
Average number of symptoms	(n = 34) 5.1	(n = 53) 4.9
EXPERIENCED SYMPTOMS OF ANXIETY IN THE PAST 30 DAYS AT PRENATAL INTAKE	29.5%	32.1%
Average number of symptoms	(n = 36) 4.6	(n = 52) 4.8
EVER EXPERIENCED OR WITNESSED AN EXTREMELY TRAUMATIC EVENT	28.7%	34.6%

INTIMATE PARTNER ABUSE AND VIOLENCE

There were no significant differences between clients who completed a postnatal follow-up and clients that did not on intimate partner abuse and violence measures. More than one-quarter of clients in both groups reported some type of partner abuse or violence in the 6 months before pregnancy (see Table AC.7).

TABLE AC.7 INTIMATE PARTNER VIOLENCE AND SEXUAL VIOLENCE BY ANY TYPE OF PERPETRATOR REPORTED BY CLIENTS AT PRENATAL INTAKE

	FOLLOWED UP	
	NO n = 122	YES n = 162
ANY TYPE OF ABUSE		
6 Months before pregnancy	30.3%	25.9%
Past 30 days	16.4%	11.7%
VERBAL ABUSE		
6 Months before pregnancy	20.5%	20.4%
Past 30 days	10.7%	8.0%
COERCIVE CONTROL		
6 Months before pregnancy	27.9%	21.0%
Past 30 days	10.7%	8.6%
PHYSICAL ABUSE		
6 Months before pregnancy	13.1%	13.0%
Past 30 days	2.5%	2.5%
STALKED		
6 Months before pregnancy	9.8%	9.3%
Past 30 days	1.6%	2.5%
SEXUAL ABUSE		
6 Months before pregnancy	4.1%	3.7%
Past 30 days	1.6%	1.2%

APPENDIX D: KIDS NOW PLUS BIRTH OUTCOME DATA COMPARISON

This section compares (A) general risk factors; (B) targeted risk factors; and (C) birth events and outcomes from the Kentucky Vital Statistics data for three mutually exclusive groups including: (1) high risk pregnant mothers involved in KIDS NOW Plus case management services who gave birth between January 2013 and January 2014 (n = 125)⁹⁸; (2) a comparison group of mothers (n = 125) matched on selected characteristics (race, age, education, metropolitan/non-metropolitan residence, marital status and smoking status); and (3) a randomly selected group of mothers (n = 125) from the general population. Only mothers who reside in regions served by KIDS NOW Plus were analyzed.

There are two units of analysis depending on the outcome being examined: (1) some outcomes use the mother as the unit of analysis and in those cases the mother will only be represented one time in the data set (although the Vital Statistics data set can include the mother multiple times if she has had multiple births (e.g., twins or siblings) during the time frame examined); and, (2) some outcomes use the birth and baby characteristics as the unit of analysis and those outcomes can include all of the babies in the Vital Statistics data set.

Overall, one KIDS NOW Plus mother and two mothers from the general population had more than one child in the sample. This means there were 126 babies in the KIDS NOW Plus sample, 125 babies in the comparison group and 127 babies in the general population sample.

GENERAL RISK FACTORS

The general risk factors compared in this section are from the Kentucky Vital Statistics data set. This section describes demographic information (e.g., age, race, and type of community in which the mother resided), socioeconomic status indicators (e.g., education and source of payment for birth of the baby), and physical health status (e.g., maternal health problems).

DEMOGRAPHICS

Table AD.1 shows that the only significant differences between the KIDS NOW Plus clients and matched comparison sample compared to the general population of mothers in the KIDS NOW Plus regions are race (with a significantly greater percentage of the general population of mothers being non-white) and metropolitan/non-metropolitan residence (with more mothers in the general population living in metropolitan communities compared to the KIDS NOW Plus and matched comparison group). In addition, a greater percentage of clients in the general population (55.2%) were married compared to the KIDS NOW Plus and comparison group (28.8%). The general population of mothers were also significantly older than the KIDS NOW Plus and matched comparison sample.

⁹⁸ While analysis on intake data includes 136 pregnant women involved in KIDS NOW Plus, a match on all characteristics for 11 KIDS NOW Plus clients could not be found in the sample of other mothers in the KIDS NOW Plus regions. Thus, clients who did not have a matched comparison were excluded from the sample leaving a sample size of 125.

TABLE AD.1. DEMOGRAPHIC DIFFERENCES BETWEEN BIRTH EVENT DATA GROUPS

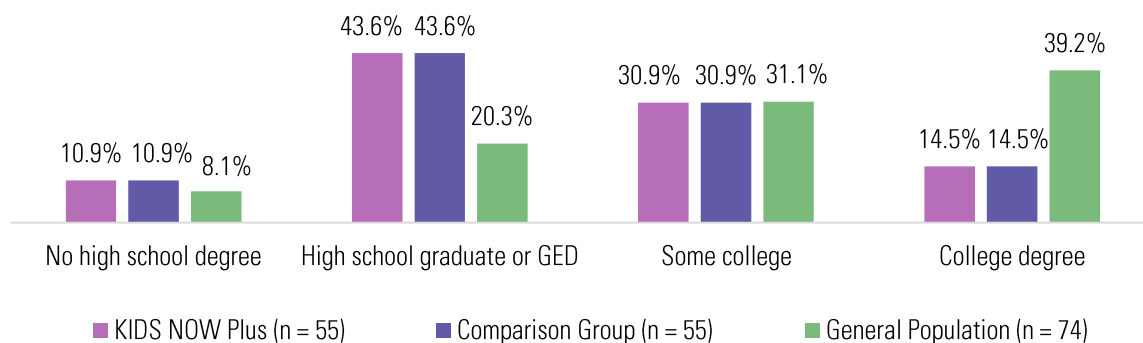
	KIDS NOW Plus (n = 125)	Comparison Group (n = 125)	General Population (n = 125)
Race***			
White	95.2%	95.2%	81.6%
Non-white	4.8%	4.8%	18.4%
Average age*			
	24.5	24.5	26.1
Metropolitan/non-metropolitan status***			
Metropolitan	41.6%	41.6%	68.0%
Non metropolitan	46.4%	46.4%	23.2%
Very rural	12.8%	12.8%	8.8%
Marital status***			
Not married	71.2%	71.2%	44.8%
Married	28.8%	28.8%	55.2%

*** p < .01, * p < .05

SOCIOECONOMIC STATUS INDICATORS

Because the KIDS NOW Plus mothers were younger than the general population it is important to compare education rates only for those who had sufficient time to finish high school. The 2010 census indicates that of Kentucky women ages 25 and older, 81% had high school degrees. When groups of women ages 25 and older are compared, 89% of KIDS NOW Plus mothers and 90.6% of mothers in the general population have at least a high school diploma or GED (see Figure AD.1). Therefore, when looking at women 25 years old or older, 10.9% of KIDS NOW Plus and the matched comparison group mothers and 8.1% of mothers in the general population had less than a high school degree. However, 39.2% of mothers in the general population received a college degree compared to 14.5% of mothers in KIDS NOW Plus and the matched comparison sample.

FIGURE AD.1. LEVEL OF EDUCATION BETWEEN BIRTH EVENT DATA GROUPS^{99**}



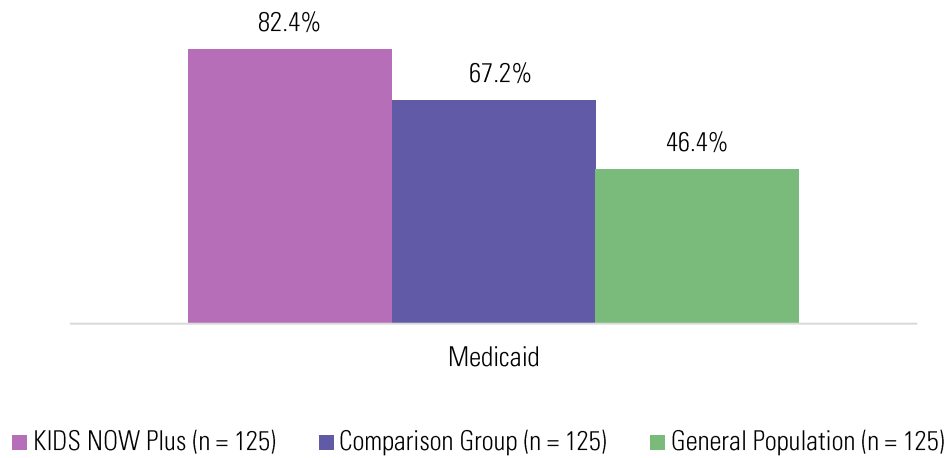
**p < .001

KIDS NOW Plus mothers were more likely to use Medicaid as their source of payment for the birth of the baby

⁹⁹ Education was unknown for one mother (1.4%) in the general population.

compared to either the matched comparison sample or the general population as Figure AD.2 shows.

FIGURE AD.2. MOTHERS WITH MEDICAID AS THE SOURCE OF PAYMENT BETWEEN BIRTH DATA GROUPS***

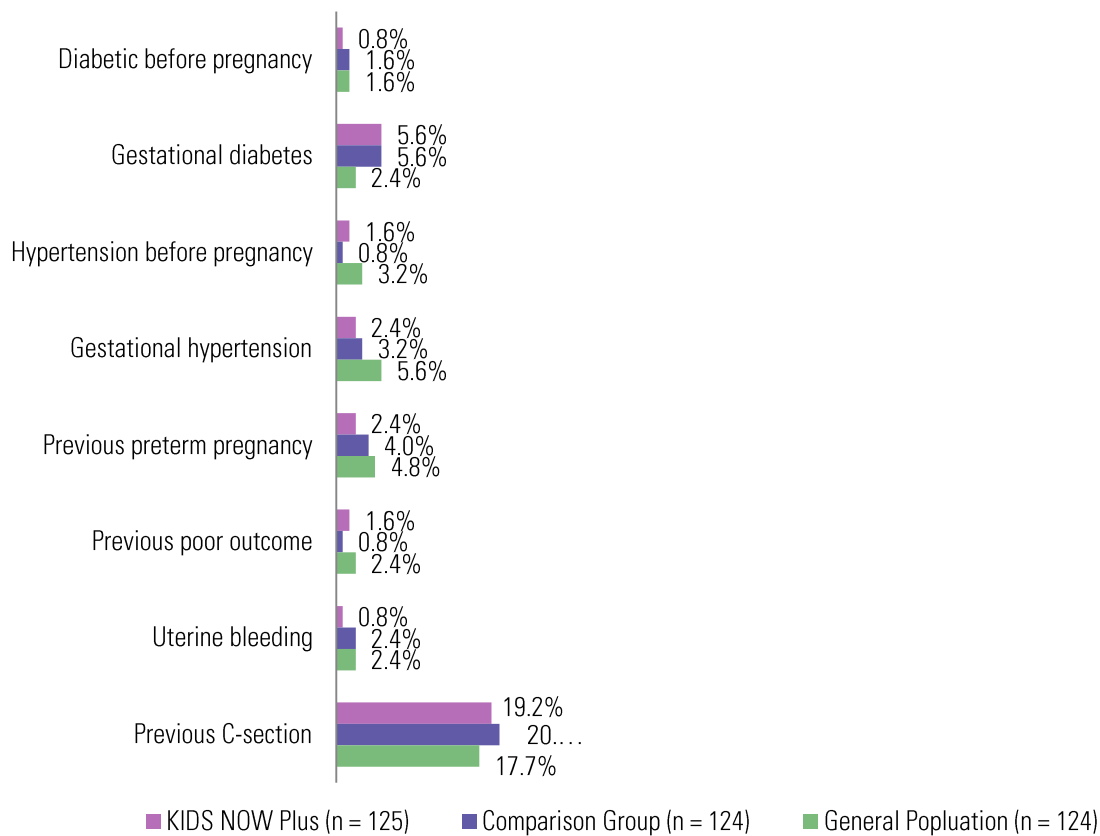


***p < .001

PHYSICAL HEALTH STATUS

General health conditions of pregnancy were examined from the Vital Statistics data set as well (see Figure AD.3). There were no significant differences between the groups on health conditions such as gestational diabetes, gestational hypertension or previous poor birth outcomes.

FIGURE AD.3. OTHER MATERNAL RISK FACTORS BETWEEN BIRTH DATA GROUPS



Note: Maternal health risk factors were unknown for one mother in the matched comparison group and one mother in the general population.

KIDS NOW Plus mothers were significantly more likely (9.6%) to have a sexually transmitted infection such as gonorrhea, syphilis, herpes, or chlamydia compared to the matched comparison group (2.4%) or the general population sample (6.5%; not depicted in a Figure).

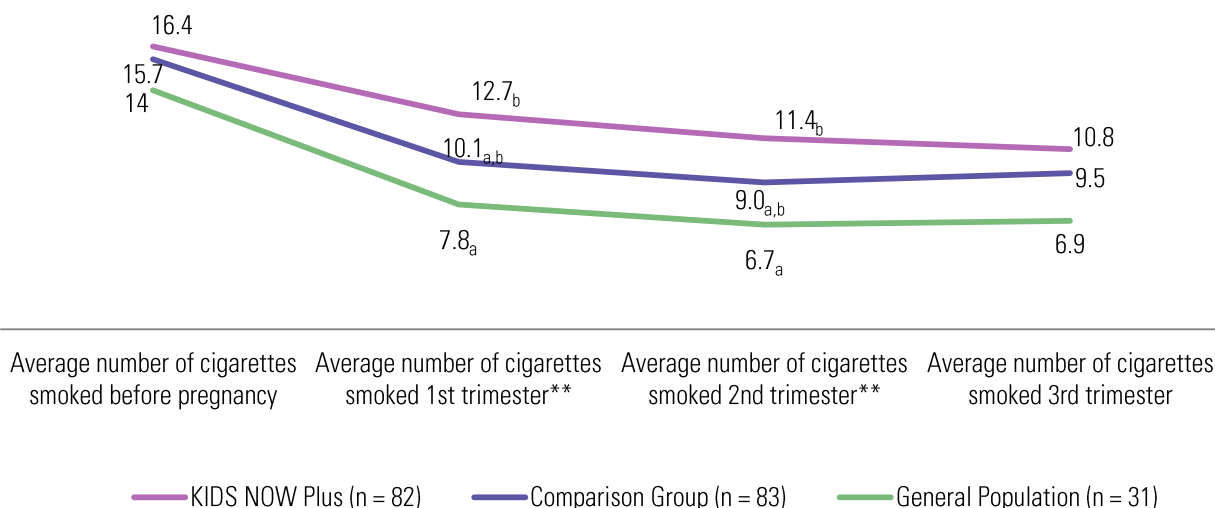
When only hepatitis B and C are examined, KIDS NOW Plus mothers were not significantly more likely to be infected (6.4%) compared to the matched comparison group (1.6%) and the general population sample (4.0%).

TARGETED RISK FACTORS

SMOKING PATTERNS

Significantly more KIDS NOW Plus clients and the matched comparison mothers reported being a smoker (66.4%) compared to the general population (25.0%) as Figure AD.4 shows. Of those who smoked, they did not report smoking significantly more cigarettes before pregnancy or in the third trimester. However, in both the first trimester and the second trimester, KIDS NOW Plus clients smoked significantly more cigarettes than the general population of mothers who smoked.

FIGURE AD.4. AVERAGE NUMBER OF CIGARETTES SMOKED PER TRIMESTER



a, b– Significance established using Tukey’s HSD test where groups that do not share coefficients are significantly different
 ** p < .01

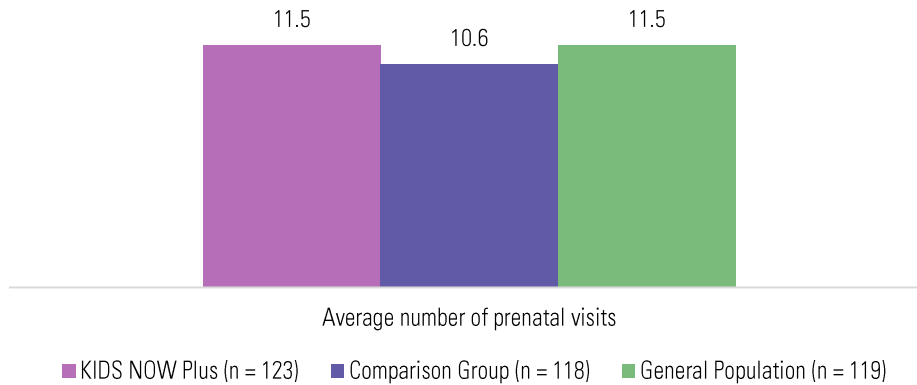
Note: One KIDS NOW Plus client was missing information on the number of cigarettes per trimester.

BIRTH EVENTS AND OUTCOMES

PRENATAL VISITS

As mentioned previously, one of the goals if the KIDS NOW Plus case management program is to engage clients in services that will improve their health and the health of the fetus. Besides referrals to substance abuse or mental health services, KIDS NOW Plus providers also engage clients in prenatal care and assist them in attending all their prenatal care visits. As a result, KIDS NOW Plus mothers had about the same average number of prenatal visits compared to the matched comparison group and the general population (see Figure AD.5). KIDS NOW Plus clients had an average of 11.5 prenatal visits, the matched comparison group had an average of 10.6 prenatal visits and the general population sample had an average of 11.5 prenatal visits.

FIGURE AD.5. AVERAGE NUMBER OF PRENATAL CARE VISITS WITH A HEALTH CARE PROVIDER ACROSS GROUPS

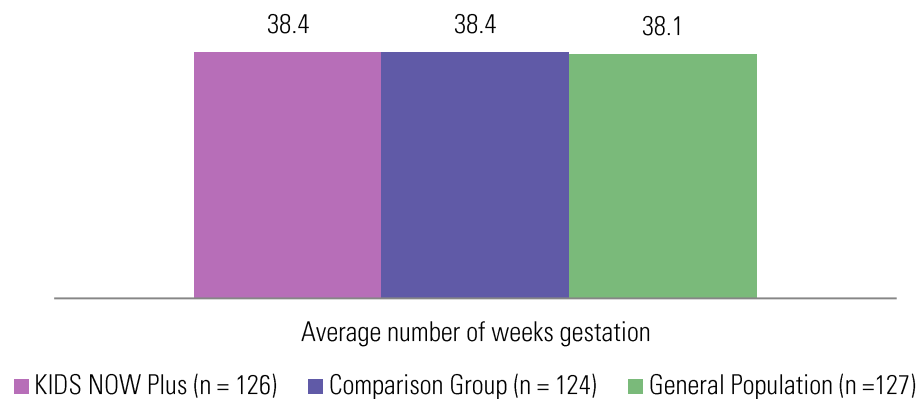


Note: Two KIDS NOW Plus mothers, 7 mothers in the comparison group and 6 mothers in the general population were missing information on the number of prenatal visits.

WEEKS GESTATION

There was no significant difference in average weeks of gestation of babies born to KIDS NOW Plus mothers compared to the matched comparison sample or to the general population of births as Figure AD.6 shows. KIDS NOW Plus babies were born at an average of 38.4 weeks, babies born to mothers in the matched comparison group were born at 38.4 weeks and babies born to mothers in the general population were 38.1 weeks.

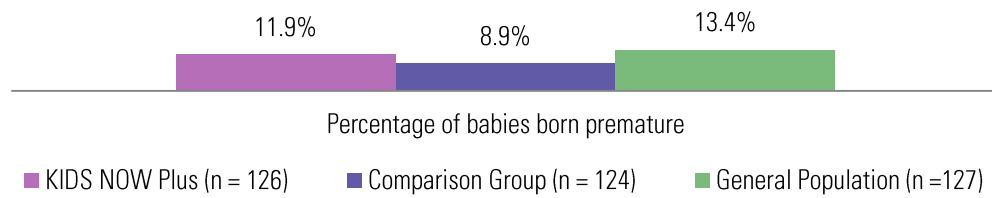
FIGURE AD.6. AVERAGE NUMBER OF GESTATIONAL WEEKS ACROSS GROUPS



Note: One baby in the comparison group was missing information on the number of gestational weeks.

Comparing all three groups, there were no significant differences in the percentage of babies that were born prematurely (before 37 weeks gestation; see Figure AD.7).

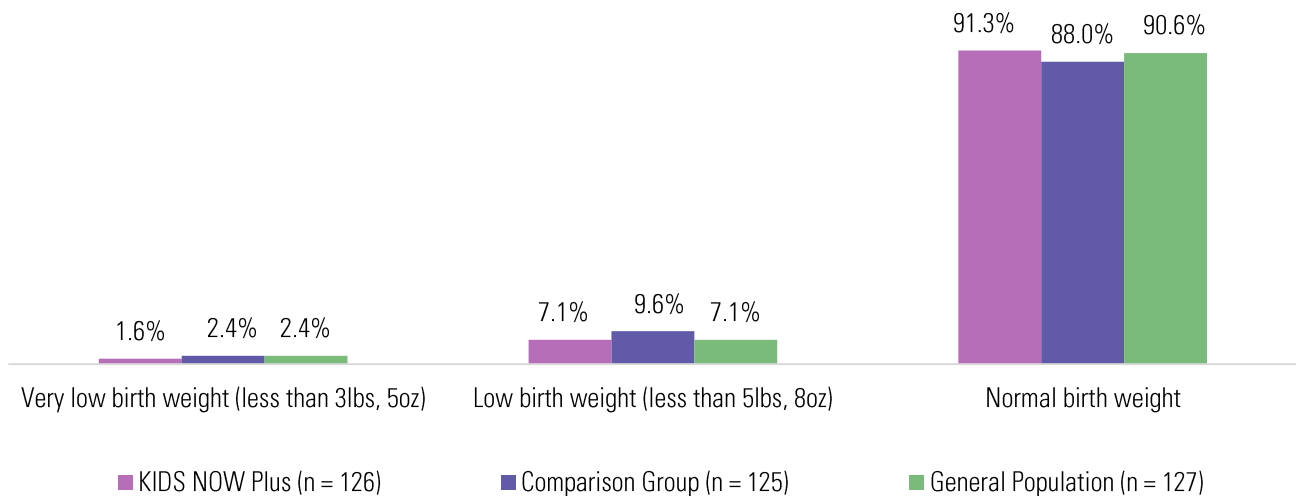
FIGURE AD.7. BABIES BORN PREMATURELY ACROSS BIRTH DATA GROUPS



BIRTH WEIGHT

There were no significant differences in birth weight between babies in the three groups. Babies born to all three groups weighed an average of 7lbs, 0oz when converted from grams to pounds and ounces. Further, there were no significant differences in rates of low birth weight babies between the three groups. Figure AD.8 shows that among KIDS NOW Plus babies, 7.1% were less than 5lbs, 8oz and 1.6% were under 3lbs, 5oz, which is considered “very low birth weight.” For the matched comparison group, 9.6% were considered low birth weight and 2.4% were very low birth weight.

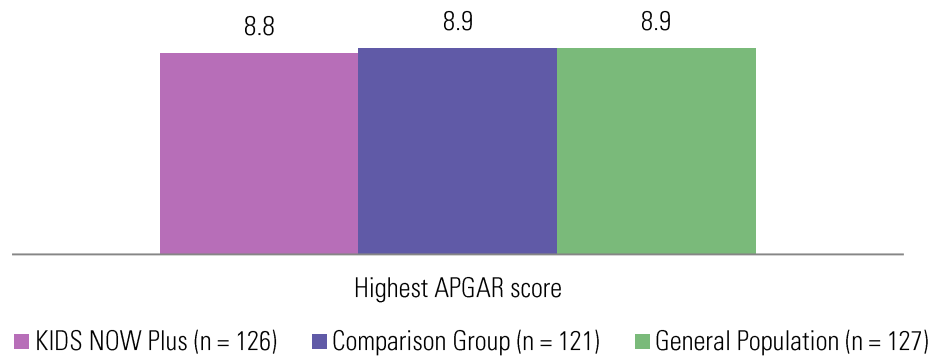
FIGURE AD.8. BIRTH WEIGHT STATUS ACROSS GROUPS



APGAR

The final APGAR scores recorded may be taken at either five minutes or ten minutes after the birth. The highest score of the 5-minute and 10-minute APGARs for each group is displayed in Figure AD.9 and shows no significant differences between the groups on average APGAR scores. Babies born to KIDS NOW Plus mothers had an average APGAR score of 8.8 while babies born to the matched comparison sample and the general population had an average APGAR score of 8.9.

FIGURE AD.9. AVERAGE HIGHEST APGAR SCORES ACROSS GROUPS

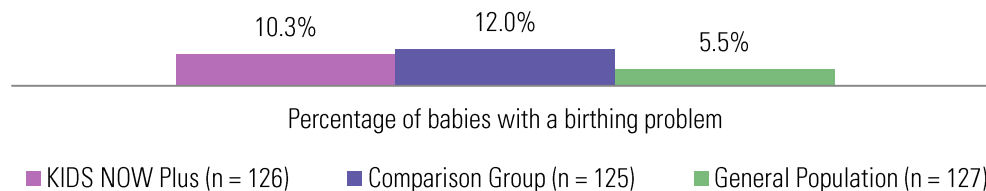


BIRTH PROBLEMS

There were no significant differences between the groups (one baby in KIDS NOW Plus, none for the babies in the matched comparison sample and one baby in the general population sample) for birth defects or anomalies (such as Down's syndrome, cleft palates, anencephaly, congenital heart failure, spina bifida, etc.).

Overall, there were no differences in the percentage of babies born with a birthing problem as Figure AD.10 shows (not including being admitted to the neonatal intensive care unit).¹⁰⁰ In addition, among those babies with birthing problems, there were no differences in the average number of birthing problems between babies in the KIDS NOW Plus group (an average of 1.3 problems) and the babies in the matched comparison sample (an average of 1.8 problems) or the general population (an average of 1.4 problems).

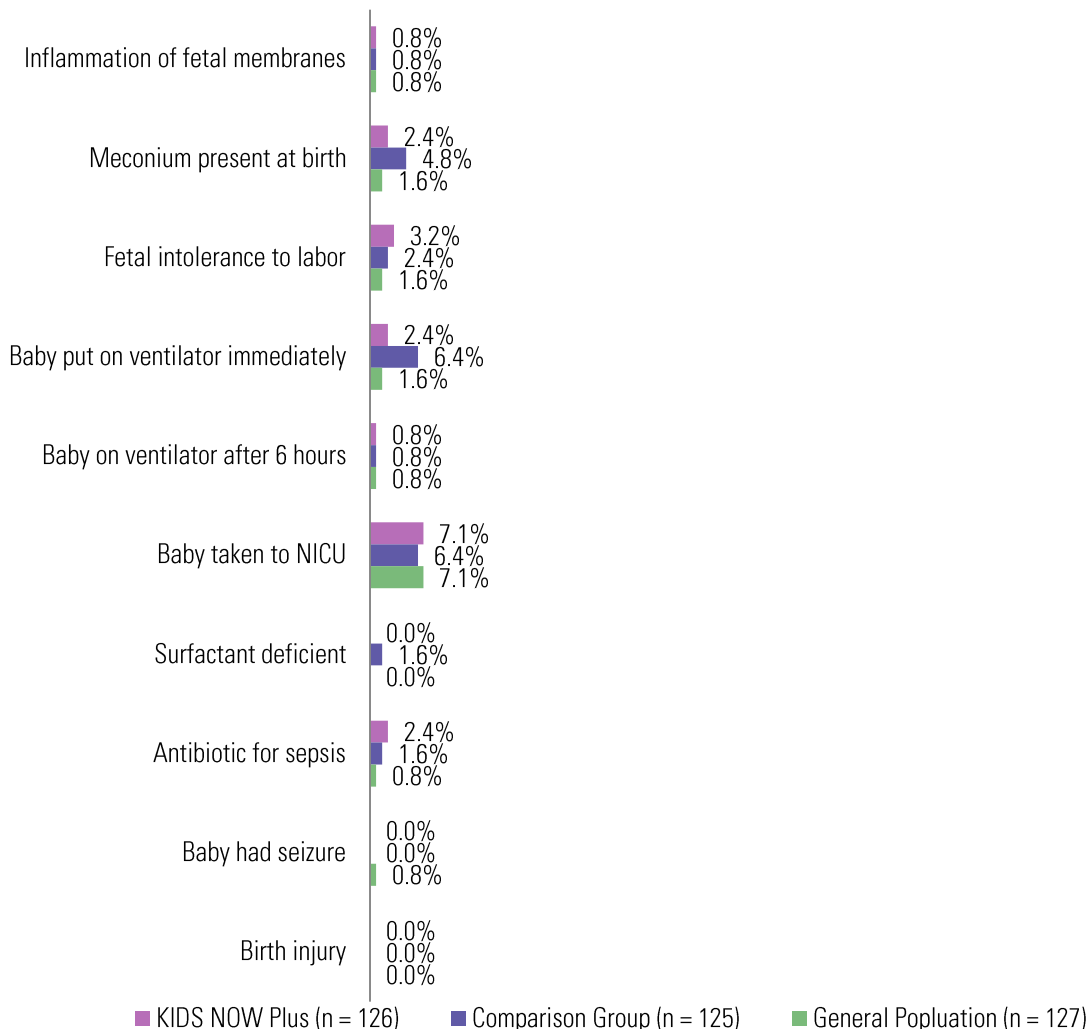
FIGURE AD.10. BABIES BORN WITH BIRTHING PROBLEMS (NOT INCLUDING NICU) ACROSS BIRTH DATA GROUPS



Specifically, KIDS NOW Plus babies were not significantly more likely to have particular birthing problems such as inflammation of fetal membranes, intolerance to labor, or being placed on a ventilator (see Figure AD.11).

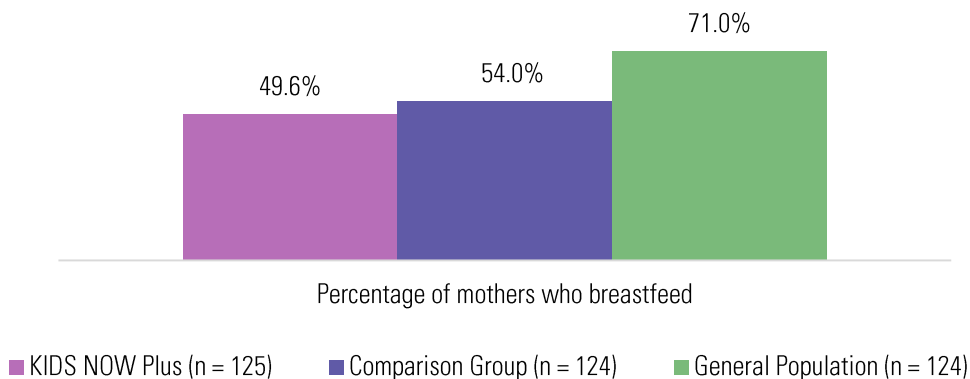
¹⁰⁰ Birthing problem index was created by looking at the proportion of births in each group that had any of the following problems: inflammation of fetal membranes, meconium present, fetal intolerance, baby put on ventilator, surfactant deficient, antibiotic for sepsis, baby had seizure, and birth injury.

FIGURE AD.11. BABIES WITH A BIRTHING PROBLEM ACROSS GROUPS



KIDS NOW Plus clients and the matched comparison group were significantly less likely to breastfeed their babies (49.6% and 54.0% respectively) compared to the general population sample of mothers (71.0%) as shown in Figure AD.12.

FIGURE AD.12. PERCENTAGE OF CLIENTS WHO BREASTFED^{101**}



¹⁰¹Breastfeeding information was missing for one mother in the matched comparison group and one mother in the general population.

CONCLUSION

In general, results of this analysis parallel the results of the multivariate analysis on birth events and outcomes. Compared to the general population of mothers giving birth in the regions served by KIDS NOW Plus case management, KIDS NOW Plus clients and mothers in the matched comparison sample were more likely to have Medicaid as their source of payment for the birth of the baby. More KIDS NOW Plus mothers smoked cigarettes before becoming pregnant than mothers in the general population. At the same time, birth events and outcomes were very similar across the three groups. Specifically, there were no significant differences for the average number of gestational weeks, the percentage of babies who were born premature, highest APGAR score, birth weight, the percentage of babies with birthing problems, or the percentage of babies being taken to the neonatal intensive care unit. In addition, there was no significant difference for the average number of prenatal care visits with a health care provider; however, KIDS NOW Plus mothers and the matched comparison group of mothers were less likely to breastfeed compared to the general population.

Kentucky currently identifies pregnant women as a priority population and they are a priority for admission to treatment. This requirement is listed in Section 2.07 of the CMHC contracts and the contracts of other providers that receive Block Grant funds. Please see excerpt below.

- *Eligibility Requirements:* The CMHC shall be responsible for delivering SUD services to: Adults, persons age eighteen (18) or older who have a substance use disorder; and Adolescents, persons age seventeen (17) or younger who have a substance use disorder and who meet general eligibility requirements for DBHDID funded services. Priority for admission to services shall be provided to members of a priority population as defined by the SAPT Block Grant requirements.

With the assistance of the Behavioral Health Quality Assurance Branch, contracts are being monitored on an on-going basis to ensure offered services are meeting the SAPT Block Grant and contract requirements.

The below information indicates the total number of programs that serve pregnant women and/or women with dependent children for the identified program criteria. There are a total of 139 State Funded programs (including program branches, as each branch has to have their own SAMHSA I-BHS#), that has completed the state administered Substance Abuse Treatment Provider Directory Application.

Outpatient: Adult Pregnant Female= 99
Outpatient: =Adol. Pregnant Female= 95
Intensive Outpatient: Adult Pregnant Female=43
Intensive Outpatient: Adol. Pregnant Female= 19
Dextox (Non Medical): Adult Pregnant Female= 4
Dextox (Non Medical): Adol. Pregnant Female = 2
Detox (Medical): Adult Pregnant Female = 1
Detox (Medical): Adol. Pregnant Female = 0
Opioid Addication Treatment: Licensed Opioid Treatment Program (908 KAR 1:340))=3
Opioid Addication Treatment: Methadone (detox)=1
Opioid Addication Treatment: Methadone (maintenance)=2
Opioid Addication Treatment: Buprenorphine (detox)=4
Opioid Addication Treatment: Buprenorphine (maintenance)=5
Inpatient (Hospital): Adult Pregnant Female= 1
Inpatient (Hospital): Adol. Pregnant Female=2
Residential (Short term approx 30 days): Adult Pregnant Female=6
Residential (Short term approx 30 days): Adol. Preg Female)=4
Residential (Short term approx 30 days): Accepts clients dependent children=0
Residential (Long term more than 30 days): Adult Pregnant Female)=6
Residential (Long term more than 30 days): Adol. Preg Female=2
Residential (Long term more than 30 days): Accepts clients dependent children=3
Family Residential: Adult Pregnant Female=2
Family Residential: Adol. Preg Female= 0
Family Residential: Accepts clients dependent children=1
Transitional Housing (Not a half-way house): Adult Pregnant Female=3
Transitional Housing (Not a half-way house): Adol. Preg Female= 1
Transitional Housing (Not a half-way house): Accepts clients dependent children= 0

There are currently a total of 20 Methadone Treatment Clinics across the state (one in every region except Region 14). The majority of these are privately funded (not receiving block grant funds) clinics and each one of them does provide services to pregnant and/or parenting women. Due to Kentucky being a mostly rural state, there are minimal state funded medication-assisted treatment options for pregnant women outside of the Louisville and Lexington Metro Areas.

Environmental Factors and Plan

20. Suicide Prevention

Narrative Question:

In the FY 2016/2017 block grant application, SAMHSA asks states to:

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised [National Strategy for Suicide Prevention \(2012\)](#).
2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.
3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document [Guidance for State Suicide Prevention Leadership and Plans](#).⁹⁶

Please indicate areas of technical assistance needed related to this section.

⁹⁶ http://www.samhsa.gov/sites/default/files/samhsa_state_suicide_prevention_plans_guide_final_508_compliant.pdf

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities

2013 - 2018 STRATEGY FOR SUICIDE PREVENTION

Goals and Objectives

Strategic Direction 1: Healthy and Empowered Individuals, Families, and Communities

GOAL 1. Integrate and coordinate suicide prevention activities across multiple sectors and settings.

- Integrate suicide prevention into the values, culture, leadership and work of BHDID, to include:
 - Departmental goals, all contracts and grants, regulations, plan and budget questions, expanded suicide prevention on state web pages.
 - Require department approved training for all BHDID professionals, contracted entities (such as peer support and KPFC) and volunteers.
 - Develop and implement suicide prevention training and T4T modules for peer support to be implemented in BHDID contracted entities.
 - Develop and implement suicide prevention training and T4T modules for consumer-operated programs to be implemented in BHDID contracted entities.
- Integrate suicide prevention into the values, culture, leadership and work of organizations and programs with a role to support suicide prevention activities to include:
 - Systems of care, The State Interagency Council for Services to Children with Emotional Disabilities (SIAC) and social services (foster programs, job assistance, domestic violence prevention, rape crisis centers, DJJ, AOC, Department of Education, community action organizations, etc.)
- Establish effective, sustainable, and collaborative suicide prevention programming at the state, regional, and local levels.
- Develop and sustain public-private partnerships to advance suicide prevention, including schools, workplaces and faith-based communities.
- Integrate suicide prevention into ALL relevant health care reform efforts.
- Align as appropriate with President’s “Now is the Time” plan for mental health training, services and funding to:
 - Provide “Mental Health First Aid” training for teachers;
 - Make sure students with signs of mental illness get referred to treatment;
 - Support individuals ages 16 to 25 at high risk for mental illness;
 - Help schools address pervasive violence;
 - Train more than 5,000 additional mental health professionals to serve students and young adults.

GOAL 2. Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors.

- Develop, implement, and evaluate communications efforts designed to reach defined segments of the population.
- Promote outreach to policymakers with dedicated communication efforts including education regarding high costs of emergency department and ambulance calls related to suicidal behavior.
- Increase communication efforts via all social media that promote positive messages and support safe intervention strategies.
- Increase knowledge of warning signs for suicide and of how to connect individuals in crisis with assistance and care.
 - This could include continued promotion of QPR gatekeeper trainings, mandated secondary school-based staff and student suicide prevention trainings, post-secondary staff and students, military/veterans and their families, and Mental Health First Aid training which includes two hours of suicide prevention training. Take advantage of conference opportunities.

GOAL 3. Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery.

- Promote effective programs and practices that increase protection from suicide risk, including resiliency training.
- Reduce the prejudice and discrimination associated with suicidal behaviors and mental and substance use disorders.
- Promote the understanding that recovery from mental and substance use disorders is possible for all. This includes promotion of recovery-oriented support systems.

GOAL 4. Promote responsible media reporting of suicide.

- Distribute media guidelines to press associations through training and information sheets. Shape messages to take into consideration their need for ratings.
- Utilize AP style book release to educate about mental health.
- Include and educate CHFS communications regarding responsible media reporting.
- Utilize post-secondary education to educate journalism majors about responsible reporting.
- Promote positive stories around “success stories” in suicide prevention (e.g. Kevin Hines and the Golden Gate Bridge).

Strategic Direction 2: Clinical and Community Preventive Services

GOAL 5. Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors.

- Strengthen the coordination, implementation, and evaluation of comprehensive state, regional, and local suicide prevention programming.
- Encourage community-based settings to implement effective programs and provide education that promote wellness and prevent suicide and related behaviors. Possible settings include:

- Clinical service providers including primary care, hospitals, urgent care and emergency departments, emergency service providers, substance abuse prevention services, public health, and other health care providers.
- Schools and other youth-serving organizations, post-secondary institutions, workplaces, faith-based organizations, justice and law enforcement, organizations providing health care, military and veteran service organizations, community prevention coalitions and other community partners.
- Educate and equip Regional Prevention Center staff to integrate suicide prevention into the Strategic Prevention Framework.
- Pursue funding opportunities for creation of suicide prevention enhancement site.
- Create and distribute suicide prevention toolkit for grassroots community partners.
- Intervene to reduce suicidal thoughts and behaviors in populations with suicide risk, to include persons with serious mental illness (SMI) or severe emotional disabilities (SED), males who are middle-aged, persons in military and veterans, youth and young adults, persons who are lesbian, gay, transgender, bisexual or questioning (LGBTQ), as well as others identified at higher risk.
- Strengthen efforts to increase access to and delivery of effective programs and services for mental and substance use disorders from any entry point.

GOAL 6. Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk.

- Integrate lethal means reduction education into all trainings to community and clinical service providers, including conference opportunities such as Kentucky School, Operation Headed Home and Operation Immersion.
- Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means.
- Integrate into BHDID monitoring protocol questions about access to lethal means (e.g. Substance Abuse Services, Impact Plus, Prevention).
- Disseminate emergency department posters and material from Suicide Prevention Resource Center.
- Partner with firearm dealers, Kentucky chapters of National Rifle Association, hunter safety classes, and gun owners to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.

GOAL 7. Provide training to community and clinical service providers on the prevention of suicide and related behaviors.

- Provide training on suicide prevention to community groups that have a role in the prevention of suicide and related behaviors.
- Provide training to mental health and substance abuse providers on the recognition, assessment, and management of at-risk behavior, and the delivery of effective clinical care for people with suicide risk per state statutes and regulations, to include persons with SMI or SED,

males who are middle-aged, persons in military or veterans and their families, and persons who are LGBTQ, as well as others identified at higher risk.

- Integrate into BHDID monitoring protocol to look for state-mandated suicide prevention training in clinical service provider personnel record.
- Promote the adoption of core education and training guidelines developed at national level on the prevention of suicide and related behaviors by all health professions, including graduate and continuing education. Utilize internal BHDID resources to connect with policy makers.
- Promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by credentialing and accreditation bodies. Utilize internal BHDID resources to connect with policy makers.
- Implement protocols and programs developed at national level for clinicians and clinical supervisors, first responders, crisis staff, and others on how to implement effective strategies for communicating and collaboratively managing suicide risk.

Strategic Direction 3: Treatment and Support Services

GOAL 8. Promote suicide prevention as a core component of health care services.

- Promote the adoption of “zero suicides” as an aspirational goal by health care and community support systems that provide services and support to defined patient populations.
- Promote inclusion of suicide risk screening and assessment questions in electronic health records.
- Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive, and least restrictive settings.
- Promote timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide.
- Promote continuity of care and the safety and well-being of all patients treated for suicide risk in emergency departments or hospital inpatient units.
- Encourage health care delivery systems to incorporate suicide prevention and appropriate responses to suicide attempts as indicators of continuous quality improvement efforts.
- Establish linkages between providers of mental health and substance abuse services and community-based programs, including peer support programs.
- Coordinate services among suicide prevention and intervention programs, health care systems, and accredited local crisis centers.
- Develop collaborations between emergency departments and other health care providers to provide alternatives to emergency department care and hospitalization when appropriate, and to promote rapid follow-up after discharge.

GOAL 9. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.

- Adopt, disseminate, and implement guidelines for the assessment of suicide risk among persons receiving care in all settings.

- Develop, disseminate, and implement guidelines for clinical practice and continuity of care for providers who treat persons with suicide risk.
- Promote the safe disclosure of suicidal thoughts and behaviors by all patients.
- Adopt and implement guidelines to effectively engage families and concerned others, when appropriate, throughout entire episodes of care for persons with suicide risk.
- Adopt and implement policies and procedures to assess suicide risk and intervene to promote safety and reduce suicidal behaviors among patients receiving care for mental health and/or substance use disorders.
- Adopt and implement standardized protocols for use within emergency departments based on common clinical presentation to allow for more differentiated responses based on risk profiles and assessed clinical needs.
- Develop guidelines on the documentation of assessment and treatment of suicide risk and establish a training and technical assistance capacity to assist providers with implementation.
- Require integration and monitoring of BHDID protocol to include suicide risk assessment questions in biopsychosocial and ALL screening and assessment instruments (to include electronic health records).
- Require CMHC crisis line staff to receive accreditation similar to the National Suicide Prevention Lifeline.
- Develop required accreditation criteria for CMHC crisis mobile unit and staff.

GOAL 10. Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.

- Adopt guideline, for effective comprehensive support programs for individuals bereaved by suicide, and promote the full implementation of these guidelines at the state, regional, and community levels.
- Provide appropriate clinical care to individuals affected by a suicide attempt or bereaved by suicide, including trauma treatment and care for complicated grief.
- Engage suicide attempt survivors in suicide prevention planning, including support services, treatment, community suicide prevention education, and the development of guidelines and protocols for suicide attempt survivor support groups.
- Adopt, disseminate, implement, and evaluate guidelines for communities to respond effectively to suicide clusters and contagion within their cultural context, and support implementation with education, training, and consultation.
- Provide health care providers, first responders, and others with care and support when a patient under their care dies by suicide.

Strategic Direction 4: Surveillance, Research, and Evaluation

GOAL 11. Increase the timeliness and usefulness of state surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action.

- Promote the improvement of the timeliness of reporting vital records data and continue to crosswalk these with CMHC and State Psych Hospital client data.
- Improve the usefulness and quality of suicide-related data.
- Improve and expand state, regional, and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions.
- Increase the number of statewide representative surveys and other data collection instruments that include questions on suicidal behaviors (e.g. KIP Survey), related risk factors, and exposure to suicide.

GOAL 12. Promote and support research on suicide prevention.

- As developed, adopt the national suicide prevention research agenda with comprehensive input from multiple stakeholders.
- Disseminate the national suicide prevention research agenda.
- Promote the timely dissemination of suicide prevention research findings.
- Utilize a repository of research resources to help increase the amount and quality of research on suicide prevention and care in the aftermath of suicidal behaviors.

GOAL 13. Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.

- Evaluate the effectiveness of suicide prevention interventions.
- Evaluate the impact of legislation on suicide prevention and interventions.
- Assess, synthesize, and disseminate the evidence in support of suicide prevention interventions.
- Examine how suicide prevention efforts are implemented in different communities to identify the types of delivery structures that may be most efficient and effective.
- Evaluate the impact and effectiveness of the Kentucky Strategy for Suicide Prevention in reducing suicide morbidity and mortality.

Suicide Prevention and Care Implementation Strategy Work Plan 2014 - 2016

Strategy: Infrastructure Development

Goal: Reduce the impact of suicide and suicidal behavior in Kentucky by systemically strengthening the foundation of suicide prevention and care efforts

Develop Infrastructure to Reduce the Impact of Suicide and Suicide Attempts in Kentucky						
1.1 Establish Effective and Functional State Strategy for Suicide Prevention Team(s)						
Task		Completed/ Started/ Not Started	Date Completed/ Date Due	Person Responsible	Progress July 2015	Challenges July 2015
1.1.1	Establish State Strategy for Suicide Prevention team(s) to guide planning and implementation processes <ul style="list-style-type: none"> • Identify roles and scope of implementation and administrative teams (grant and non-grant) • Recruit external team members and partner organizations (KPFC, KVDRS, etc.) or representation on other councils (SIAC, Mental Health Council, SPCK etc.) • Determine meeting frequencies for each team 	Started	April 2015	Jan/Patti Connie/ Maggie Administrative and Implementation Teams	External team members and partner organizations involved in ZSI grant and SEOW	Staffing changes and vacancies
1.1.2	Schedule initial and reoccurring meetings (face to face or conference call) with ZSI SAMHSA grant partners as identified in grant application to SAMHSA, regarding anticipated scope of work and expectations <ul style="list-style-type: none"> • Adanta CMHC - Jamie, Kathrina, Beverly • Adanta RPC - Sherri Estes • KPFC • VA Louisville • REACH of Louisville 	Started	April 2015	Connie/ Maggie	Ongoing meetings occurring with all	Staffing changes and vacancies
1.1.3	Hire three Zero Suicide Initiative (ZSI) SAMHSA grant personnel Project Coordinator Prevention Enhancement Site (PES) Treatment Enhancement Site (TES) Coordinators <ul style="list-style-type: none"> • Develop job descriptions • Send to Georgianne • Approve EKU descriptions and salary 	Started (PES Coordinator has been filled)	5/15/15	Connie/ Maggie/ Georgianne EKU	PES Coordinator (Cathy Prothro) on staff in Somerset	Reposting ZSI admin position - interviews on 7/16 May have to repost TES position

Suicide Prevention and Care Implementation Strategy Work Plan 2014 - 2016

	<ul style="list-style-type: none"> • Post positions • Define interview team • Complete hiring process 					
1.1.4	Finalize year 1 contractual agreements with ZSI SAMHSA Grant partners	Completed	1/15/15	Connie/Maggie Patti/Jan Sara/Barbara Michele		
1.1.5	Attend American Association of Suicidology conference as a ZSI grant team building opportunity April 15-18, 2015 <ul style="list-style-type: none"> • Determine who should attend • Costs - travel for two state and three ECU people in ZSI SAMHSA Grant • To date, Patti and Cathy have been approved to apply (both ECU) 	Completed	2/27/15	Connie/ Maggie	Jan and Patti attended	
1.1.6	Complete ZSI grant continuation application as required by SAMHSA	Completed	2/26/15	Jan/Patti/Sara/ Ricky		
1.2 Needs Assessment, Resources and Evaluation						
1.2.1	Hire evaluator to develop and deliver statewide suicide-related needs assessment and resource scan	Complete (REACH of Louisville)	3/01/15	Connie, Maggie, Georgianne		
1.2.2	Arrange meeting with REACH evaluation team regarding development of: <ul style="list-style-type: none"> • statewide suicide-related needs assessment • environmental scan including, including crisis call centers and web presence • workforce surveys • surveillance systems • evaluation needs 	Started	4/01/15	REACH, Connie, Maggie Jan, Patti, Cathy	In progress	
1.2.3	Develop suicide-related needs assessment, environmental scans and evaluation tools guided by SAMHSA ZSI grant requirements and the Strategic Prevention Framework	Started	5/01/15	REACH, Jan, Patti,	In progress	
1.2.4	Develop Suicide-related Epidemiological Outcomes Workgroup or partner with existing State Epidemiological Outcomes Workgroup to identify data and surveillance needs for data-based planning	Started	5/01/15	Implementation Team REACH/	New members added to State Epi Outcomes Team to	

Suicide Prevention and Care Implementation Strategy Work Plan 2014 - 2016

	<ul style="list-style-type: none"> Identify epidemiological assets and gaps in related to completed suicide, suicide attempts, and suicidal ideation Identify data sharing capabilities Identify and invite internal and external partners (such as KVDRS, Child Fatality Review, Vital Statistic, Public Health, Coroners, Hospital Association, other) as Implementation Team members 			KVDRS	represent suicide outcomes data	
1.2.5	<p>Identify and assess suicide prevention and care related database and distribution list needs</p> <ul style="list-style-type: none"> Research possible options for creation of database to house information Develop strategy to meet database and distribution list needs based on identification, assessment and research of options 	Not Started	5/01/15	REACH/UKY Jan, Patti, Cathy		Not started
1.2.6	Utilizing Strategic Prevention Framework, develop culturally and linguistically competent strategic plan as a result of statewide suicide-related needs assessment and environmental scan outcomes, including evaluation of efforts and web presence as required by SAMHSA in the ZSI Grant	Started	6/1/15	Implementation Team	In progress	
1.2.7	Utilizing the Strategic Prevention Framework, begin implementation of systemic, statewide strategic plan	Started	7/1/15	Implementation Team	In progress	
1.3 Identify Funding and Technical Assistance Resources for Statewide Expansion of Suicide Prevention and Care Activities						
1.3.1	<p>Obtain SAMHSA Youth Suicide Prevention Grant funding \$3.68 million/five years (ZSI SAMHSA Grant)</p> <ul style="list-style-type: none"> Participate in required new grantee activities including trainings, technical assistance calls and webinars 	Completed (to date)	9/30/14	Jan/Beth/ Patti	Ongoing	
1.3.2	<p>Apply for and participate in the Zero Suicide Breakthrough Series behavioral health services technical assistance from National Action Alliance for Suicide Prevention/National Council for Behavioral Health</p> <ul style="list-style-type: none"> Determine pilot site as required for application (the Adanta Group) <ul style="list-style-type: none"> Collaborate with pilot site on application, including completion of Zero Suicide Organizational Self-Assessment Receive notice of award for technical assistance Collaborate with pilot site on required assignments Participate in on-going technical assistance activities and assignments including trainings, TA calls, webinars including completion of Zero Suicide 	Started	9/30/15	Jan/Maggie TES coordinator Kathrina Riley Beverly Loy	Ongoing	

Suicide Prevention and Care Implementation Strategy Work Plan 2014 - 2016

	<p>Work Plan with pilot site</p> <ul style="list-style-type: none"> Attend face to face Zero Suicide Breakthrough meeting in Washington, D.C. regarding suicide-related behavioral health services TA 					
1.3.3	<p>Participate in on-going expert led multi-state Zero Suicide Learning Collaborative conference calls for suicide care</p> <ul style="list-style-type: none"> Mentor Dr. Mike Hogan (former Commissioner of BH in NY) KY, TX, WI, OK on state calls Utilize knowledge gained in learning collaborative to inform strategic plans 	Started	On-going	Jan /TES coordinator	On-going	TES coordinator position not yet filled (candidate chosen, salary issues)
1.4 Increase sustainable statewide capacity to reduce the impact of suicide and suicidal behavior						
1.4.1	<p>Supply Technical Assistance and Resources to Suicide Prevention Consortium of Kentucky (SPCK) for strategic planning</p> <ul style="list-style-type: none"> Provide ongoing technical assistance to SPCK Determine evaluation measures (increased attendance, increased member organizations, increased activities, etc.) Share statewide needs assessment and resource scan results with SPCK for strategic planning retreat Provide financial support for strategic planning meeting 	Started	7/30/15	Jan/Cathy/Patti SPCK members	On-going: 3 EKU facilitated meetings have taken place, two more planned in August and September. Facilitated Planning Retreat in October.	
1.4.2	<p>Provide technical assistance and resources to state, regional and local initiatives to reduce the impact of suicide and suicidal behavior to:</p> <ul style="list-style-type: none"> First Responders organizations (fire, law enforcement, EMT, etc.) Survivors of Suicide Loss and Attempt support groups Local and regional mental health or suicide prevention organizations Youth serving organizations Others as requested 	Started	On-going	Jan/Patti/Cathy/RPC/TES Coordinator	On-going	Staffing vacancies
1.4.3	<p>Develop sustainable Kentucky Suicide Prevention Resource Center</p> <ul style="list-style-type: none"> Consider options - who would lead it, funding, sustainability, possible roles of RPCs, etc. Utilize statewide needs assessment and environmental scan results to develop strategic plan including web presence, marketing, etc. 	Not Started	12/1/15	Implementation Team	Not started	

Suicide Prevention and Care Implementation Strategy Work Plan 2014 - 2016

Strategy: Improved Suicide-related Treatment and Support Services

Goal: Promote suicide prevention and care as a core component of health care services

Provide Effective Behavioral Health Services						
2.1 Effective provision of Suicide-Related Behavioral Health Services with Fidelity						
Task		Completed/ Started/ Not Started	Date Completed/ Date Due	Person Responsible		
2.1.1	Identify existing tools to determine strengths and gaps in suicide-related behavioral healthcare (ZS Organizational Self-Assessment and Work Plan)	Completed (to date)	2/1/15	Jan	Completed	
2.1.2	Provide technical assistance to pilot site to complete ZS Organizational Self-Assessment tool developed by the National Action Alliance for Suicide Prevention as required by ZS Breakthrough Series and as a needs assessment for the grant pilot site	Completed	11/18/14 (required by ZS Breakthrough Series)	Jan Kathrina Riley	On-going	
2.1.3	Utilize Zero Suicide Work Plan tool developed by National Action Alliance for Suicide Prevention along with ZS Org Self-Assessment results to assist in development of grant pilot site safer suicide care strategy <ul style="list-style-type: none"> • Assist Adanta in development of their ZS work plan • Provide technical assistance and grant funding to assist with implementation of ZS work plan • Develop evaluation measures • Evaluate efforts as required by ZSI grant 	Started	1/07/15 (required by ZS Breakthrough Series)	Jan Kathrina Riley TES coordinator	On-going	
2.1.4	Identify cohort 1 CMHC site to pilot suicide-related evidence-based practices in suicide screening, assessment, management, treatment and follow up	Completed	January 2014	Initial State Strategy Team	Completed	
2.1.5	Administer second statewide Behavioral Healthcare Workforce Survey <ul style="list-style-type: none"> • Develop updated behavioral workforce survey • Administer to clinicians statewide • Develop Strategic Plan based on results of compiled workforce survey 	Started	5/1/15	Patti/Marlene Huff	In progress	Delay on behalf of non-BHDID person
2.1.6	Synthesize CMHC Suicide Care Improvement Work Plans <ul style="list-style-type: none"> • Roll up existing 2014 CMHC suicide care work plans 	Started	6/1/15	Jan TES Coordinator	In progress	

Suicide Prevention and Care Implementation Strategy Work Plan 2014 - 2016

	<ul style="list-style-type: none"> Analyze results of CMHC suicide care work plans Develop Strategic Plan for statewide suicide care based on results of compiled work plans 			REACH		
2.2 Increase the number of clinical service providers trained to assess, manage, and treat suicide risk						
2.2.1	Obtain funding to support training opportunities to fulfill KRS 210.366	Completed	9/30/14	Jan/Patti/Beth	completed	
2.2.2	Develop model list of trainings as required by KRS 210.366; submit to Interim Joint Health and Welfare Committee	Completed	12/15/14	Jan/Commissioner Begley	completed	
2.2.3	Identify training resources, funding and opportunities for clinicians and clinical organizations for assessing and treating those identified as at-risk for suicidal behaviors (such as AMSR, CAMS, QPR-T)	Started	On-going	Jan	Completed (trainings are ongoing)	
2.2.4	Develop strategic plan for statewide clinical suicide assessment, treatment and management training to support KRS 210.366 <ul style="list-style-type: none"> 700 providers trained in AMSR between June 2014 and Jan. 2015; over 300 additional providers to be trained in Winter 2015 Kentucky has 34 AMSR trainers Several CAMS trainings have been conducted or scheduled Identify partnership opportunities (clinical boards, professional associations, universities, etc.) Evaluate results 	Started	5/15/15	Jan/TES Coordinator Implementation team		
2.2.5	Provide on-going support for 34 KY Assessing and Managing Suicide Risk clinical trainers to maintain and grow capacity <ul style="list-style-type: none"> Webinar for approved trainers Conference call for participants not yet approved Contract with experienced AMSR trainer for technical assistance to state trainers with ZSI grant funding 	Started	5/15/15	Jan/ TES Coordinator Lisia/Laurie with SPRC	Ongoing	
2.2.6	Investigate opportunities to embed AMSR and other research-based trainings in graduate schools, doctorate programs, etc. <ul style="list-style-type: none"> Facilitate conference call with Lindsey Wilson College and SPRC about 	Started	2/16/15	Jan Lisia/Laurie with SPRC	Started	

Suicide Prevention and Care Implementation Strategy Work Plan 2014 - 2016

	<p>AMSR opportunities</p> <ul style="list-style-type: none"> • Provide technical assistance to LWC to create strategic plan based on LWC decision • Identify additional partnership and next steps 			Implementation Team		
2.3 Suicide-related Behavioral Healthcare Policy Development						
2.3.1	<p>Develop plan to integrate suicide prevention and care into values, culture, leadership and work of BHDID, such as creating regulations or contract requirements regarding suicide identification, referral, pathways to care, screening, assessment, management, treatment and follow up for CMHCs, state hospitals, MCOs and other contracted service providers</p> <ul style="list-style-type: none"> • Determine who decision makers are and who needs to be at the “table” • Consider requiring department approved training for all BHDID professionals, contracted entities and volunteers • Develop workgroup to evaluate regs or contractual requirements as a result of investigation findings • Develop strategic plan based on results • Present recommendations and proposals to BHDID leadership 	Not Started	9/01/15	Jan TES coordinator Dr. Brenzel	Not started	TES coordinator not yet hired
2.4 Promote the increased awareness and utilization of National Suicide Prevention Lifeline						
2.4.1	Identify funding stream for crisis call centers to be Lifeline certified	Completed	9/30/14	Jan/Patti/Beth	Completed	
2.4.2	Develop needs assessment and environmental scan around existing crisis call centers	Not Started	9/01/15	Jan/TES coordinator/Cathy REACH	Not started	
2.4.3	<p>Investigate best and promising practices in crisis call centers in other states (such as Georgia’s “air traffic control” approach)</p> <ul style="list-style-type: none"> • Research best and promising practice options • Present to BHDID leadership for consideration • Determine team to visit best and promising practice call centers • Schedule visit • Compile information gathered 	Started		Jan/TES coordinator/Cathy	On hold	

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	<ul style="list-style-type: none"> Present to BHDID for review 		9/01/15			
2.4.4	Implement needs assessment	Not Started	11/01/15	Jan/TES coordinator/ Cathy/REACH	In progress	SCS CMHC dropped their whole state coverage; KY calls rolling to backup centers
2.4.5	Develop strategic plan to improve utilization of and access to Kentucky crisis call centers, including Lifeline certified call centers	Not Started	12/01/15	Jan/TES coordinator/ Cathy/REACH	Awaiting initial completed needs assessment report	
2.5 Improved Screening, Referral and Follow Process in Primary Care and Emergency Departments						
2.5.1	Conduct environmental scan for primary care and emergency department staff to determine access points (where can we meet them?) and continuity of care <ul style="list-style-type: none"> Conferences Licensing Organizations Associations 	Not Started	6/1/15	REACH Jan/TES Coordinator Dr. Brenzel	Not started	TES coordinator not yet hired
2.5.2	Determine scope of project (possible small pilot?) based on environmental scan <ul style="list-style-type: none"> Determine who needs to be involved Set up meetings Identify potential pilot site(s) 	Not Started	7/1/15	Jan/TES Coordinator	Not started	TES coordinator not yet hired
2.5.3	Develop needs assessment to determine existing resources and gaps in screening, referral and follow up in PC and ED <ul style="list-style-type: none"> Implement needs assessment 	Not Started	8/1/15	Jan/TES Coordinator	Not started	TES coordinator not yet hired
2.5.4	Develop Strategic Plan based on results of healthcare suicide-related resources and gaps <ul style="list-style-type: none"> Determine what existing tools and resources are available (such as Suicide Prevention Toolkit for Rural Primary Care Providers, "Is Your Patient Suicidal?" poster for EDs, etc.) Develop marketing and awareness tools and strategy 	Not Started	9/30/15	Jan/TES Coordinator	Not started	TES coordinator not yet hired

Suicide Prevention and Care Implementation Strategy Work Plan 2014 - 2016

<ul style="list-style-type: none"> • Implement project 					

Strategy: Healthy and Empowered Individuals, Families, and Communities to Prevent Suicide and Suicidal Behavior

Goal: Integrate and coordinate suicide prevention activities across multiple sectors and settings

Healthy and Empowered Individuals, Families, and Communities						
3.1 Outreach/Education						
	Task	Completed/ Started/ Not Started	Date Completed/ Date Due	Person Responsible	Progress July 2015	Challenges July 2015
3.1.1	Utilize statewide needs assessment and suicide death and attempt surveillance data to determine target audiences, including those identified in current ZSI SAMHSA grant (see section 1.2)	Not Started	8/1/15	REACH, Cathy/Patti	In progress	
3.1.2	Produce rollup of existing 2014 survey assessing secondary school staff and student suicide-related training and awareness to develop strategic plan for support of 2010 legislation requiring suicide prevention training and awareness for staff and students	Not Started	5/15/15	Patti		Patti has taken another job
3.1.3	Implement evidence-based suicide prevention/resiliency building program Sources of Strength in pilot region with fidelity as specified in ZSI SAMHSA Grant requirements <ul style="list-style-type: none"> • Meet (face to face or conference call) with RPC director in pilot site • Arrange phone call with Sources of Strength staff • Identify KY pilot school site(s) • Purchase materials from Sources of Strength • Arrange training dates • Provide technical assistance to school(s) for implementation of Sources of Strength 	Started	9/1/15	Cathy/ Patti	In progress	

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3.1.4	Identify funding streams or braided funding for the support of evidence-based trainings and programs (providing ASIST training for TAYLRD grant efforts, Good Behavior Game for elementary age, suicide-related training/consultation for Peer Support Specialists/Veteran Peer Support etc.)	Started	5/30/15	Implementation Team	In progress - ASIST training in the works for TAYLRD grant	
3.1.5	Develop strategic plan for support of 2010 legislation requiring suicide prevention training and awareness for staff and students including evaluation <ul style="list-style-type: none"> • Review 2010 - 2014 efforts including roll up of RPC school reports • Assess gaps and strengths • Identify partners • Develop plan including evaluation prior to end of school year 	Started	5/30/15	Jan/Patti/Cathy/REACH	In progress	
3.1.6	Partner with Kentucky Partnership for Families and Children, and Kentucky Youth Move to Develop Safe and Effective Messaging for Youth <ul style="list-style-type: none"> • Meet with KPFC and KYM to define roles and determine structure, including participation on state strategy team • Develop collaborative strategic plan with youth representation • Host focus groups • Involve youth/young adults in the development of safe messaging • Utilize the Framework for Successful Messaging in the development of messages • Send all potential messages to Suicide Prevention Resource Center technical assistance for review • Develop and implement marketing and awareness plan • Evaluate marketing and awareness efforts 	Not Started	4/01/15	Cathy/KPFC/KYM/SPRC/Patti/Jan Connie/Maggie	In progress - initial focus groups conducted	
3.1.8	Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides. <ul style="list-style-type: none"> • Engage suicide attempt survivors, those affected by a suicide attempt or bereaved by suicide in development of needs assessment and strategic planning for support programs and clinical care. • Develop strategic plan based on results of needs assessment, environmental scan and surveillance system data. • Adopt, disseminate, implement and evaluated guidelines for responding effectively to suicide clusters and contagions within their cultural context, 	Not Started	3/1/16	Cathy/Patti/Jan REACH	Not started	

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	and support implementation with education, training, and consultation.					
3.1.9	Identify additional marketing and awareness needs based on needs assessment, environmental scan and surveillance system data, including lethal means reduction	Not Started	11/15/15	Cathy/Patti/Jan REACH	Not started	
3.2 Role of the Regional Prevention Centers in Suicide Prevention						
3.2.1	Determine who needs to be at the table to determine long-term role of RPCs in Suicide Prevention	Not Started	5/1/15	Cathy/Connie/Patti	In progress	Connie/Patti are no longer with BHDID
3.2.2	Hold meeting to determine scope of project (capacity of RPC, funding needs, etc.)	Not Started	5/15/15	Cathy/Connie/Patti	In progress	Connie/Patti are no longer with BHDID
3.2.3	Develop strategic plan for sustainable RPC involvement in Suicide Prevention efforts	Not Started	6/1/15	Cathy/Connie/Patti	In progress	Connie/Patti are no longer with BHDID
3.2.4	Develop plan for recruitment of future cohort ZSI grant prevention pilots <ul style="list-style-type: none"> • Develop criteria for acceptance including evaluation • Determine incentives • Develop and disseminate RFP 	Not Started	7/1/15	Cathy/Connie/Patti	Not started	
3.3 Promote the increased awareness and utilization of National Suicide Prevention Lifeline						
3.3.1	Identify funding stream for crisis call centers to be Lifeline certified (ZSI SAMHSA Grant)	Completed	9/30/14	Jan/Patti/Beth	Completed	
3.3.2	Investigate best and promising practices in crisis call centers in other states (such as Georgia's "air traffic control" approach) <ul style="list-style-type: none"> • Set up conference call with industry crisis call center subject matter experts (Lou, CJ, Chrissy, Jan in 2014) • Present to BHDID leadership to determine next steps (Lou presented to leadership in 2014) • Revisit this with BHDID leadership to determine next steps (2015) 	Started	7/1/15	Jan /Maggie TES Coordinator	On-hold	
3.3.3	Develop strategic plan to improve crisis call centers related to suicide <ul style="list-style-type: none"> • Develop needs assessment and resource scans around existing statewide 	Started	8/1/15	Jan /Maggie TES Coordinator	In progress	

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	crisis call centers and gaps in system <ul style="list-style-type: none"> Identify new crisis centers interested in becoming Lifeline certified including ZSI SAMHSA Grant pilot site Implement needs assessment and environmental scan Use results to develop strategy and evaluation tools 					
3.4 Upstream Prevention Efforts						
3.4.1	Investigate upstream prevention data, strategies and programs, including co-occurring violence prevention <ul style="list-style-type: none"> Who needs to be involved; who will do the work? Consider existing early childhood mental health programs, PBIS, Green Dot program, KVDRS intimate partner violence research, alcohol and other drug abuse prevention programs, etc. for sustainability Research costs and feasibility of integration with existing programs Utilize needs assessment results to develop strategic plan for upstream prevention efforts 	Started	9/30/15	Implementation Team	In progress	

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Strategy: SMVF

Goal: Support Kentucky Military Support Program

Support Service Members, Veterans and their Families (SMVF) initiatives related to suicide prevention and care			
4.1 Implement SMVF Plan			
Task	Completed/ Started/ Not Started	Date Completed/ Date Due	Person Responsible
-> See recently submitted SMVF Implementation Plans for specific steps, etc.			

Environmental Factors: 20. Suicide Prevention

- 1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised*
- 2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.*
- 3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans.*

Please indicate areas of technical assistance needed related to this section.

The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities employs one FTE who is the State Suicide Prevention Coordinator, housed in the Behavioral Health Prevention and Promotion Branch, within the Division of Behavioral Health. Kentucky is currently implementing its third SAMHSA-funded Suicide Prevention Grant. The goals of the current funding initiative, in brief, are to:

- Provide suicide safer communities and suicide safer care services for youth and young adults aged 10-24 who are at a higher risk of suicide;
- Integrate best practices in suicide care and prevention; and
- Integrate and coordinate suicide prevention activities across multiple sectors and setting for Suicide Safer Communities.

In addition to the efforts of the Department, there are other grassroots efforts aimed at preventing suicide deaths in KY. One of the most prominent of these is the Kentucky Suicide Prevention Group. It is comprised of people who have been affected by suicide, either personally or professionally. In their words, "We are moms, dads, daughters, sons, brothers, sisters, friends, uncles, aunts, clinicians, mental health advocates and others who have either lost someone close to us, are survivors of attempts or family members of someone close who has attempted. And we are here to put a human face on suicide." The Suicide Prevention Consortium of Kentucky (SPCK – Live Long) was formed in 2014 to bring together various entities that are involved in suicide prevention and related efforts.

The Department provides support and technical assistance to these and other groups and communities to implement statewide needs assessments, coalition building and other educational/outreach activities. Of particular concern to the grassroots efforts are various high risk groups including those with behavioral health disorders including youth with SED and adults with SMI, military and veteran, and LGBTQ youth. From 2011 to 2014, DBHDID hosted trainings for providers of services to LGBTQ youth around culturally competent suicide care for this population.

Kentucky law requires that public middle and high school teachers, principals and counselors receive two hours of suicide prevention training annually, and middle and high school students must receive suicide prevention information by September 1 annually. DBHDID supplies technical assistance and resources for school staff and student training, including regional trainings around effective practices for schools and students, including evidence-based programs such as Lifelines, Signs of Suicide, More than Sad, LEADs curriculum, along with the promotion of the SAMHSA Toolkit for High School Suicide Prevention.

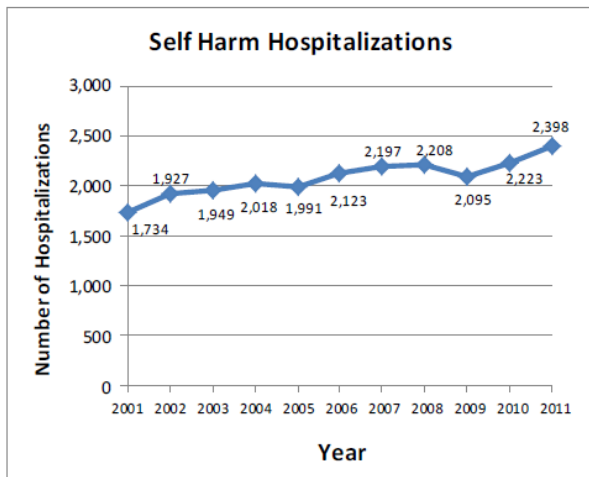
As of 2015, Kentucky law requires behavioral health clinicians to take 6 hours of suicide assessment, treatment and management training. DBHDID hosted a training for trainers (TOT)

in 2014 for the *Assessing and Managing Suicide Risk (AMSR)* training, which is on the Suicide Prevention Resource Center's Best Practice Registry. DBHDID supplies ongoing support for this training including trainer fees, materials and CEUs for clinicians who work with clients with mental health and/or substance use disorders including those with SMI and SED. DBHDID also supported two workshops on the *Collaborative Assessment and Management of Suicidality (CAMS)* in 2014 and anticipate further supporting future CAMS trainings.

Kentucky has been involved in the *Zero Suicide in Healthcare and Behavioral Health Care* which is a system of care approach to reducing suicide for all populations. Kentucky current SAMHSA grant, called Zero Suicide Initiative (ZSI) with a strong focus on Zero Suicide for youth and young adult populations; is aimed at health and mental health providers and organizations serving clients with mental health and/or substance use disorders including those with SMI and SED.

Kentucky has a large military and veteran population with two Army bases, strong National Guard presence and Reserve Units. DBHDID partners with military and veteran organizations, those who serve these populations around multiple initiatives to reduce suicidal behaviors, among these populations. DBHDID hosts Operation Immersion, Operation Headed Home for this population and those who provide services to this population, and Service Members, Veterans and Families (SMVF) suicide prevention implementation team which meets monthly with ongoing technical assistance from SAMHSA. This group is planning to merge with a similar SMVF substance use prevention implementation team in order to better braid or blend efforts for the prevention of negative outcomes such as suicide, mental illness and substance use for military, veterans and their families.

The Kentucky Injury Prevention Research Center has posted two new reports (*Released in Nov 13, 2012*). One is on *Suicides and Suicide Attempts in KY*, and the other is on *Injury Indicators*. The data compare suicides versus homicides and other unintentional injuries. Both are richly illustrated with graphs, charts and tables to tell their stories.



The Executive Summary for the Suicide and Suicide Attempts report includes these top four troubling statistics:

1. There were 605 suicides among Kentucky residents in the year 2010, up 7% from the 567 recorded in the year 2009.
2. The Kentucky resident age-adjusted suicide rate increased from 12.8 per 100,000 population in 2009 to 13.5 per 100,000 population in 2010, a 5.5% in-crease.
3. Firearms were the primary means of completed suicide from 2001-2010.
4. Kentucky residents aged 45-54 were the age group that completed suicide most frequently in 2010.

Suicide and Suicide Attempts report link: http://www.mc.uky.edu/kiprc/PDF/suicide_report.pdf

The second report focuses on *Kentucky Injury Indicators for 2010*. The leading causes of fatal injuries in Kentucky in 2010 were *unintentional poisonings* (923), *motor vehicle traffic accidents*

(758), and *suicide by firearm* (386). Unintentional poisoning was the leading cause of injury death for Kentucky residents in 25-64 age group. Unintentional falls were the leading cause of injury death for Kentuckians aged 75 and older. For children the leading cause of death varied by age group: suffocation for infants, fire for children ages 1-4, and motor vehicle traffic crashes for children ages 5-14.

The leading causes of injury hospitalizations in Kentucky in 2010 were *unintentional falls* (10,753), *motor vehicle traffic accidents* (2,385), and *intentional self-harm by poisoning* (2,056). Unintentional falls were the leading cause of injury hospitalizations for Kentucky residents age fourteen and younger and age 45 and older. Motor vehicle traffic accidents were the leading cause of injury hospitalization for Kentuckians ages 15 to 24, and unintentional poisonings were the top cause for those ages 25 to 44.

The leading causes of injury-related emergency department visits in Kentucky in 2010 were *unintentional falls* (136,204), *motor vehicle traffic accidents* (53,055), and *accidentally being struck by or against an object or person* (52,288). Unintentional falls were the leading cause of injury-related emergency department visits across the entire lifespan.

The link to this report is: <http://www.mc.uky.edu/kiprc/PDF/KY-state-injury-report-2010.pdf>

Attached is the KY Suicide Prevention and Care Team Implementation timeline. The state plan was revised and while reviewed at least annually is in place through 2018.

Environmental Factors and Plan

21. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG programs 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. Examples of partnerships may include:

- The SMA 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 any Medicaid populations;
- The state justice system authorities working 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, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of emergency management/homeland security and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please consider the following items as a guide when preparing the description of the state's system:

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.
2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

The state was not able to address this EFP at this time.

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Narrative Question:

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created [Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration](#).⁹⁷

Additionally, [Title XIX, Subpart III, section 1941 of the PHS Act \(42 U.S.C. 300x-51\)](#) applicable to the SABG and the MHBG, 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 block grant 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 SAMHSA.

For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.

For MHBG and integrated BHPC: States must include documentation that they shared their application and implementation report with the Planning Council; please also describe the steps the state took to make the public aware of the plan and allow for public comment.

SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).
2. What mechanism does the state use to plan and implement substance abuse services?
3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

*Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.*⁹⁸

⁹⁷<http://beta.samhsa.gov/grants/block-grants/resources>

⁹⁸There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) 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 (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

22. State Behavioral Health Planning and Advisory Council and Input on the Mental Health and Substance Abuse Block Grant Application

1. *How was the Council actively involved in the State Plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).*

The Kentucky Behavioral Health Planning and Advisory Council's Finance and Data Committee held a meeting on April 16, 2015. Members were provided with copies of the SFY 2015 and the proposed SFY 2016 SABG and MHBG allocations for direct services through the community mental health centers, statewide projects, miscellaneous initiatives (e.g., data collection and advocacy organization deliverables), and audit reserves. Staff reviewed the documents and committee members were encouraged to provide feedback on the allocations.

Following that discussion, members were provided with an overview of projects to potentially fund with reserve block grant funds. Finance Committee members voted to support the following initiatives:

- Peer Support- mental health and substance use, adults, youth and family
- First Episode Psychosis – Funds in addition to the required 5% set aside for FEP
- Oxford House – Funds to support up to two additional Oxford House Case Managers

The minutes from the April 16, 2015 Finance and Data Committee meeting are attached at the end of this document.

DBHIDID chose to focus on increasing public attendance at the quarterly Behavioral Health Planning and Advisory Council meeting, held August 13, 2015, rather than having an additional Public Forum as has been held in the past. This served as an opportunity to educate guests about the Planning Council and make membership applications available.

Department staff drafted the state plan and Council members and the public were invited to provide comments. The draft of the plan was placed as a "Hot Topic" on the home page of the Department's website. The website also contains a document that lists opportunities to provide written and/or verbal feedback on the 2016-2017 funding application. Council members and the public were invited to the quarterly meeting of Council as one opportunity to provide verbal or written feedback. As is customary with all Council meetings, members are offered travel reimbursement and a stipend to support their attendance. Staff provided a PowerPoint presentation on the application instructions and the drafted application. Time was given on the agenda for anyone to offer feedback/comments. The Council created a letter confirming their participation and opportunity to review and provide feedback on the Plan. At the Council meeting, staff encouraged the public and members to continue to submit feedback/comments and provided information about how to submit comments via email, US Mail or by phone to the lead Block Grant staff. Comments were encouraged until close of business on August 28, 2015. 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. A copy of the August 13, 2015 minutes is attached at the end of this document.

Per KRS 45.351, the Department provides a draft of the Plan to the Legislative Research Commission (LRC) for their review. The public is made aware of these hearings by the LRC's weekly The Legislative Calendar and

email notification by statewide advocacy organizations. Video streaming of Interim Joint Committee meetings is occasionally available through Kentucky Educational Television (KET), the PBS affiliate.

2. What planning mechanism does the state use to plan and implement substance abuse services?

Department program staff conducts monitoring and technical assistance site visits of the DBHDID funded substance use disorder treatment programs statewide. The site visit format includes an hour-long discussion with clients of the program. These dialogues provide rich information about the strengths and gaps of the system of care.

The Department is hoping that the Planning Council will be able to provide guidance in this area, but so far our state has experienced difficulty in recruiting membership applications from individuals in recovery from substance use disorders. The Membership Committee is planning to use its new Council brochure to try to increase outreach to this population.

The Department has been sponsoring an annual substance abuse prevention and treatment conference called the Kentucky School of Alcohol and Other Drug Studies for forty-two years. This conference is planned by and attended by many individuals in recovery and their family members. It is attended by individuals in who work in the field in corrections, juvenile justice, homeless services, child welfare, behavioral health, Medicaid, independent providers, court services, and others. During this conference, staff receives vital feedback on the system of care, particularly related to service gaps and workforce needs. Videos and discussions held in the evenings are a particularly rich opportunity. This year's conference was held August 16-20, and there were 740 individuals in attendance, including several SAMHSA staff.

Department staff also solicits input from the regional substance abuse treatment directors and the Regional Prevention Center (RPC) Directors at quarterly peer group meetings. The Department collaboratively creates the agenda and retains summaries of these meetings.

2. 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 and Council members 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** – The Council’s 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 participated in a presentation and subsequent dialogue regarding the work of the Regional Prevention Centers, including prevention goals and strategies, and Kentucky data.
- **May 2012** – The Council participated in a presentation and subsequent dialogue regarding the work of the funded substance abuse treatment providers (CMHCs), including services array, priority populations served, importance of integrated treatment, trauma-informed care and Kentucky 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 was awarded targeted technical assistance to integrate substance abuse prevention and treatment onto the Council.

- **July 2013** – The Council held a special meeting with TA Consultant Fredrick Sandoval and developed a list of prospective members, communication outlets, and voted to add two new Council committees.
- **August 2013** – The Council developed 2 Committees (Advocacy & Policy Committee and Services Committee) and a new committee structure of 5-7 committee members who are more active administratively, less reliant on staff and who use technology to meet on a more regular basis, possibly monthly. The new structure was less expensive and more productive. Committees are still open meetings per Kentucky’s Open Meeting Law.
- **September 2013** – The Membership Committee voted to recommend a representative on the Council from the Regional Prevention Center.
- **January 2014** – The Membership Committee recommended strengthening the marketing of the Council in order to increase integration and diversity of the Council.
- **April 2014** – The Membership Committee held a conference call to begin drafting a Member Handbook and to revise the Council’s brochure.
- **June 2014** – The Advocacy and Policy Committee submitted their inaugural set of Legislative Priorities to the Council. Members approved the Legislative Priorities and encouraged one another to use the information to engage their representatives in a dialogue.
- **April 9, 2015** – The Bylaws Committee recommended revisions to the Bylaws consistent with the new mission of the Council.
- **April 15, 2015** – The Membership Committee presented the new Member Handbook at the Member Orientation. The member-led Member Orientation was also revised to be consistent with the new mission of the Council.

4. 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.

All applicants (100 percent of applicants reviewed in January 2015) chose to answer this question and Committee members find the information valuable as they consider membership. The diversity responses are usually the most influential to Committee members because members learn where an applicant can truly fill a gap or provide a voice on the Council.

One 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/under represented. The Council experiences difficulty recruiting members from the far western portion of the state. A different time zone and distance are barriers. Contrary to the roads and interstates approaching Frankfort from the east, north and south, the interstate from the western portion of the state has long stretches where there are no exits, gas stations, restaurants or rest areas. Joyce Soularie, our June 2014 CMHS Monitoring Visit Peer Reviewer from Arkansas, compared it to frontier territory. The Council plans to strengthen marketing efforts in the West by widely distributing the revised Council brochure in that area.

In 2011 the Membership Committee revised its Member Orientation and included Cultural Awareness as a topic. That section was prepared by a Council member using resources from the NAMI Multicultural Action Center. This material is presented annually by a Council member during the Member Orientation. The Membership Committee plans to review and update the material in the near future.

5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI and SED.

The Planning Council is comprised of the following adults in recovery, parents, and family members who all bring their diverse experiences and the input of those they collaborate with to the Council:

- Six adults in recovery from mental health disorders and/or substance use disorders;
- Six parents/grandparents/guardians/foster parents who have custody of a child (birth through age 20) with behavioral health challenges;
- Six family members of an adult in recovery from behavioral health disorders;
- One young adult in recovery from behavioral health disorders (age 18-25);
- One organization for individuals in recovery from substance use disorders;
- One organization for individuals in recovery from mental health disorders and/or co-occurring substance use disorders;
- One organization for family members of adults in recovery from mental health disorders and/or substance use disorders; and
- One organization for youth and family members of youth with significant behavioral health challenges.

The following is an excerpt from the Bylaws of the Council duties:

- 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 September 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.

The Council recognized a need to assist members with advocacy efforts so it established a Policy and Advocacy Committee in 2013. As noted above, the Committee submitted its inaugural set of Legislative Priorities to the Council for approval, in June 2014. They were approved and members were educated on how and when to use the information. This year, the Committee has submitted its legislative priorities for the upcoming legislative session (included at end of this document) and again educated members on advocacy best practice.

Each of the advocacy organizations are connected with thousands of members and contacts. They are a valuable resource for sharing Council information across the state via email. One advocacy organization has been very successful at gathering meaningful information about system of care strengths and gaps through the use of online surveys and its vast following of contacts on its email distribution list. Over the next two years the Council will consider using this successful idea and build on it in the following ways:

1. The Finance and Data Committee will establish workgroups to develop surveys of the state's behavioral health system of care strengths and gaps individualized to the target population of each of the four statewide advocacy organizations;
2. A report of each survey will be created;
3. The results of the surveys will be reviewed by the Finance and Data Committee and recommendations submitted to the Council; and
4. The Council will submit recommendations to the Commissioner of the Department for Behavioral Health, Developmental and Intellectual Disabilities.

Kentucky Behavioral Health Planning and Advisory Council
Finance Committee Meeting Summary
April 16, 2015 10:00am to 2:00pm
KY Transportation Cabinet, 200 Mero Street, 1st Floor, Conference Room C118, Frankfort, Kentucky

Members Present: Betty Jo Moss, Mary Singleton, Gayla Lockhart, Maggie Krueger, Sherry Sexton, Becky Clark, Becky Burton, LeeAnn Kelley, Brandon Kelley, Yayo Radder (KDE)

Staff Present: Michele Blevins, Missy Runyon, Christie Penn

Topic	Discussion	Next Steps
Call to Order & Introductions	Betty Jo Moss, Committee Chair, called the meeting to order at 10:04 AM. Committee members and staff introduced themselves.	
Overview of CMHCs	Michele Blevins reviewed the DBHDID SFY 2016 Budget for the CMHCs.	
Review of Kentucky's 2015-2016 Biennium Budget	Michele Blevins provided an informational overview of the Kentucky's 2015-16 Biennium Budget providing copies of the SFY 15 & 16 SA & MH Block Grant Allocations. Members reviewed the information and Michele answered questions.	
Block Grant Drafted Budgets for 2016	Committee members reviewed the SFY 2015 MHBG & SABG allocations. Members reviewed the information and Michele answered questions. Janice Johnston provided an overview of the 5% set aside for first episode psychosis grant. Summarized plans for the first year and long term goal over the following 6 years.	
Discussion and Recommendations	<ul style="list-style-type: none"> • Janice Johnston provided an overview of the TAYLRD grant. • Member stated - SA Budget is 3X the MH budget. "Is this because so many people are using drugs?" and "When looking at SA Treatment, do they look at those who are self-medicating?" • One member stated, "It looks like we are being more specific on how we are spending our money." • Seven Counties reports that it costs \$350,000/year to operate its Crisis line. • ACT, SE, SH, PS, TCM = DIVERTS to address the needs of individuals with mental health conditions who are coming out of Personal Care Homes (PCHs) or hospitals or at risk of going into PCH or hospital. 	
Fund requests	<ul style="list-style-type: none"> • Homeless Prevention Project – Adanta requested \$19,300 in additional funding for SFY 2016 (Current Funds: \$96,500. MHBG) for the Homeless Prevention Project aimed at assisting individuals with mental health issues exiting institutions who do not have a home to go to. ** No members were opposed. • DBH staff requested \$10,000. Of Substance Abuse Treatment funds to support the Oxford House Model. ** Members supported it. • Request was made to provide \$60-65,000 MHBG funds for First Episode of Psychosis (in excess of 5% set aside for First Episode of Psychosis) to allow \$200,000 for each chosen implementation site. ** Members supported it. <p>Members were also in support of spending additional SAPT BG funds for Peer Support (SA) although a specific funding request was not shared.</p>	

Adjournment	Mary Singleton made a motion to adjourn the meeting, Lee Ann Kelley seconded and Motion passed. The meeting adjourned at 2:17 PM.	<u>Next Meeting</u> April 21, 2016 10:00 AM - 2:00 PM Location TBD
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At the 4/17/14 Finance Committee Mtg. of the KY BHPAC members were asked to provide feedback and recommendations to the BHDID staff regarding MH Block Grant Allocations for SFY 2015.

Recommended Priorities

With the implementation of ACA, SAMHSA has directed states that Block Grant funds should be directed toward four (4) purposes, including:

- (1) To fund priority treatment and support *services for individuals without insurance* or who cycle in and out of health insurance coverage;
- (2) To fund those priority treatment and support *services not covered by Medicaid, Medicare or private insurance* and that demonstrate success in improving outcomes;
- (3) To fund universal, selective and targeted *prevention activities* and services; and
- (4) To *collect performance and outcome data* to determine effectiveness and to plan the implementation of new services.

1. SAMHSA's 6 Strategic Initiatives

- Prevention
- Health Care and Health Systems Integration
- Trauma and Justice **(1)**
- Recovery Support **(1)**
- Health Information Technology
- Workforce

2. Services

- Suicide Prevention **(2)**
- Supported Employment **(1)**
- Peer Support **(1)**
- Supported Housing **(2)**
- Transition Services for Young Adults **(2)**
- Consumer Operated Peer Services **(3)**
- Other (please specify): **(1)**
 - Adolescent recovery Groups – SAFE ones
 - Quality safe child care for parents in treatment at consumer run centers

3. Populations

- Adults with SMI **(2)**
- Children with SED **(3)**
- Military, Veterans, and Family Members **(2)**
- Individuals with Substance Use Disorders **(1)**
- Individuals with Co-occurring Disorders **(2)**
- Transition-Age Youth **(3)**
- Individuals Who Are LGBTQ **(1)**
- Individuals Who Are a Racial or Ethnic Minority **(2)**
- Individuals Who Are Homeless **(1)**
- Individuals Residing in Rural Areas **(2)**
- Other (please specify): **(1)**
 - Mental Health Support Groups in Schools

Kentucky Behavioral Health Planning and Advisory Council Meeting Summary
August 13, 2015 10:00am to 2:00pm
Transportation Bldg., 200 Mero Street Meeting Room 107, Frankfort, Kentucky

Members Present: Mary Singleton, Gayla Lockhart, Kerri Verden for Jennifer Dudinskie, Betty Jo Moss, Maggie Krueger, Cathy Epperson, Mike Barry, Matthew Smith, Rebecca Burton, Laura Beard for Joy Varney, Steve Lyons, Brandon Kelley, Yayo Radder, LeeAnn Kelley, Susan Abbott, Sherry Sexton, Valerie Mudd, Bill Heffron, Steve Shannon, Ann Hollen, Lynn Haney

Staff Present: Mary Begley, Missy Runyon, Michele Blevins, Christie Penn, David O'Daniel, Luanne Steele, Kate Hackett

Visitors: Terry Sanderson, Marie Grant

Topic	Discussion	Next Steps
Call Meeting to Order	Mary Singleton, Chair, called the meeting to order at 10:07 AM and welcomed attendees. Council members and guests introduced themselves. Quorum was confirmed.	
Approval of May Meeting Summary	Members reviewed the May 2015 meeting summary. Cathy Epperson made a motion to accept the minutes as written. Brandon Kelley seconded. Motion passed.	Approved minutes will be available online at http://dbhdid.ky.gov/dbh/kbhpac.aspx
Council Committee Reports	<p><u>Executive Committee</u> Committee has not met since last Council meeting. No updates. <i>Last met in January 2015</i></p> <p><u>Membership Committee</u> Mary Singleton, Membership Chair, reminded the Council that they had decided at the May quarterly meeting to take nominations for Vice Chair, to fill the office for its remaining term which expires March 2016. Members of the Membership Committee had already agreed at the May Council meeting, to accept three (3) nominations for this office (Sherry Sexton, Betty Jo Moss, and Becky Clark). The Council had requested a Membership Committee meeting before August 13, to consider nominations due to unforeseen circumstances, there was no meeting held. Council voted to go ahead and make a recommendation for Vice Chair at today's meeting. Mary asked for additional nominations from the floor and none were given. Two (2) of the nominated individuals provided written information about themselves and why they were interested in the office for which they were nominated. Two of the three nominees were present at today's Council meeting and were given an opportunity to speak to the Council and Council members asked questions of them. Council members were given the opportunity to vote by silent ballot and two candidates were announced as nominations from the Council. These two names (Sherry Sexton and Betty Jo Moss) will be sent to the Commissioner who will make an appointment to the office of Vice Chair.</p> <p><u>Finance and Data Committee</u> Committee has not met since last Council meeting. No updates. <i>Last met on April 16, 2015</i></p> <p><u>Bylaws Committee</u> Steve Shannon, Committee Chair, reviewed the proposed changes to the</p>	Submit Behavioral Health Order to Commissioner Begley for appointment of Vice Chair.

	<p>current Bylaws discussed in the Bylaws conference call held on April 9, 2015. Today's packets included current Bylaws with proposed changes highlighted. Members were encouraged to read the proposed changes and e-mail Steve Shannon and staff with any additional proposed changes or comments. Two small changes were requested. 1. Change page 4 to say "The Council" instead of the Membership Committee. 2. On page 5, change the capitalization of Ad Hoc to say ad hoc. Maggie Krueger made a motion to add these two changes to others proposed. LeeAnn Kelly seconded. Motion passed.</p> <p><u>ad hoc Committees</u> <u>Advocacy & Policy Committee</u> Cathy Epperson, Committee Chair, reported this Committee had a conference call meeting on August 12, 2015. Cathy distributed the updated list of advocacy priorities. There was some discussion with some minor additions in wording. Maggie Krueger made a motion to approve the document and LeeAnn Kelly seconded. Motion passed. Cathy will update the document and it will be included in packets for the November quarterly meeting. It was also requested that the document be copied and shared at the PAR booth at KY School next week.</p> <p><u>Managed Care Committee</u> Committee Chair not present. No updates.</p>	<p>Include updated proposed changes to Bylaws in the November Council meeting packet. Council may vote to adopt revised Bylaws at the November Council meeting.</p> <p>Cathy will send staff changes and document will be included in the November Council meeting packets.</p>
MHBG Site Visit Report Update	<p>Michele informed the Council that the Department has received the drafted report from the SAMHSA/CMHS On site Monitoring visit (June 2014). The Department is given an opportunity to request edits before the report is finalized. KY comments are due by September 2, 2015.</p>	<p>Distribute final copy of report to Council when it becomes available.</p>
SAMHSA/C SAT Site Visit	<p>Michele informed the Council that KY will participate in an On-site Monitoring visit from CSAT September 14-18, 2015. The visit is three-pronged to review financial, administrative and programmatic areas. The reviewers will meet with DBHDID leadership, Division leadership and substance use disorder treatment staff, two local programs (Bluegrass and Cumberland River) as well as administrative (contracts and monitoring) and financial (budgets and expenditures) staff at the state and local level.</p>	<p>Update Council on CSAT's preliminary findings and recommendations for BHDID at the November Council meeting.</p>
Block Grant Application	<p>Michele presented information about Kentucky's drafted MHBG/SABG application for 2016/2017 which is due by electronic submission on September 1, 2015. A PowerPoint was shared and members were instructed to review the drafted block grant application on the Department's website at www.dbhdid.ky.gov. Click on Block Grant announcement under "Hot Topics." <i>Please note that the document is 172 pages if you intend to print.</i> Comments are encouraged and may be submitted to Michele.Blevins@ky.gov by August 28 or by calling 502-782-6150. Council Chair shared drafted letter to be included in the grant application stating that the Council discussed/reviewed key pieces (Performance Indicators, BG Planned Expenditures –MH and SAPT) of the application at today's Council meeting.</p>	<p>Please see www.dbhdid.ky.gov for block grant application</p>
Meeting Locations	<p>Council briefly discussed location for future meetings. Staff agreed to work towards having meetings held at either the Transportation Bldg. on Mero Street or at the AOC Offices on US 127S. Meetings will not be held at the Capital Plaza Hotel due to Council objections.</p>	<p>Staff will schedule meeting locations and notify members.</p>

<p>DBHDID Updates</p>	<p>Michele shared Department Updates: <u>Newly Awarded Grants:</u> (Handout provided) 1) Partnerships for Success (SPF-PFS) grant for substance abuse prevention; 2) Kentucky Supporting Mothers to Achieve Recovery Treatment Supports (SMARTS) grant for medication assisted treatment for opioid addicted pregnant and postpartum women; 3) Cooperative Agreement to Benefit Homeless Individuals (CABHI) grant to provide community based services to Veterans and other individuals who are homeless and have behavioral health disorders. <u>Grants Applied for:</u> (Handout provided) 1- Yr. Planning Grant for Certified Community Behavioral Health Clinics (SAMHSA) Council to serve in Advisory Capacity should KY receive award. Michele shared information about the newly created <i>KY Institute for Excellence in Behavioral Health</i> housed at EKU (Handout provided).</p>	<p>Staff will keep the Council updated on these initiatives.</p>
<p>Council Member Updates</p>	<p>Members shared updates and information about important upcoming events in round robin format. Some of the highlights included:</p> <ul style="list-style-type: none"> • Cathy Epperson reported a new NAMI program called Ending the Silence. 3 NAMI affiliates in Kentucky are now using this program and several individuals have been trained. • NAMI KY annual conference will be held on September 26th in Louisville. \$25.00 registration fee. • Valerie Mudd reminded members that August 22nd at Boyd's Orchard in Versailles will be a kick-off celebration for the NAMI Walk that is scheduled for October 10 at noon at Masterson Station Park. This is during Mental Illness Awareness Week. • Sherry Sexton announced that she has been asked to speak at the KR Conference in Louisville in September. Sherry also reported to the Council about her attendance at the Mike Townsend Leadership Academy a few weeks ago at Natural Bridge State Park. This was the first year this event was open to individuals in recovery from both substance use and mental health disorders. This 3-day training was impactful and Sherry reported action groups were developed and were working together in communities all over Kentucky to continue work on identified projects. • Mike Barry reminded members about the Rally for Recovery led by PAR on September 20, from 2-4:30 at Water Tower Park in Louisville. • KPFC is having a Family Leadership Academy Core Competency Training. 	
<p>Adjournment of Meeting</p>	<p>The meeting adjourned at 2:00 PM.</p>	<p>Next Meeting: November 19, 2015 Transportation Building, 230 Mero Street Frankfort, KY 40601</p>

Kentucky Behavioral Health Planning and Advisory Council

Legislative Goals



"The Council is the active voice promoting awareness of and access to effective, affordable, recovery-oriented and resiliency-based services in all communities."

1.) Increase access to effective mental health, substance use, prevention, treatment and recovery.

- Build a stronger provider network (first responders, courts, juvenile justice, peer support, hospitals, treatment and recovery facilities and mental health providers)
- Stronger integration of system of care to decrease barriers to services and use holistic approach in serving the co-occurring population (outpatient and inpatient services and peer support services that address co-occurring disorders)
- Maintain current funding of Medicaid expansion and Kentucky Health Insurance Exchange
- Enhance early intervention and family support systems of care to better meet the social, emotional, and behavioral needs of children age birth to 5, and their families, by partnering with Early Childhood organizations and agencies and increasing awareness and screening for children at risk.
- Ensure managed care organizations approves intensive Case Management and Peer Support Services as a billable service at a competitive rate.

2.) Promote integration of mental health, substance use and physical health care.

- Ensure adequate and stable funding to meet community needs of families to make them whole and healthy.
- Ensure all providers are trained in service integration.

3.) Provide housing for transition age youth and adult individuals living with co-occurring disorders.

- Ensure necessary supports and services to help individuals live successfully in the community (case management, peer support, and Individual Placement and Support (IPS) supported employment)
- Ensure supports and services for transition age youth to smoothly transition into adult services (case management, housing, peer support, IPS Supported Employment)
- Educate individuals on their legal rights regarding housing options and choices
- Ensure individualized access to Individual Placement and Supports (IPS) Supported Employment in every Kentucky County.

Kentucky Behavioral Health Planning & Advisory Council

Mary Singleton, Chair • Vacant, Vice Chair • Gayla Hayes, Secretary
275 East Main Street, Frankfort, Kentucky 40601

August 13, 2015

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, MD 20857

Dear Ms. Simmons:

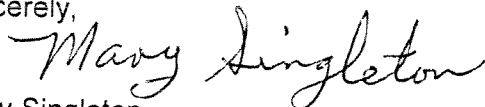
I am writing on behalf of Kentucky's Behavioral Health Planning & Advisory Council to confirm that Council members have reviewed Kentucky's drafted FY 2016-2017 Combined Behavioral Health Assessment and Plan. Time was allocated at today's Council meeting to discuss the state plan and solicit comments before the September 1st due date. The Department for Behavioral Health, Developmental and Intellectual Disabilities will continue to accept comments until the end of August 2015.

Our Council has met quarterly over the past year. Committees have met to carry out their work and members have been diligent as we continue to build a solid Council that guide the development of Kentucky's behavioral health system of care. Recent activities of the Council include the following:

- The Council Bylaws have been revised to reflect the expanded scope of the Council and to include a prevention representative as a voting member;
- The Policy and Advocacy Committee recommended legislative priorities, which the Council adopted and members used to advocate with legislators;
- Finance Committee members reviewed Block Grant appropriations and made recommendations for reserve funds;
- The Membership Committee has revised its Member Orientation and Council brochure to reflect the expanded scope of the Council and has created a Member Handbook;
- The Department has recently been awarded several SAMHSA grants and has asked the Council to serve in an advisory capacity as these are implemented. We look forward to these opportunities and the benefit they promise for our citizens.

Thank you for the continued support of community-based services for adults and youth with behavioral health disorders. Our Council membership is honored to serve as advisors for planning in Kentucky.

Sincerely,



Mary Singleton
Chair, Kentucky Behavioral Health Planning & Advisory Council

Cc: Mary Begley, Commissioner, Department for Behavioral Health, Developmental & Intellectual Disabilities
Natalie Kelly, Director, Division of Behavioral Health

Department for Behavioral Health, Developmental and Intellectual Disabilities
275 East Main Street, 4W-G
Frankfort, KY 40621

Mental Health and Substance Abuse Prevention and Treatment Block Grants
Comments on Application for 2016/2017

(1) A Behavioral Health Planning and Advisory Council meeting was held on August 13, 2015, at the Transportation Building at 200 Mero Street, Frankfort, KY 40601, from 10:00am until 2:00pm Eastern Time. The Block Grant process and pending application were discussed at this meeting. Individuals were instructed to go to the Department website at www.dbhdid.ky.gov and review available written portions of the application and submit comments to Michele.Blevins@ky.gov, by August 28, 2015. Individuals were also welcomed to provide comments to Michele Blevins in writing at the above address, or to call her at 502-782-6150.

(2) The following people submitted written comments via the public comment process:

<u>NAME AND TITLE</u>	<u>AGENCY/ORGANIZATION/ENTITY/OTHER</u>
Maggie Krueger Parent of Child with SED	BHPAC member/citizen
Anonymous Caller	Other

(3) The following people from DBHDID responded to the comments received:

<u>NAME AND TITLE</u>	<u>AGENCY/ORGANIZATION/ENTITY/OTHER</u>
Michele Blevins Assistant Director	DBHDID
Melissa Runyon Program Administrator	DBHDID

SUMMARY OF COMMENTS AND AGENCY'S RESPONSES

(1) Subject: Planning Table Priority 2: Children and Youth with SED. Youth involved with DJJ having access to CMHC evidence based practices.

(a) Comment: From the planning table, Priority #2 addresses children and youth with Severe Emotional Disabilities (SED). The goal is to increase access to evidence based practices for children/youth with SED. The objective is to track the total number of youth who receive High Fidelity Wraparound services.

The Department of Juvenile Justice which is within the Kentucky Systems of Care construct has numerous youth committed to them who have SED. They operate within a treatment team concept under the guidance of a treatment director. Each youth has a counselor who works with them on goals identified in an Initial Treatment Plan meeting. Each facility has a psychiatrist who administers medication and talks with youth about coping skills, etc.

These are youth that we know have SED to a degree that it necessitates their separation from family and community. They have been identified and we can control and easily measure the treatment that they receive. It would be advantageous for DJJ to operate with the same best practices that are received in the community. Interface with regional CMHC's would demonstrate cooperation between agencies and consistent modeling of best practices. This would help facilitate transition into the community at release. Most would come back to the community as transition age youth. This would be consistent with SIAC recommendations to expand the System of Care values among its member agencies. It would support the recommendation to make a strong and dedicated shift to community based services. And it would be consistent with the recommendation for agencies to increase the use of evidence based

practices. As a part of peer support they could move in the direction of forensic peer support specialists, providing youth assistance from someone with lived experience in reentry to the community.

- (b) Response: DBHDID staff concurs and are hopeful that with all of the changes brought about by the passage of Senate Bill 200 (Juvenile Justice Reform) that there will be improved screening, assessment and treatment services available to youth who are involved in the Juvenile Justice system.
- (2) Subject: An anonymous caller requested information about the purpose of Block Grant funding and how/to whom it is disbursed.

SUMMARY OF STATEMENT OF CONSIDERATION
AND ACTION TAKEN BY DBHDID

**REVISION REQUEST
BLOCK GRANT APPLICATION 2016/2017**

22. State Behavioral Health Planning/Advisory Council

9-23-15 e-mail request. Which council members represent - Child Welfare and Housing Agency? What agency does Jeanette Rheeder represent?

Jeanette Rheeder is the representative on the Council for the Kentucky Housing Corporation. 1231 Louisville Road, Frankfort, KY 40601.

Kalon Bagby is the representative on the Council from the Department for Community Based Services, which includes child welfare. 275 East Main Street, 3E-B, Frankfort, KY 40621.

10-6-15 e-mail request. How will the public have the opportunity to comment on the state block grant plan after the submission of the plan to SAMHSA?

Each submitted block grant application is posted on the Department website, www.dbhdid.ky.gov, under the Behavioral Health Planning and Advisory Council webpage, which has a link to the block grant information. The application submitted for 2016/2017 is currently posted at that location.

There is a link that describes what the block grant is, the status of the applications, and the timelines for submission. The document at that link explains in detail how to provide comments for block grant plans and behavioral health reports. The public is invited to attend Planning and Advisory Council meetings and make comments during that time. They may also provide comments via e-mail to Michele Blevins at Michele.Blevins@ky.gov. They may also provide comments via U.S. mail to the following address: Department for Behavioral Health, Developmental and Intellectual Disabilities, Division of Behavioral Health, Michele Blevins – State Planner, 275 East Main Street, 4W-G, Frankfort, KY 40621. They may also provide comments via fax to Michele Blevins at 502-564-9010.

Environmental Factors and 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)		869 Sparta Court Lexington, KY 40504 PH: 859-309-2856	Kelly@namilex.org
Michael Barry	Others (Not State employees or providers)		People Advocating Recovery, 1425 Story Ave Louisville , KY 40206 PH: 502-552-8573	mike@peopleadvocatingrecovery.org
Jennifer Dudinskie	State Employees		Department for Aging & Independent Living, 275 E. Main Street, 3E-E Frankfort , KY 40601 PH: 502-564-6930	Jennifer.Dudinskie@ky.gov
Kalon Bagby	State Employees		Department for Community Based Services, 275 E Main Street 3E-B Frankfort , KY 40601 PH: 502-564-2136	Kalon.Bagby@ky.gov
Yayo Radder	State Employees		Department of Education, 500 Mero Street, 18th Floor Frankfort, KY 40601 PH: 502-564-4970	Yayo.radder@education.ky.gov
Cheryl Hall	State Employees		Department of Corrections, 2605 W. Highway 146 LaGrange , KY 40031 PH: 502-222-7808	CherylT.Hall@ky.gov
Bill Heffron	State Employees		Department for Juvenile Justice, 1025 Capital Center Drive, Building 3, Third Floor Frankfort , KY 40601 PH: 502-573-2738	BillM.Heffron@ky.gov
Ann Hollen	State Employees		Department for Medicaid Services, 275 East Main Street, 6W-B Frankfort , KY 40601 PH: 502-564-1647	Ann.Hollen@ky.gov
Natalie Kelly	State Employees		Department for Behavioral Health, Developmental and Intellectual Disabilities, 275 East Main Street, 4W-G Frankfort , KY 40601 PH: 502-782-6173	Natalie.Kelly@ky.gov
Shelley Adams	State Employees		Department for Public Health, 275 East Main Street, HS2WA Frankfort , KY 40601 PH: 502-564-2154	Shelley.Adams@ky.gov

Jeanette Rheeder	State Employees	1231 Louisville Road Frankfort , KY 40601 PH: 502-564-7630	
Susan Abbott	State Employees	Kentucky Protection & Advocacy, 100 Fair Oaks Lane, 3rd Floor Frankfort , KY 40601 PH: 502-564-2967	susan.abbott@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
Steve Shannon	Providers	Kentucky Association of Regional Program, 152 W. Zandale Drive, Suite 201 Lexington , KY 40503 PH: 859-272-6700	SShannon.KARP@iglou.com
Amy Jeffers	Providers	Regional Prevention Center Director, PO Box 790 Ashland , KY 41105-0790 PH: 606-329-8588	amy.jeffers@pathways-ky.gov
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: 502-513-5453	lyonssadsack@aol.com
Gayla Lockhart	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	401 Pebbles Ave. 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_btyi@yahoo.com
Carmilla Ratliff	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	94 Appomattox Drive Frankfort , KY 40601 PH: 606-694-3634	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: 606-558-5076	angels2830@gmail.com
Sherry Sexton	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	2500 Alumni Drive Apt. 14205 Lexington , KY 40517 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: 606-928-6234	lak77goherd@yahoo.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	
LeeAnn Kelley	Family Members of Individuals in Recovery (to include family members of adults with SMI)	5704 Hicks Road Ashland , KY 41102 PH: 606-928-6234	
lynn Haney	Family Members of Individuals in Recovery (to include family members of adults with SMI)	P.O. Box 54 Florence, KY 41022-0054 PH: 859-282-9166	
Valerie Mudd	Family Members of Individuals in Recovery (to include family members of adults with SMI)	2206 Alexandria Drive Lexington, KY 40504 PH: 859-313-5026	valeriemudd@gmail.com
Mathew Smith	Family Members of Individuals in Recovery (to include family members of adults with SMI)	2980 Trailside Drive Lexington, KY 40511 PH: 859-233-1243	msmith@Campbellandsmithlaw.com

Maggie
Krueger

Parents of children with SED

265 Tamarack Road
Columbia , KY 42728
PH: 270-384-1134

maggie.krueger@winstream.net

Rebecca
Burton

Parents of children with SED

115 Sawgrass Lane #20
Grayson , KY 41143
PH: 606-225-4123

rburton@pathyways-ky.org

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2016

End Year: 2017

Type of Membership	Number	Percentage
Total Membership	36	
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*	2	
Vacancies (Individuals and Family Members)	<input type="text" value="5"/>	
Others (Not State employees or providers)	4	
Total Individuals in Recovery, Family Members & Others	23	63.89%
State Employees	11	
Providers	2	
Federally Recognized Tribe Representatives	0	
Vacancies	<input type="text" value="0"/>	
Total State Employees & Providers	13	36.11%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="4"/>	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="5"/>	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	9	
Persons in recovery from or providing treatment for or advocating for substance abuse services	<input type="text" value="6"/>	

* 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?

Child Welfare is represented by the Department for Community Based Services representative, Kalon Bagby.

Housing is represented by the Kentucky Housing Corporation representative, Jeanette Rheeder.

Footnotes:

Environmental Factors and Plan

23. Syringe Services (SSP)

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction^{1,2} on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the [Consolidated Appropriations Act, 2016](#) (P.L. 114-113) signed by President Obama on December 18, 2015³.

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of a SSP other than to purchase sterile needles or syringes. However, directing FY 2016 SABG funds to SSPs will require a modification of the 2016-2017 SABG Behavioral Assessment and Plan (Plan). States interested in directing SABG funds to SSPs must provide the information requested below and receive approval on the modification from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when modifying the Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers⁴. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016 the federal government released three guidance documents regarding SSPs⁵: These documents can be found on the Aids.gov website:<https://www.aids.gov/federal-resources/policies/syringe-services-programs/>,

1. [Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016](https://www.aids.gov/pdf/hhs-ssp-guidance.pdf) from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy <https://www.aids.gov/pdf/hhs-ssp-guidance.pdf>,
2. [Centers for Disease Control and Prevention \(CDC\) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016](http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf) The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention <http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf>,
3. [The Substance Abuse and Mental Health Services Administration \(SAMHSA\)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs](http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf) <http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf>,

Please refer to the guidance documents above when requesting a modification to the state's 2016-2017 Behavioral Health Assessment and Plan.

Please follow the steps listed below to modify the Plan:

- Request a Determination of Need from the CDC
- Modify the 2016-2017 Plan to expend FFY 2016 and/or FFY 2017* funds and support an existing SSP or establish a new SSP

- Include proposed protocols, timeline for implementation, and overall budget
- Submit planned expenditures and agency information on Table A listed below
- Obtain State Project Officer Approval
- Collect all SSP information on Table B listed below to be reported in the FFY 2019 SABG report due December 1, 2018

End Notes

¹ Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. ? 300x-23(b)) and 45 CFR ? 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2016 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit an amendment to its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan amendment is applicable to the FY 2016 SABG funds *only* and is consistent with guidance issued by SAMHSA.

²Section 1931(a)(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C.? 300x-31(a)(1)(F)) and 45 CFR ? 96.135(a)(6) explicitly prohibits the use of SABG funds to provide persons who inject drugs (PWID) with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

³ Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2016 (P.L. 114- 113)

⁴ Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. ? 300x-24(a)) and 45 CFR ? 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. ? 300x-24(b)) and 45 CFR 96.128 requires ?designated states? as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

⁵*Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016* describes a SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all of the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a description of the elements of a SSP that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;

- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;
- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing a opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

Footnotes:

Environmental Factors and Plan

Syringe Services (SSP) Program Information-Table A

Syringe Services Program SSP Agency Name	Main Address of SSP	Dollar Amount of SABG funds used for SSP	SUD Treatment Provider	Number Of Locations (include mobile if any)	Narcan Provided
No Data Available					
Footnotes:					

Environmental Factors and Plan

Syringe Services (SSP) Program Information-Table B

[Please enter total number of individuals served]

Syringe Service Program Name	# of Unique Individuals Served		HIV Testing	Treatment for Substance Use Conditions	Treatment for Physical Health	STD Testing	Hep C
	0	ONSITE Testing	0	0	0	0	0
		Referral to testing	0	0	0	0	0

Footnotes:

JUL 7 2015

Ms. Mary Begley
Kentucky Department for Behavioral Health,
Development and Intellectual Disabilities
275 East Main Street 4W-F
Frankfort, KY 40621

Dear Ms. Begley:

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) invites you to apply for the Mental Health Block Grant (MHBG) for federal fiscal year (FY) 2016. The FY 2016-2017 Uniform Application (0930-0168), which will serve as the application to the Secretary for the MHBG for FY 2016, must include funding agreements, assurances, certifications and planning tables for FY 2016.

The FY 2016-2017 Uniform Application is available electronically via the Block Grant Application System (Web-BGAS). An Adobe Acrobat version of the FY 2016-2017 Uniform Application may be downloaded from SAMHSA's block grant website. A copy of the authorizing legislation (42 USC § 300x-21 et seq) available on Web-BGAS under the Frequently Asked Questions section as well as SAMHSA's block grant website.

The FY 2016 Justification of Estimates for Appropriations Committees, includes a table of the estimated State/Territory allotments for the FY 2016 MHBG. However, a final FY 2016 Departments of Labor, Health and Human Services, Education (Labor-HHS-ED) and Related Agencies appropriations bill is pending. Upon enactment of the FY 2016 appropriations for Labor-HHS-ED and related agencies, a final allotment table for FY 2016 MHBG will be sent to you and uploaded on BGAS. In the interim, please refer to the enclosed FY 2016 MHBG allocation as authorized by the Consolidated Appropriations Act, 2016 (P.L. 112-74) for purposes of completing the FY 2016 Intended Use Plan (Table 7) and related planned expenditure checklists (Table 6 & Table 8).

All states and jurisdictions are required to prepare and submit their respective FY 2016-2017 Uniform Applications on or before September 1, 2015. All states and jurisdictions are required to execute the "Application Complete" function not later than Tuesday, September 1, 2015 at 11:59 p.m. EST. When a state or jurisdiction executes the "Application Complete" function, the Web-BGAS records "Application Completed by State User." This is SAMHSA's only evidence that a state or jurisdiction has complied with the statutory requirement regarding the September 1 receipt date.

Page – 2 Ms. Begley

Any state or jurisdiction planning to submit a combined FY2016-2017 Uniform Application must execute the “Application Complete” function not later than Tuesday, September 1, 2015 at 11:59 p.m. SAMHSA’s block grant programs are subject to an annual audit pursuant to the Office of Management and Budget Circular A-123, “Management’s Responsibility for Internal Controls,” and one of the controls involves a review of how SAMHSA ensures states’ and jurisdictions’ compliance with the statutory receipt dates as described in sections 1917(a)(1) and 1932(a)(1) of Title XIX, Part B, Subpart I and Subpart II of the PHS Act, respectively.

The contact person for questions related to MHBG business management issues is:

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, Maryland 20857
TEL. (240) 276-1422

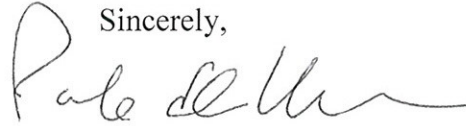
Please submit a single copy of the Funding Agreements, Assurances Non-Construction Programs, Certification and Lobbying Disclosure Form, signed by the state’s chief executive officer or designee, to SAMHSA and upload an electronic copy to Web-BGAS using the Attachments Tab. If one or more of the documents described above is signed by a designee, please include a current delegation of authority letter(s) from the state’s chief executive officer. Forwarding any paperwork related to the FY 2016-2017 Uniform Application to any other addressee results in processing delays. To ensure express/overnight mail delivery, please use the following address:

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, 7-1109
Rockville, Maryland 20850
Telephone: (240) 276-1422

Questions of a fiscal or programmatic nature should be directed to your respective State Project Officer within CMHS’s Division of State and Community Systems Development. Enclosed is a State project officer directory.

Page – 3 Ms. Begley

Sincerely,

A handwritten signature in black ink, appearing to read "Paolo del Vecchio". The signature is fluid and cursive, with a long horizontal stroke at the end.

Paolo del Vecchio, M.S.W.
Director
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration

cc: Michele Blevins
Melissa Runyon
Christie Penn
Mary Singleton

Enclosures:
2016 MHBG Prospective Allotments
MHBG Project Officer Directory