Kentucky

UNIFORM APPLICATION
FY 2018/2019 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

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

OMB - Approved 06/12/2015 - Expires 09/30/2020
(generated on 08/29/2017 6.17.30 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 2017

End Year 2019

State SAPT DUNS Number

Number 927049767

Expiration Date

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 40621

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

First Name Dee

Last Name Werline

Agency Name Cabinet for Health and Family Services

Mailing Address 275 East Main Street 4W-G

City Frankfort

Zip Code 40621

Telephone 502-782-6173

Fax 502-564-9010

Email Address Michele.Blevins@ky.gov

State CMHS DUNS Number

Number 927049767

Expiration Date

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 40621

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

First Name Wendy

Last Name Morris

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

Mailing Address 275 East Main Street 4W-F

City	Frankfort
Zip Code	40621
Telephone	502-564-4527
Fax	502-564-5478
Email Address	wendy.morris@ky.gov

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

From	
To	

IV. Date Submitted

Submission Date	8/29/2017 6:16:16 PM
Revision Date	

V. Contact Person Responsible for Application Submission

First Name	Michele
Last Name	Blevins
Telephone	(502)782-6150
Fax	(502)564-9010
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 2018

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32
Section 1935	Core Data Set	42 USC § 300x-35
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53

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

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: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

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

Footnotes:

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

Fiscal Year 2018

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
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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: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

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

Footnotes:

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

Title

Organization

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:

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.

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.

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 Department 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.

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

- Office of the Secretary
- Office of Health Policy (including Certificate of Need and Health Policy Development)
- Office of Kentucky Health Benefit Exchange
- Office of the Inspector General (Licensing and Regulation Authority)
- Office of Communications and Administrative Review
- Office of the Ombudsman
- Department for Public Health (Local and State Public Health Programs)
- Department for Medicaid Services (Medicaid Authority)
- Department for Aging and Independent Living (Aging, Guardianship, Long-term Care Services)
- Department for Community-Based Services (Adult and Child Protection, Child Welfare)
- Department for Income Support (Disability Determinations, Child Support Enforcement)
- Department for Family Resource Centers and Volunteer Services
- Commission for Children with Special Health Care Needs

http://chfs.ky.gov/about/default.htm

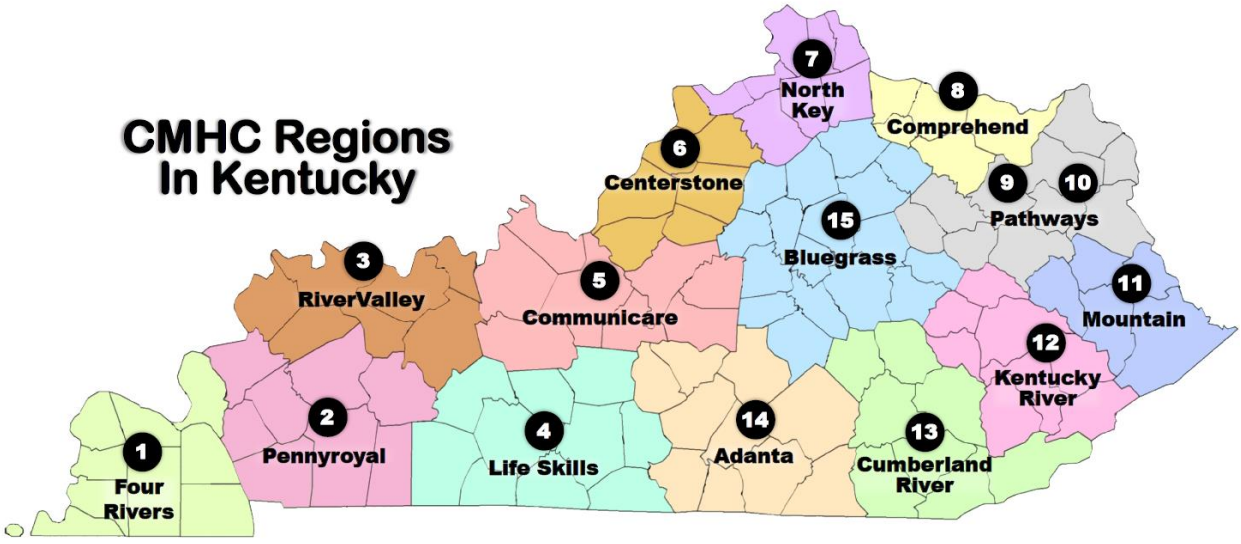
Within DBHDID, there are four Divisions, including: Administration and Financial Management; Developmental and Intellectual Disabilities; Program Support and Behavioral Health. The Division of Behavioral Health is a product of the merger of the Division of Substance Abuse and the Division of Mental Health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

- *Behavioral Health Prevention and Promotion Branch* – Consists of the Substance Abuse Prevention Program, which targets the prevention of the abuse of alcohol, tobacco and other drugs in Kentucky, as well Suicide Prevention and Zero Tolerance programs. The Substance Abuse Prevention Program of the Division of Behavioral Health is responsible for completing the Annual Synar Report. The Office of Alcoholic Beverage Control enforces the Synar Regulation and conducts the annual Synar survey;

- *Adult Substance Abuse Treatment and Recovery Services Branch* – Provides administrative oversight for the community based and outpatient and residential services, including those for women, pregnant women and women with dependent children. The Branch also houses the Driving Under the Influence (DUI) Program

- *Children's Behavioral Health and Recovery Services Branch* - Responsible for the oversight of services and supports for children and youth who have or are at-risk of developing behavioral health concerns (including both mental health and substance use), and their families. This includes assisting providers and families in accessing training and coaching in a variety of evidence-based and promising approaches.
- *Adult Mental Health Services and Recovery Branch* - Responsible for planning and oversight of and support to the 14 regional Community Mental Health Centers for the delivery of behavioral health services to adults with severe and persistent mental illness

Kentucky is divided into fourteen geographic regions for the purposes of planning and providing publicly funded community mental health, substance use and prevention services. 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 generally 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."



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.

KRS 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 there main focus in 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 several CMHCs and a few other community-based, non-profit, entities to provide additional targeted services. Examples of these include programming for Supported Employment, Supportive Housing, and specialized residential treatment for men, women, pregnant women and parents with dependent children, youth, and individuals with substance use disorders and individuals who are homeless.

BHDID collects client-level data monthly, including fields for gender, race, and ethnicity from the following entities:

- Fourteen community mental health centers;
- Two state-owned psychiatric hospitals;
- Two state-contracted psychiatric hospitals;
- Four intermediate care facilities for individuals with intellectual disability; and
- Two non-profit agencies contracted to provide specialized services to individuals with substance use disorders.

Kentucky is not a very diverse state racially and there are no designated tribes but it is considered very diverse in culture from one area of the state to the other and there are great differences in income/wealth among residents across the state. The population of Kentucky is 88% White alone, 7.8% Black or African American alone, 1.1% Asian alone, .1% Native Hawaiian or Other Pacific Islander alone, 3% Other or Mixed Race. The percent of the population that is Hispanic or Latino is rising some in recent years and is currently around 3.5%. The median income in Kentucky is $43,740/year.

CHFS and BHDID is committed to addressing health disparities, particularly access to quality behavioral health services for all citizens. DBHDID is a member of the Juvenile Justice Oversight Council, Juvenile Justice Advisory Board, Subcommittee for Equity and Justice for All Youth, Differential Treatment Workgroup, and the Disproportionality and Disparities Standing Committee. The Treatment workgroup is currently analyzing statewide and regional program performance data, disaggregated by race, ethnicity, gender and disability to determine if there are differences in access, use and outcomes. Providers are responsible for ensuring all staff participate in cultural awareness and sensitivity training regularly and that their policies and procedures do not discriminate but rather encourage inclusion by all citizens. Many CMHCs also focus on cultural competency and racial, ethnic and sexual gender awareness in employee

performance evaluation efforts and provide specific and detailed goals and objectives whenever deficits are identified.

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 2006	SFY 2014	SFY 2015	ADC* SFY 2016	ADC* SFY 2017**
Western State Hospital/ Hopkinsville State Operated	140	124	136	126	113
Central State Hospital/ Louisville State Operated	110	55	46	47	57
Eastern State Hospital/Lexington Contracted	173	119	119	115	130
Appalachian Regional Hospital (ARH) Psychiatric Center/Hazard Contracted	78	73	75	74	56
TOTAL	501	371	376	362	356

*ADC= Average Daily Census

** SFY 2017 data not certified until October 2017.

Kentucky Correctional Psychiatric Center (KCPC) 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 2016 was 64 people.

Kentucky does not operate any state funded inpatient facilities for children/youth under eighteen years of age. There are currently 609 available child psychiatric beds located in 14 hospitals that are geographically located in 9 of the 14 regions. 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, the child welfare agency.

Psychiatric Inpatient Utilization - Statewide - Children and Adolescents 0-17 Years of Age								
Year	Number of Hospitals	Total # Licensed Child/Adol Beds	Total # Child/Adol Beds in Operation	Total # Admissions	Total # Inpatient Days	Average Daily Census (ADC)	Average Length of Stay (ALOS)	Occupancy %
2004	13	612		8,536	187,892	513	21.60	
2013	14	625	622	9,867	126,963	348	12.50	55.66%
2014	13	611	608	11,989	116,274	319	9.68	52.14%
2015	13	627	595	11,287	121,630	333	10.49	53.15%
2016	13	712	609	10,609	123,612	338	11.90	47.44%

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

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.

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 funding from the residential/facilities side of the equation and increased access to much needed services in the community. However, both remain at the bottom of state spending as rankings range from 45th to 47th among several sources, in recent years.
www.governing.com/gov-data/health/mental-health-spending-by-state.html
http://www.pewtrusts.org/en/archived-projects/state-health-care-spending
https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/State-Mental-Health-Legislation-2015/NAMI-StateMentalHealthLegislation2015.pdf

The availability and funding of behavioral health services in Kentucky has seen some significant changes in recent years 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 history of recent changes.

In November 2011, Kentucky transitioned its Medicaid program to managed care by initiating 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, 2017, 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, Aetna, Anthem and Passport Health Plan.

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 allowed Medicaid eligible individuals to sign up for coverage through the marketplace. Medicaid coverage for the expansion population began Jan. 1, 2014. To date, 450,000 Kentuckians have enrolled in health coverage under Medicaid expansion and an additional 105,877 have enrolled in coverage through a Qualified Health Plan. The current Administration believes that Kentucky's Medicaid program is not financially sustainable and has submitted a waiver, and subsequent amendment, to propose a revised plan. The proposal is called Kentucky HEALTH (*Helping to Engage and Achieve Long Term Health)* and encourages Kentuckians to get healthier and to transition to the commercial health insurance market to

become independent of the government program. Kentucky's waiver proposal has yet to be acted upon but is considered favorable by CMS.

The Kentucky Department for Medicaid Services has had State Plan Amendments (SPAs) approved in recent years and this has resulted in the expansion of 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. 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 number of behavioral health providers who are able to seek reimbursement for Medicaid payment, through the MCOs, is growing steadily. 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 regulations has ensued.

Another catalyst for new legislation and regulatory changes has been the escalation of the misuse of prescription drugs and other opioid use in Kentucky. All age groups have been effected by this epidemic and efforts are currently underway to address the increase in opioid overdose deaths, substance exposed infants, increase in children placed in out-of-home care due to the death, incarceration and drug use by parents who are endangering the health and safety of children.

Planning Steps

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

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current behavioral health system as well as the data sources used to identify the needs and gaps of the required 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 the 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 sets 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 use disorderprevention, and SUD 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 M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of 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[1] 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.

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[1] 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

Narrative Question**:**

This step should identify the unmet needs and critical gaps in the state's current behavioral health system as well as the data sources used to identify the needs and gaps of the required 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 the unmet service needs and gaps.

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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:

- Analyzing Data Reports for Performance Indicators and Deliverables in Provider Contracts;
- Communicating Data Trends to Providers in Various Forums;
- Children's System of Care Redesign;
- Evaluation Process for six (6) Regions in Central Kentucky for Baseline Readiness for Certified Community Behavioral Health Clinics (CCBHC) grant application planning process;
- 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:

- The implementation of the Affordable Care Act and Medicaid Expansion in Kentucky;
- The 1115 Medicaid Waiver request to CMS to transform Kentucky's Medicaid program, by the current Administration;
- The 21st Century Cures Act and the subsequent award of $10.5 million in Kentucky Opioid Response Effort (KORE);
- The increasingly large network of Medicaid/MCO enrolled behavioral health providers that are working to implement an array of behavioral health services;
- The continued work on implementation of additional rehabilitation and targeted case management services as outlined in the amended Medicaid state plan (January 2014), especially services for substance use disorder services, crisis services and evidence based practices for adults with SMI;
- The continued promulgation new/amended regulations, in collaboration with DMS, DAIL, DCBS, and other sister agencies, in order to adequately outline all available services and supports;
- The full implementation of performance based contracting, by DBHDID;
- The reduction in state general funds allocated to DBHDID as a result of anticipated savings with more services being Medicaid billable and more individuals receiving Medicaid funded behavioral health benefits ($21 Million in SFY 2015; $30 Million in SFY 2016);
- The ten percent (10%) funding cut imposed as a result of state revenues not meeting the State Budget Director's office's expectations for SFY 2017;
- The *Amended Settlement Agreement* between the Cabinet of Health and Family Services and Kentucky Protection and Advocacy (October of 2015), stipulating the transition of at least 675 individuals with SMI out of personal care homes and into community housing by October 2018;
- The rebalancing of DBHDID facility funds to community funds for *Direct Intervention Very Early Response Treatment System* (DIVERTS) services to support individuals identified through the Amended Settlement Agreement (approximately $6 million dollars);
- The transition, by the Kentucky Department for Medicaid Services (DMS), to managed care oversight for all of health, including behavioral health care, services. There are currently five MCOs contracted to serve Kentucky and each has its unique required processes for prior authorizations, billing and monitoring activities, etc.;
- The recent legislative actions (including unfunded mandates);
- The influx of returning Service Members, Veterans and their Families (SMVF) with behavioral health needs;
- The continued workforce issues and shortages, especially in rural areas;
- The current Administration's priorities; and
- The underfunded state pension system and the increased retirement contributions required by the majority of the CMHCs.

Priorities identified by the Kentucky Behavioral Health Planning and Advisory Council (BHPAC) include the following, as discussed at the Finance and Data Committee meeting of the BHPAC in April 2017:

- Transitional Housing, including individuals in recovery from substance use disorders with dependent children;
- Oxford Houses, an evidence based practice for supported housing for individuals in recovery from substance use disorders;
- Diversion programming from criminal justice or juvenile justice settings;

- Adolescent substance use treatment;
- Jail Triage activities (telephonic response for jailers with inmates in psychiatric crisis/suicidal);
- Treatment for SMVF; and
- Emergency preparedness planning.

The following DBHDID priorities have been identified by DBHDID leadership:

- Administering the $10.5M, SAMHSA funded, KORE initiative;
- Preserving and enhancing the behavioral health safety network to ensure access to meaningful services for at-risk and underserved populations;
- Decriminalization of behavioral health disorders;
- Continuing full implementation of electronic medical records (EMRs) at each of the DBHDID facilities; and
- Comprehensive assessment of the capacity of facilities, operated by DBHDID, to ensure the most effective/efficient use of state resources.

Kentucky Priority Populations

As required in the instructions above, the following provides information for each of the priority populations by providing Prevalence Data, Unmet Needs and Critical Service Gaps***,*** Addressing the Need, and Data Sources Used. Additional detail about the activities to address identified needs is located in other areas of the plan as required by the block grant application instructions, particularly in the *Environmental Factors and Plan* Section.

Adults with SMI

Prevalence Data for this population: The following table uses the federal prevalence rate formula of 2.6% and the 2010 census data to estimate the percentage of the targeted population serviced by the Regional Boards during SFY 2016.

Regional Boards	Adult Census 2010	Estimated Prevalence (2.6% of the Adult Census)	Kentucky Adults with SMI Served in SFY 2016	Penetration Rate - SMI Served
Four Rivers	161,545	4,200	3,483	83%
Pennyroyal	158,100	4,111	2,447	60%
RiverValley	161,977	4,211	2,264	54%
LifeSkills	217,231	5,648	1,874	33%
Communicare	200,640	5,217	3,394	65%
Centerstone	730,843	19,002	7,127	38%
NorthKey	326,235	8,482	3,154	37%
Comprehend	42,757	1,112	656	59%
Pathways	170,601	4,436	3,612	81%
Mountain	119,756	3,114	3,643	117%
Kentucky River	89,550	2,328	1,936	83%
Cumberland River	181,110	4,709	2,843	60%
Adanta	160,202	4,165	2,313	56%

Bluegrass	595,449	15,482	3,271	21%
TOTAL	**3,315,996**	**86,216**	**42,017**	**49%**

Note: The data for SFY 2017 is not certified until October 2017 thus SFY 2016 data is used.

Unmet Needs and Critical Service Gaps:

A Settlement Agreement was signed between the Cabinet for Health and Family Services and Kentucky Protection and Advocacy beginning in 2013, showed that there were approximately 2300 adults with SMI living in personal care homes. The agreement states that 675 adults with SMI must be transitioned from personal care homes into community based living by October 2018. One of the critical gaps is the limited availability of safe, affordable housing in the community, for adults with SMI, especially in rural areas, as well as limited availability of housing assistance such as housing vouchers, rental assistance, etc. In addition, there is limited availability of supervised housing in the community, thwarting efforts to assist individuals with complex and intensive service needs.

During SFY 2017, Kentucky System Transformation Advocating Recovery Supports (KYSTARS), through a contract with DBHDID, conducted fidelity assessments with consumer run programs across the state. This assessment gathered information regarding six (6) primary areas:

- Structure
- Environment
- Belief Systems
- Peer Support
- Education
- Advocacy

These programs were funded by DBH and developed based on the SAMHSA Consumer Operated Services Program (COSP) toolkit. These programs were designed to serve primarily adults with SMI. A KYSTARS review team interviewed leadership and participants of each consumer run program funded by DBH at that time. (e.g. eight (8) programs). For the three (3) initial programs funded in SFY 2014, a full fidelity review utilizing the Fidelity Assessment Common Ingredients Tool (FACIT) was performed. For the five (5) additional programs, funded at a later date, the programs each performed a self-assessment based on the FACIT and then the results were authenticated/collaborated by KYSTARS staff during the fidelity visit. KYSTARS found that all programs were performing at or above national benchmarks on all six (6) primary areas. would benefit from additional training in various program areas. Gaps discovered across programs included:

- Issues with staff turnover;
- Knowledge related to purpose behind the domains measuring on the FACIT (e.g. not just see the item on the fidelity tool, but embrace the true meaning of what the item is truly measuring); and
- Knowledge of recovery principles and how to incorporate the principles into programming.

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. It was noted at that time 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. Looking at this data again utilizing certified 2016

KY MIS Client/Event data, approximately 49% of adults with SMI in Kentucky received serves from the Regional Boards, and about 7% of them received targeted case management services. While the number of adults with SMI served by the Regional Boards seems to rise, the number of those individuals receiving targeted case management services continue to decline. DBH considers targeted case management for this population a critical need.

An additional need discovered by reviewing available data gathered in Client/Event Data Set as well as through the CMHC contract monitoring process, is increasing the utilization of crisis stabilization programs and other crisis services as alternatives to psychiatric hospitalization for this population.

Addressing the Need:

Due in part to the impetus of fulfilling the terms of the Settlement Agreement, DBHDID began working on enhancing the community based behavioral health system in Kentucky for adults with SMI. Several new community evidence based services are now available, that have not traditionally been available, including assertive community treatment (ACT), peer support, and individual placement and support (IPS) supported employment. Each of these services are at different points of implementation, with IPS being the farthest along due to the jumpstart of a Dartmouth grant several years ago. IPS supported employment is available to adults with SMI in most CMHC service regions. However, it is not available in every county in Kentucky. Kentucky ACT services are in beginning stages of implementation and vary by region with regards to adherence to the ACT model. In addition, access to peer support services for adults with SMI has been progressively expanding, but the process of transformation of a service system has been slow.

To address some of the issues related to housing assistance, during SFY 2017, DBHDID made $500,000 of additional funding available, through a contract with Kentucky Housing Corporation (KHC), specifically for housing vouchers for individuals served through the Settlement Agreement.

KYSTARS used the findings from COSP fidelity reviews to design beneficial workshops at their annual conference for peers and providers in May of 2017. An entire conference track was dedicated to peers working in consumer run programs. KYSTARS will continue to work with these programs, offering fidelity reviews and training and technical assistance, via contracting with DBH.

DBH began participating in quarterly meetings with each of five (5) Managed Care Organizations (MCOs) during SFY 2017. These meetings provide an opportunity for dialogue and data sharing between DBHDID, Kentucky Department for Medicaid Services, and the MCOs, and are attended by the DBHDID Medical Director and Deputy Commissioner. A variety of topics, including authorization for services, are regularly discussed.

DBH continues work towards full implementation of community based evidence based practices in Kentucky. While DBHDID continues to work collaboratively with MCOs and Medicaid on many issues, including efficient reimbursement rates, other efforts for sustainability continue. Such as training for agencies who hire peer support specialists, specifically in how to recruit, retain and supervise these individuals. Most agencies have not traditionally hired peers in the behavioral health workplace, and training includes information about defining roles and incorporating the peer as a part of the continuum of care for individuals with SMI. DBH also continues to provide training and technical assistance around ACT, including guidance on team building and engagement. In the area of IPS supported employment, a structured team, led by

DBH but consisting of employees of two (2) state universities, supply fidelity assessments, training and coaching to providers of this service. Efforts towards all of these initiatives require collaborative efforts between multiple stakeholders.

DBH also has been working towards implementation of *Person Centered Recovery Planning* for all adults with SMI who receive behavioral health services at CMHCs. This initiative involves the best practices of shared decision making and person centered planning, in a stage wise format, along with the mechanics of adequate documentation of medical necessity.

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.
- KYSTARS FACIT review data
- University of Kentucky Human Development Institute (HDI) IPS site data
- Kentucky Institute for Excellence IPS Fidelity data
- Interim Settlement Agreement (signed August 2013)
- Amended Settlement Agreement (signed October 2015)

Early Serious Mental Illness

Prevalence Data for this population:

Unmet Needs and Critical Gaps:

Information gathered from the CMHCs during SFY 2018 planning processes indicate the following unmet needs and service gaps related to this population:

- Training and technical assistance on first episode of psychosis;
- Additional training for workforce on transition age issues in general;
- Expansion of youth, adult and family peer support programs;
- Housing, including emergency, permanent and transitional supportive housing;
- Employment and education supports, especially in rural areas;
- Communication and collaboration between child serving and adult serving systems of care; and
- Youth engagement and support services.

Addressing the Need:

DBH requires, via contract, each CMHC to assign at least one (1) key contact for youth or young adults experiencing their first episode of psychosis from the children's service system and at least one (1) key contact for youth or young adults experiencing their first episode of psychosis from the adult service system. This encourages collaborative between systems of care for this vulnerable population. In addition, the DBH has two (2) program administrators assigned to coordinate the statewide effort for this population, one (1) program administrator from the Children's service branch and one (1) program administrator from the Adult services branch.

These key contacts from across the state are targeted for training opportunities, technical assistance, funding opportunities, and other information regarding this target population. A

statewide education and technical assistance meeting, coordinated by DBH, is held two (2) times per year, targeted this workforce. This meeting provides an opportunity to education the workforce on issues related to early psychosis and assistance with coordinating evidence based services for this population.

For SFY 2016 and SFY 2017, DBH provided numerous training opportunities for providers across the state who serve this population. A learning collaborative for cognitive behavior therapy for psychosis (CBTp) began with a three (3) day training offered to clinicians from international and state experts in the field. This training was followed by a targeted supervisory training and technical assistance conference calls. The Early Assessment and Support Alliance (EASA), from Oregon, has provided consultation to Kentucky for this population since 2014. They have provided several overview trainings and several specific trainings related to evidence based services for this population such as Multi Family Group Therapy, Coordinated Specialty Care (CSC), and Feedback Informed Therapy. EASA provides a monthly consultation call to each site that provides CSC, as well as a monthly project management call for DBH. In addition, EASA has provided training opportunities for providers regarding differential diagnosis for this population.

Kentucky has made other training opportunities available that benefit this population including a Motivational Interviewing learning collaborative, Applied Suicide Intervention Skills Training (ASIST), Mental Health First Aid (MHFA) Youth and Adult, Assessing and Managing Suicide Risk (AMSR), Wellness Recovery Action Plan (WRAP), and person centered planning, as well as training in numerous screening and assessment tools.

Data Sources Used:
Kentucky Plan and Budget/CMHC Contract
Kentucky MIS Client/Event Data Set

Children with SED

Prevalence Data for this population:
Using 2010 census data and the state's agreed upon prevalence rate estimate of five (5) 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 Interagency Planning Councils. Kentucky Kids Count, the annual report distributed by Kentucky Youth Advocates is also helpful for program planning. (www.kyyouth.org.)

The following denotes the child population in Kentucky 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 SED Children Served SFY 2015 – 29,267 or 57% (of the 5% SED population)
Kentucky SED Children Served SFY 2016 – 26,925 or 53% (of the 5% SED population)

Regional Boards	Child Census 2010	Estimated Prevalence (5% of the Child Census)	Kentucky Children with SED Served in SFY 2015	Penetration Rate of Children with SED Served in SFY 2015	Kentucky Children with SED Served in SFY 2016	Penetration Rate of Children with SED Served in SFY 2016
Four Rivers	44,367	2,218	1,471	66%	1,460	66%
Pennyroyal	51,686	2,584	543	21%	413	16%
RiverValley	51,495	2,575	1,206	47%	1,278	50%
LifeSkills	66,964	3,348	1,072	32%	1,204	36%
Communicare	68,477	3,424	2,905	85%	2,462	72%
Centerstone	228,248	11,412	6,259	55%	5,634	49%
NorthKey	112,412	5,621	2,638	47%	2,542	45%
Comprehend	13,721	686	747	109%	642	94%
Pathways	48,935	2,447	2,268	93%	2,119	87%
Mountain	34,337	1,717	1,509	88%	1,780	104%
Kentucky River	25,212	1,261	1,243	99%	989	78%
Cumberland River	55,508	2,775	3,002	108%	2,916	105%
Adanta	47,054	2,353	1,503	64%	1,217	52%
Bluegrass	174,955	8,748	2,901	33%	2,269	26%
TOTAL	**1,023,371**	**51,169**	**29,267**	**57%**	**26,925**	**53%**

Unmet Needs and Critical Service Gaps:
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.

A Gap Analysis calculated by DBHDID based on 2010 Census numbers and utilizing certified 2016 KY MIS Client/Event data, approximately 53% of children with SED were served by Regional Boards and approximately 17% of them received targeted case management services. DBHDID believes that targeted case management services for this population are critical for ensuring that children and youth are able to remain in their own homes, schools and communities. Notably, there is a very large gap between the children with SED being served and those receiving targeted case management.

Addressing the Need:
DBH staff participated in quarterly meetings with each of five (5) Managed Care Organizations (MCOs) during SFY 2017 in an effort to increase dialogue and data sharing between DBHDID, DMS, and the MCOs. These meetings are attended by the DBHDID Medical Director and Deputy Commissioner, along with a number of program staff. A variety of topics, including authorization for services, delayed payment to providers and target populations are regularly discussed.

Data Sources Used:

- Kentucky MIS Client/Event Data Set
- Kentucky State Data Center www.ksdc.louisville.edu
- Kentucky Youth Advocates and the Kids Count Report www.kyyouth.org
- 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.

Co-occurring Disorders

Prevalence Data for this population:

During SFY 2016, 9,437 individuals over the age of eighteen and 599 under the age of eighteen, diagnosed with co-occurring mental health and substance use disorders were served by the Regional Boards. This number has increased over the last few years, due in part to the new Medicaid state plan amendment approved by CMS in January 2014 that included Medicaid reimbursement for substance use disorder treatment. 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 state general funds and other grants. Many individuals did not receive treatment/adequate length of treatment, and many were not diagnosed appropriately due to fear of not being reimbursed if substance use was mentioned in a medical record.

In addition, data gathered through quarterly Assertive Community Treatment (ACT) team leader meetings identified that many of the individuals served on these teams were diagnosed with serious mental illness as well as a substance use disorder. Reviews showed that few ACT staff had expertise in treating individuals with co-occurring disorders. Between SFY 2015 and SFY 2017, DBHDID contracted with Case Western Reserve University to provide training in Integrated Dual Diagnosis Treatment (IDDT), an evidence-based practice that has been renamed Integrated Treatment for Co-Occurring Disorders by SAMHSA, to staff working on ACT teams in Kentucky. Several ACT teams now employ additional therapists with substance use disorder expertise.

Children and youth identified substance use disorders and co-occurring mental health and substance use disorders are also more readily being identified and served since the Medicaid state plan was amended to include coverage for substance use. Kentucky has also been awarded several grants over the past decade to address adolescent substance use and co-occurring conditions.

Unmet Needs and Critical Service Gaps:

As a result of several years of fidelity assessments, utilizing the Dual Diagnosis Capability in Addiction Treatment (DDCAT) and Dual Diagnosis Capability in Mental Health Treatment (DDMHT) tools, it became clear that there was a gap in essential support groups for individuals with co-occurring disorders. These fidelity assessments occurred through a team of integration specialists developed by DBHDID, through work with a national consultant and a Transformation Transfer Initiative (TTI) grant. In addition, fidelity self-assessments were made a requirement for individual contracted agencies.

It also became apparent that Kentucky had workforce development needs for the behavioral health service system that provides services to individuals with co-occurring disorders. Both the service system traditionally serving adults with serious mental illness and children with severe emotional disturbances, as well as the service system traditionally serving those with substance use disorders, have gaps in skills related to training, technical assistance and coaching on integrated treatment. For example, ACT teams in Kentucky need to fully implement integrated principles of co-occurring disorder treatment into their service package. Individuals being served by ACT teams 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. There are a few intensive outpatient treatment programs for individuals with mental health disorders. However, it is unclear how either of these programs serves individuals who have co-occurring disorders. Either program, 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 and available across the behavioral health service system in Kentucky. More work needs to be done in this area to ensure proper training, adequate numbers of peer support specialists to work with all populations, and adequate support and supervision.

Addressing the Need:

To address the identified needs and gaps, Kentucky DBHDID has done, or is planning to do, the following:

- Contract with Case Western Reserve University to provide IDDT training to ACT teams in Kentucky;
- Work with peers in recovery, advocacy groups, and others across the state, to spread the development of Double Trouble in Recovery (DTR) support groups. DTR is an evidence based model for peer led group support for individuals with co-occurring mental health and substance use disorders. Peer support through mutual support and mutual aid groups is one of SAMHSA's ten (10) guiding principles of recovery. At present, the Veteran's Administration in Kentucky, and at least nine (9) regions provide DTR as a support for individuals. More DTR availability is occurring with continued support from DBHDID;
- Work with the Institute for Excellence, and others, to provide national consultants and a learning collaborative around Motivational Interviewing for all regional staff across the state;
- Provide workshops at Kentucky School for Alcohol and Other Drug Studies (which has traditionally been designed for substance use disorders only) that focus on co-occurring topics and integrated treatment;
- Include contract requirements for CMHCs to include hiring at least 2.0 FTE peer support specialists with lived experience in substance use disorders and/or co-occurring

disorders, and for agencies to provide fidelity self-assessments of co-occurring capability by utilizing the DDCAT/DDMHT tools;
- Include administrative staff in traditional "mental health" branches in DBH who have experience in administering substance use and co-occurring programs; and
- Restructure the plan and budget statutory process to include plans for all treatment, including integrated treatment.

Providers serving children and youth have received training and technical assistance from DBHDID to effectively screen, assess and provide treatment for youth with co-occurring mental health and substance use disorders. A number of evidence based programs have been implemented across the Commonwealth including the use of the GAIN, Sources of Strength and Seven Challenges. Enhancing the knowledge and skills of professionals serving youth in behavioral health settings as well as school, child welfare and juvenile justice has been a strong focus of DBHDID's efforts to address the increasing needs of children and youth with co-occurring disorders.

Data Sources Used:
- Kentucky MIS Client/Event Data Set
- DBHDID SFY 2017/2018 Plan and Budget Documents
- Institute of Pharmaceutical Outcomes and Policy (IPOP) Data
- DBHDID/CMHC SFY 2017/2018 contracts
- http://media.samhsa.gov/co-occurring/news-and-features/integrated-treatment.aspx (Toolkit for Integrated Treatment for Co-Occurring Disorders)
- https://www.centerforebp.case.edu/resources/tools/best-of-samhsa-resources-for-ddcat-and-ddcmht (DDCAT/DDMHT information)
- http://www.hazelden.org/web/go/dtr (Double Trouble in Recovery)
- http://www.samhsa.gov/recovery

Service Members, Veterans and their Families in Kentucky

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 of stakeholders for planning purposes, including Military leaders, the federal and state Departments of Veterans Affairs, statewide service organizations, higher education representatives, and the backing of military leadership.

Kentucky has a strong military history and presence. Approximately 7% of the 4.4 million Kentuckians are Veterans, compared to less than 1% that serve our military nationwide. According to the U.S. Department of Veterans Affairs (VA) 298,860 military Veterans reside in Kentucky, of which 24,084 are female and 274,776 are male.
As of July 2017, there were a total number of 24,084 women Veterans in Kentucky, which is slightly down by 409 from the 24,493 reported from the previous data in September 2014. Unfortunately, some women Veterans are not aggressive in seeking services, as some do not

consider themselves a “Veteran”. Hopefully, with the current awareness campaigns and events encouraging individuals with prior military service to register with the Veterans Administration, male and female Veterans will begin to receive the care they so richly deserve.

There are approximately 42,995 current military personnel, predominately Army (including the Reserve and National Guard), with two large army military instillations located within our borders - Ft. Campbell and Ft. Knox. Kentucky currently ranks twelfth highest among the fifty states with 34,595 active duty military personnel stationed in the Commonwealth, and sixteenth in the number of total military personnel (including civilian workers, reservists, and National Guard). Kentucky has the fourth highest number of active-duty Army personnel following Texas, Georgia and North Carolina.

The Kentucky National Guard is comprised of approximately 8,400 Soldiers and Airmen in the Army National Guard and the Air National Guard. The Kentucky National Guard has mobilized and deployed more than 16,000 Soldiers and Airmen in support of the Global War on Terror. More than two-thirds of those military connected individuals live within our communities and access community resources for behavioral health needs.

According to the most recent report from 2015, the Department of Veterans Affairs estimated that there are 103,073 Veteran households with children and youth (ages 0 to 18) residing in Kentucky. Military families and Veterans in Kentucky are recognized as underserved populations as it pertains to physical and behavioral health needs.

Service Members and 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 Hospital Administration (VHA). However, there are nineteen VHA Community Based Outpatient Clinics (CBOCs) in Kentucky that provide mental health services. These clinics suffer from workforce shortages at times. Service Members and Veterans in Kentucky are also seeking services at the Community Mental Health Centers (CMHCs) and private behavioral health providers in an effort to keep the diagnosis and treatment information out of their military records. 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. This is occurring, in part, because of the fear of stigma and the fear of hindering career advancement of the Service Member. Often the individual is paying out of pocket and in cash for confidentiality purposes.

Kentucky communities and behavioral health providers have recognized an increase in the number of Service Members returning from Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn with undiagnosed Traumatic Brain Injury (TBI) and Post Traumatic Stress Disorder (PTSD). As people become more aware of the resources, the assumption is that they will use the resources and get treatment. Resources can become more fragmented which can decrease the service quality. Without new funding, resources and additional behavioral health staff in place to assist the Service Members and Veterans as they return home, our Heroes and their families will suffer.

Prevalence Data for this Population:

- Approximately 7% of Kentucky’s 4.4 million residents have served in the military
- Kentucky currently has a Veteran population of 298,860 in 2016
- In the Commonwealth, there are:
    - 24,084 Female Veterans

- 274,776 Male Veterans
- 103,073 Veteran Households With Children
- 194,654 Veteran Households Without Children
- 34,595 Active Duty Military Personnel
- 8,400 Soldiers & Airmen in the Army National Guard & the Air National Guard
- 42,995 Total Military Personnel

Veteran and Active Duty Personnel Served by CMHCs by State Fiscal Year						
CMHC	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
01 - Four Rivers Behavioral Health	248	233	188	283	311	335
02 - Pennyroyal Regional Center	326	412	525	519	526	378
03 - River Valley Behavioral Health	86	104	82	69	58	51
04 - LifeSkills	280	103	188	212	125	159
05 - Communicare	155	159	144	323	353	272
06 - Centerstone	356	387	311	337	354	363
07 - NorthKey	210	179	158	194	225	194
08 - Comprehend, Inc.	106	133	166	125	108	116
10 - Pathways, Inc.	330	355	331	313	297	320
11 - Mountain Comprehensive Care	155	135	170	145	162	219
12 - Kentucky River Community Care	72	181	212	218	202	152
13 - Cumberland River	175	179	19	15	37	117
14 - Adanta	252	206	173	186	213	254
15 - Bluegrass	456	398	380	330	338	208
Total Unduplicated Count	3,189	3,148	3,032	3,250	3,288	3,098
Certified TEDS Data for SFY 2016						

Active Duty Personnel Served by CMHCs by State Fiscal Year						
CMHC	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**

01 - Four Rivers Behavioral Health	58	51	37	39	33	53
02 - Pennyroyal Regional Center	104	100	105	116	132	81
03 - River Valley Behavioral Health	47	54	30	35	32	29
04 - LifeSkills	255	42	78	88	49	42
05 - Communicare	14	18	15	85	97	80
06 - Centerstone	75	79	66	84	82	83
07 - NorthKey	56	53	44	41	47	48
08 - Comprehend, Inc.	47	52	47	39	46	42
10 - Pathways, Inc.	49	63	54	48	62	49
11 - Mountain Comprehensive Care	93	72	96	55	60	78
12 - Kentucky River Community Care	32	105	121	114	110	71
13 - Cumberland River	1	4	6	6	11	40
14 - Adanta	51	37	30	39	48	58
15 - Bluegrass	85	79	83	81	77	52
Total Unduplicated Count	964	808	811	870	886	806

Certified TEDS Data for SFY 2016

Veterans Served by CMHCs								
Center			**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
01 - Four Rivers Behavioral Health			192	183	151	247	278	286
02 - Pennyroyal Regional Center			223	316	421	407	395	298
03 - River Valley Behavioral Health			39	50	52	34	26	22
04 - LifeSkills			186	61	112	130	77	117
05 - Communicare			141	142	129	238	256	192
06 - Centerstone			287	319	250	259	282	280
07 - NorthKey			160	130	117	158	182	149
08 - Comprehend, Inc.			59	82	119	86	67	77
10 - Pathways, Inc.			283	292	279	265	236	271
11 - Mountain Comprehensive Care			63	64	74	91	102	141
12 - Kentucky River Community Care			40	76	91	105	92	81
13 - Cumberland River			174	175	13	9	26	78
14 - Adanta			204	172	143	149	168	197
15 - Bluegrass			373	328	301	262	265	156
Total Unduplicated Count			2,416	2,383	2,244	2,431	2,441	2,318
Certified TEDS Data for SFY 2016								

Unmet Needs/Critical Service Gaps:

- Increased access to effective Behavioral Health services for SMVF population
- Increase help-seeking behavior for SMVF population
- Reduce access to potentially lethal means for SMVF population
- Effective leadership, structure, and sustainability for SMVF service system

Addressing the Needs:

Military Behavioral Health Coordinators

In 2013, DBH inserted language into the Community Mental Health Center (CMHC) contracts that require 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 within their organization, they also 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+) dedicated members who are connected and committed to providing counseling, information, resources, and support to Service Members, Veterans and their Families.

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 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 addressed the following identified needs: Traumatic Brain Injuries (TBI), Post-Traumatic Stress Disorder (PTSD), suicide prevention, reintegration, family and caregiver support, available resources and benefits, transitioning to work and school, Polytrauma, polypharmacy, substance abuse prevention and treatment, and hearing loss and tinnitus from blast injuries. Normal attendance for this event is over 300 individuals.

The intent of future conferences will be to establish a core group of individuals within each region that would be lead or guided by the MBHC to bring about awareness and support systems unique to that region for Service Members, Veterans and their Families. 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-day training in military culture and issues unique to Service Members, Veterans and their Families. This training immerses Behavioral Health Providers and Professionals in aspects of military culture and the deployment experience. Attendees will sleep in barracks, participate in early morning physical training, chores and inspection, learn about military culture/structure, experience the Field Leadership Reaction Course, electronic combat simulators unique to the military, combat missions, enjoy MREs (Meal, Ready-to-Eat), 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, Comprehensive Soldier and Family Fitness (CSF2), Trauma Informed Care and current best practices to treat military clients and their families. Kentucky has held seven (7) 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. Three hundred and fifty-two (352) behavioral health professionals/providers have attended this hands-on event to learn about military culture and focus on how to help the SMVF population in Kentucky.

In the fall of 2015, Kentucky combined two (2) policy academy teams into one (1) unified team that refined goals with technical assistance from SAMHSAs SMVF Technical Assistance Center. The overarching goal of the unified team is to develop and implement a comprehensive statewide strategic plan serving the behavioral health needs of the SMVF population.

Addressing the Need:

1. Increased Access to Effective Behavioral Health Services

- Encourage help-seeking behavior by increasing access in utilization of available services by SMVFs.
- Continue to train, educate and develop the workforce of professionals/providers 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 clinical providers working in behavioral health. Prior to receiving the designation, providers will participate in Operation Immersion, complete web-based educational sessions, receive 2-day in-depth training in suicide prevention assessment, management, and treatment. Following designation, providers will be required to maintain designation through continued education opportunities, some of which will be provided through Operation Headed Home events. Designated providers will then be considered preferred providers for those in the SMVF population seeking behavioral health services.

Military Preferred Provider Designation Outline: Clinical Route Only

Component 1:

- Requires completion of 8 online modules and completion of Operation Immersion (OI)
- Online Modules to be completed within one year

Substance Use	Resiliency
Trauma-Informed Care – including Combat Stress and TBI	Military Families
Evidence-based Treatment Modalities	Sexual Trauma / Domestic Violence
Mental Illness – to include anger management, depression, anxiety, and suicide prevention	Help seeking and Stigma
Physical Wellness (Mind/Body Connection)	Faith-based / Spirituality
Military 101, perhaps in addition to the session provided at Operation Immersion	

*Developing in partnership with EKU, UK and the Adanta Group

*Utilizing current OI content and modules obtained through Defense Center of Excellence, National Council for Behavioral Health and the Center for Deployment Psychology

- **Operation Immersion** event consisting of military specific classroom and field trainings designed to offer providers an opportunity to experience a brief glimpse of what it takes to serve in the military with detailed insight into the SMVF population
  * Participants will receive an Associate Level Designation upon completion of OI
  *The individual has one year to complete this phase, either from beginning the online modules or completing Operation Immersion

Component 2:

Clinical Focus Tract
Completion of Assessing and Managing Suicide Risk (AMSR) / Collaborative Assessment and Management of Suicidality (CAMS) two-day training ***those who have taken the AMSR training with the past six (6) years will be grandfathered and will not need to repeat until required for licensure** ***Currently 34 AMSR trainers operating within Kentucky**
Participation in a learning collaborative process post AMSR/CAMS training to ensure fidelity of implementation

*Participants will receive Full Preferred Provider Status upon completion of Component II

* Assessment of Components I and II to occur every 3 years for the clinical tract, if not compliant with CEU requirements in Component III individual must recertify

- **Component 3**: *Can happen at any point along the continuum*
    - Continuing education – approximately 10 hours annually, can be concurrent with other license trainings
        - Will be offered through future **Operation Headed Home** conference (a conference designed to increase local and statewide networking and resources, as well as provide professionals with support and innovative practices to serve the SMVF population
        - Provide on-going Technical Support and linkage to resources
        - Learning collaborative process follows training process

Peer Support Phase / SMVF Targeted Case Management

- Peer Support specialists will be afforded opportunities to participate in non-clinical pathways to increasing connections with clinical provider. The Division of Behavioral Health has identified twenty (20) veterans 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 Specialists may have the opportunity to provide peer support at the fourteen (14) Community Mental Health Centers (CMHC) across Kentucky.

2. Increase Help-Seeking Behavior

- Provide Technical Assistance to CMHCs, Managed Care Organizations regarding TRICARE and encourage agencies to accept and work with TRICARE for the SMVF population in Kentucky
- Create and distribute marketing information linking SMVF population to services in their area, as well as state-wide services
- Increase help-seeking behavior by raising awareness of available resources and encouraging in utilization of said services by SMVF
- Expand the Provider Directory/Database for SMVF population
    - Kentucky has collaborated with United Way of the Bluegrass to add Military and Veteran resources to their toll-free 211 – telephone information system and website directory of services
    - Determine additional mechanisms to house the resource directory of available SMVF services
    - Investigate the cost of creating and maintaining a database/resource directory
    - Regional Prevention Centers have completed a survey of available resources for their respective region
- Review the 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 technical assistance from SMVF TA Center regarding evaluation and marketing

The DBHDID and the Kentucky National Guard are continuing to collaborate on ways 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.

3. Reduce Access to Lethal Means

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

Engage multiple entities including the Regional Prevention Centers within the CMHCs, 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/pilot projects 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
- Safety plan handouts provided 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; check with MBHCs to ensure that a clinical person is on hand to help with the warm hand off
- All materials and events should follow the safe messaging guidelines and Framework for Successful Messaging

4. Strengthen Leadership, Structure and Sustainability

- A comprehensive SMVF needs assessment will be conducted as part of the Zero Suicide Initiative.
  - Capture data to assist with decision making
    - Effective July 17, 2014, Gov. Beshear realigned the military behavioral health initiative to DBHDID, with continued input from Kentucky Department of Veterans Affairs (KDVA, Kentucky Department of Military Affairs (KDMA), Kentucky Commission on Military Affairs (KCMA) and Administrative Office of the Courts (AOC) at the discretion of the Cabinet for Health and Family Services.
  - Improvement in SMVF Data:
    - DBHDID's Data Information System Coordinator is working to identify the best 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 the SMVF clients and address their needs, especially for Veterans with less-than-honorable discharge.

Data Sources Used:

- U.S. Department of Veterans Affairs, Veteran Data
  https://www.va.gov/vetdata/Veteran_Population.asp
  https://www.va.gov/vetdata/stateSummaries.asp
  https://www.va.gov/vetdata/docs/QuickFacts/Veteran_Households_Children.xlsx
- The Kentucky Commission on Military Affairs
  https://kcma.ky.gov/Documents/Final%20Report.pdf
- Military Active-Duty Personnel, Civilians by State http://www.governing.com/gov-data/military-civilian-active-duty-employee-workforce-numbers-by-state.html
- DoD Personnel, Workforce Reports & Publications
  https://www.dmdc.osd.mil/appj/dwp/dwp_reports.jsp
- The Kentucky National http://kentuckyguard.dodlive.mil/about-us/

Substance Abuse Prevention

The Behavioral Health Prevention & Promotion Branch (Branch), within the Department for Behavioral Health, Developmental & Intellectual Disabilities (DBHDID) is responsible for the planning and implementation of data-driven, evidence-based strategies in Kentucky's 120 counties to reduce the use and misuse of substances by its citizens. The Branch uses SAMHSA's Strategic Prevention Framework (SPF) as its model for planning, implementing and evaluating the work occurring across the state. By using a comprehensive set of strategies that address all levels of the social ecology and provide strategies that approach prevention from the universal, selective and indicated Institute of Medicine (IOM) lenses, and using the six strategies required by the Center For Substance Abuse Policy (CSAP), the Branch works through its approved providers to change the community norms and improve the collective community knowledge regarding the impacts that substances have on a person's behavioral and physical health.

As part of the Branch's SPF process, the Branch utilizes the expertise and guidance provided by the State Epidemiological Outcomes Workgroup (SEOW) to drive much of its needs assessment process. The KY-SEOW, a creation of the Kentucky DBHDID, is housed and managed by REACH of Louisville. Since the inception in 2010, the SEOW has worked 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 serve to advise the DBHDID 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 are 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 date, and providing guidance for the development of state and community profiles. Four (4) subcommittees were recently formed: The Evidence-Based Practice Subcommittee, the Evaluation Subcommittee, the Youth Suicide Prevention Data Subcommittee and the Surveillance Subcommittee.

Current SEOW members are:

Steve Cambron	Division of Behavioral Health (DBH)
Phyllis Millspaugh	Branch Manager, Prevention & Promotion Branch, DBH
Van Ingram	Executive Director, Kentucky Office of Drug Control Policy
Teresa McGeeney	Epidemiologist, REACH of Louisville
Paul Vido	Director of Enforcement, Alcoholic Beverage Control (ABC)
Josh Crain	Assistant Director of Enforcement, ABC
Dr. Vestena Robbins	Executive Advisor, DBH
Dr. Ramona Stone	University of Kentucky
Monica Clouse	Child Fatality Review Team
Patti Clark	DBH
Lesa Vanderpool	DBH
Julie Parent	Suicide Treatment Enhancement Site Coordinator, DBH
Dave Hopkins	Program Manager, KY All-Schedule Prescription Electronic Reporting
Dana Quesinberry	Kentucky Injury Prevention and Research Center, Department of Public Health Policy and Program Evaluator
Genia McKee	Coordinator, KY Safe Communities, Kentucky Injury Prevention and Research Center
Dr. Michael Singleton	Senior Data Management Specialist, Kentucky Injury Prevention and Research Center
Dr. Sabrina Brown	Principal Investigator, Kentucky Violent Death Reporting System
Sarojini Kanotra,	Epidemiologist, Department for Public Health
Dr. Mark Wilson	Professor and Chair, Department of Health Promotion and Behavioral Sciences, School of Public Health, University of Louisville
Stephanie Bunge	School Health Consultant, Department of Education
Cathy Prothro	Suicide Prevention Enhancement Site Coordinator, DBH

Prevalence Data for Kentucky's Selected Substances:

SUBSTANCE 1: ALCOHOL

Despite the significant gains that the Kentucky prevention system has made in reducing underage drinking, (see graph below) alcohol remains the number one drug of choice by Kentucky's youth. The most recent Kentucky Incentives for Prevention (KIP) survey data (2016) reveals that 19.4% of 10th graders drank alcohol in the past 30 days, and of that number 15.2% also report have been drunk on at least one occasion in the past 30 days. This means that an alarming 67% of 10th graders who reported drinking in the past 30 days also have been intoxicated on at least one occasion within that same time frame. Furthermore, 10.4% of 10th graders have engaged in binge drinking (defined by SAMSHA as drinking five or more alcoholic

drinks on the same occasion) in the past 30 days. To put this number in perspective roughly, one out of every ten 10th graders surveyed, or 2,873 10th graders have engaged in binge drinking in the past 30 days. Even though Kentucky binge drinking data trends show positive outcomes (from 19.7% in 2004 to 10.4% in 2016) the number of Kentucky youth who engage in past 30-day drinking and binge drinking is still unacceptably high.

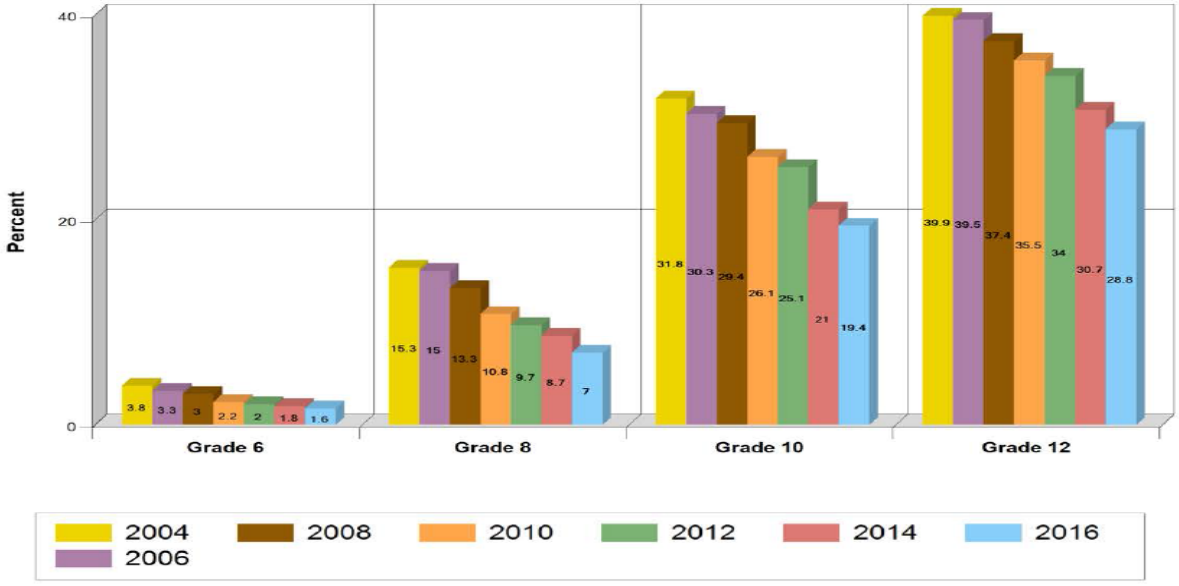
30 Day Alcohol Usage

Kentucky

Question 26b - On how many occasions (if any) have you had alcoholic beverages (beer, wine, or hard liquor) to drink - more than just a few sips - in the past 30 days?

Percent that answered at least 1 occasion

Grade	2004	2006	2008	2010	2012	2014	2016
6	3.8%	3.3%	3%	2.2%	2%	1.8%	1.6%
8	15.3%	15%	13.3%	10.8%	9.7%	8.7%	7%
10	31.8%	30.3%	29.4%	26.1%	25.1%	21%	19.4%
12	39.9%	39.5%	37.4%	35.5%	34%	30.7%	28.8%



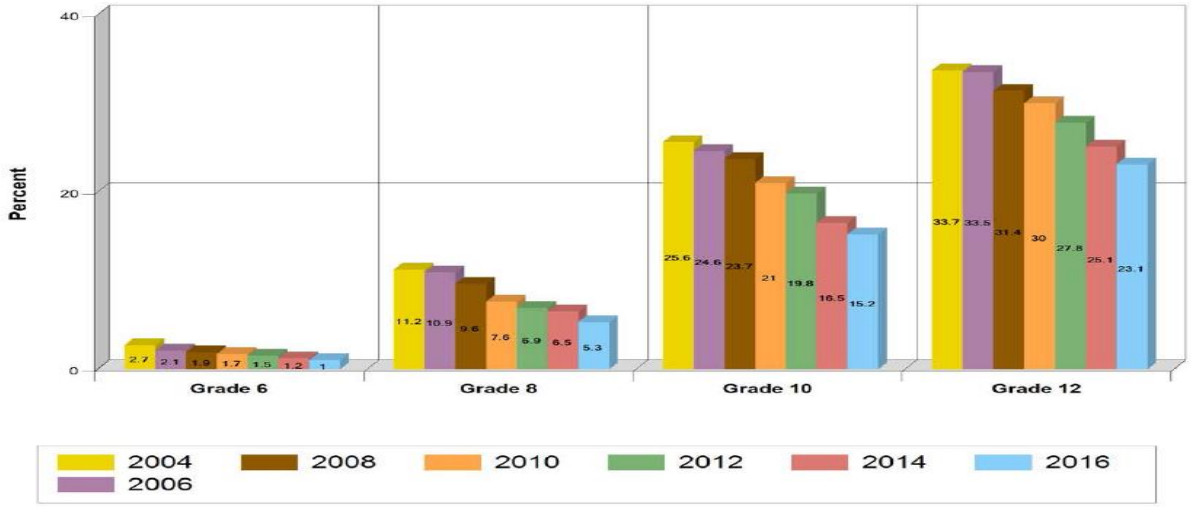
30 Day Drunkenness Frequency

Kentucky

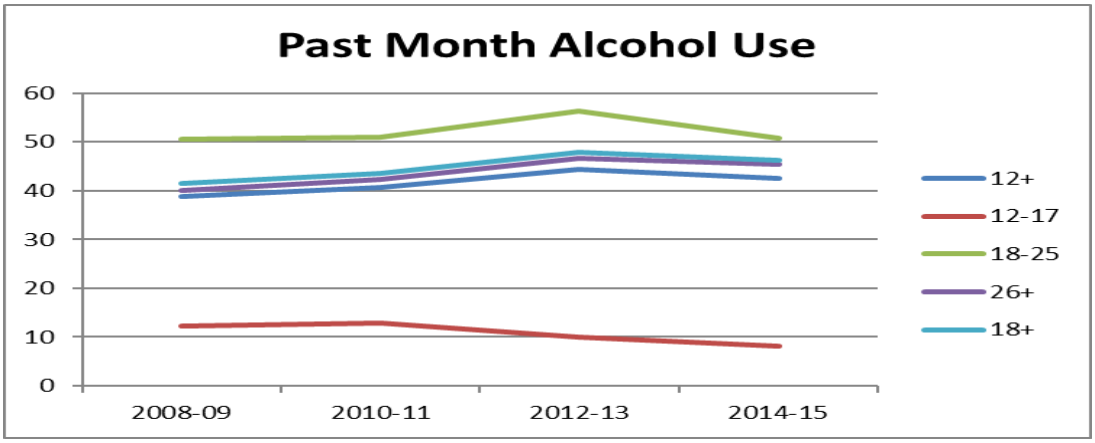
Question 27 - On how many occasions (if any) during the past 30 days have you been drunk or very high from drinking alcoholic beverages?

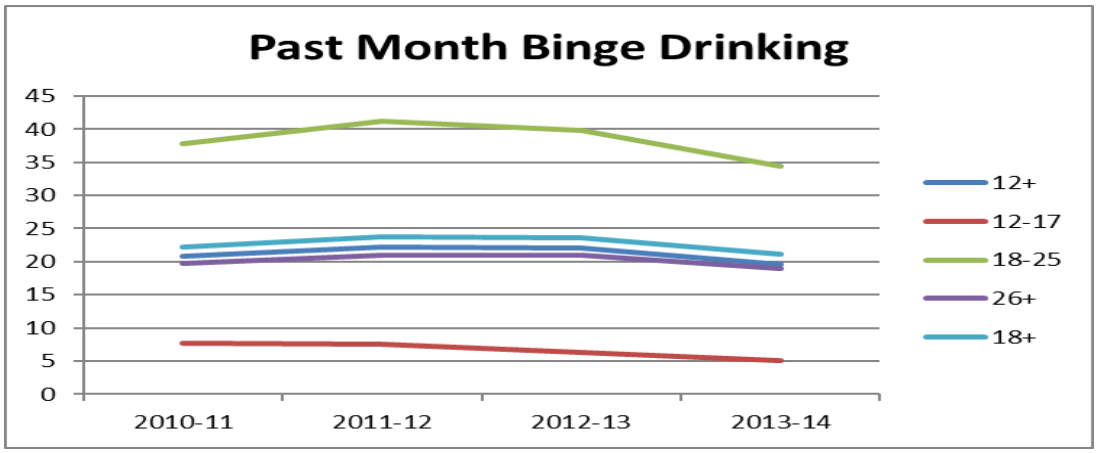
Percent that answered at least 1 occasion

Grade	2004	2006	2008	2010	2012	2014	2016
6	2.7%	2.1%	1.9%	1.7%	1.5%	1.2%	1%
8	11.2%	10.9%	9.6%	7.6%	6.9%	6.5%	5.3%
10	25.6%	24.6%	23.7%	21%	19.8%	16.5%	15.2%
12	33.7%	33.5%	31.4%	30%	27.8%	25.1%	23.1%



Adult binge drinking in Kentucky, while slightly below the national rate - 6.6% for Kentucky compared to 6.7% nationally, according to the National Survey on Drug Use and Health (NSDUH) - has seen less of a decline than youth drinking. Of all the age groups reported, alcohol consumption is highest among 18-25 year olds. According to the latest NSDUH past 30-day, drinking among this age group remains virtually unchanged. (50.64% in 2008-9 to 50.69% in 2014-15.) Past 30-day binge drinking has declined only slightly within that same period, from 37.9 to 34.2. (See graphs below.)





Binge drinking is responsible for 77% of the total excessive drinking costs in all states and responsible for a number of serious health problems including alcohol poisoning, fetal alcohol spectrum disorder, sexually transmitted disease and unintended pregnancy. Binge drinkers are 14 times more likely to report alcohol-impaired driving than non-binge drinkers, making them likely to cause driving-related injuries, which could result in mortalities.

SUBSTANCE 2: ILLICIT DRUGS

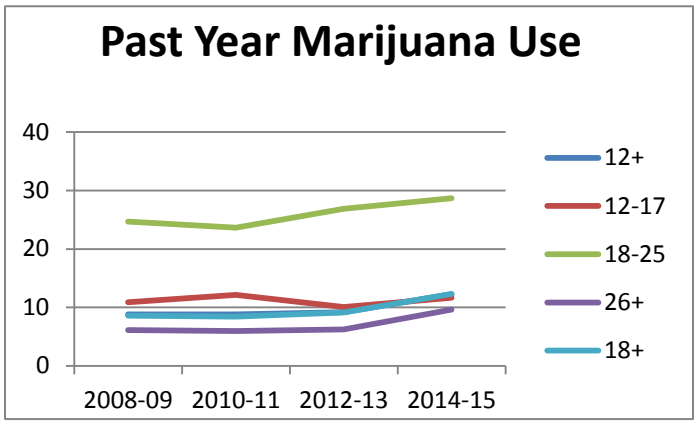
Illicit drug use has been identified as a significant issue in Kentucky, across the lifespan, but especially in the 18-25 age range. The Kentucky Incentives for Prevention (KIP) survey is administered on a biannual basis to 6th, 8th, 10th and 12th graders. Among those students, nearly 60% of 10th graders report that drug use is a problem in their school and about 40% of 10th and 12th graders report that dealing drugs is a problem at school. Identified illicit drug use of concern include opioids/heroin, marijuana, cocaine, methamphetamines, and opioids/heroin, including non-medical use of prescription drugs.

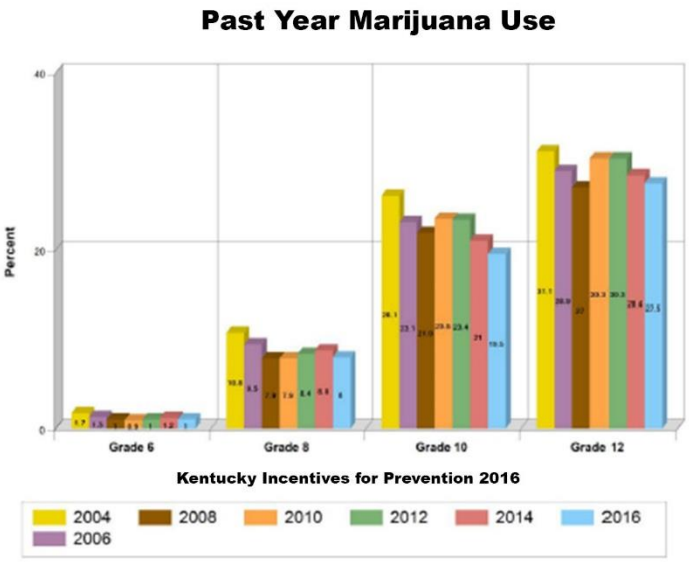
Marijuana

Marijuana remains the most widely used illegal substance by young people in Kentucky (KIP, 2016) despite the fact that 30-day use of marijuana by 10th grades is lower than the national rate for this age group and use among middle and high school students has been on the decline since 2010. Marijuana use among 10th graders has fluctuated on a national level over recent years. Since 2013, marijuana use among US 10th graders has steadily dropped. Kentucky mirrors these trends, and in recent years has fallen below the national average of marijuana use for 10th graders.

The Pennyroyal region had the highest rate of use among 10th graders with 14.7% reporting past 30-day marijuana use. The lowest rate in the state was among 10th graders in the Mountain region in Eastern Kentucky, where only 7% of 10th graders reported past 30-Day marijuana use.

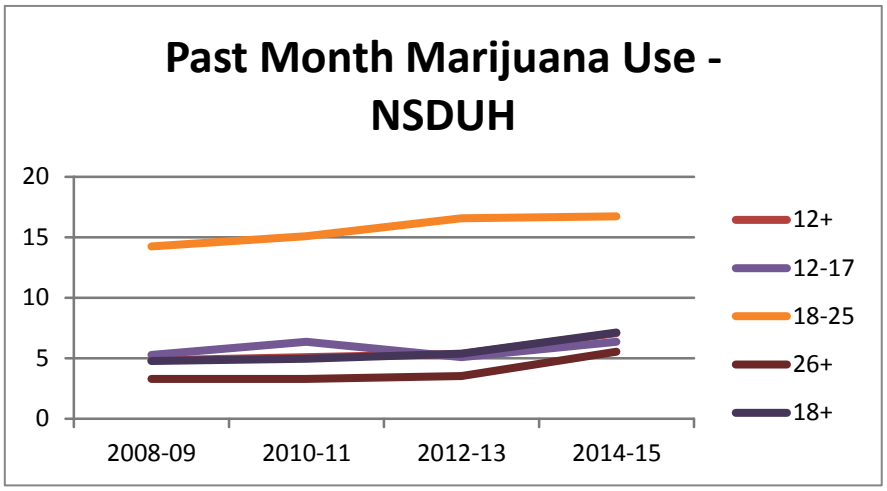
NSDUH Data 2008-2015





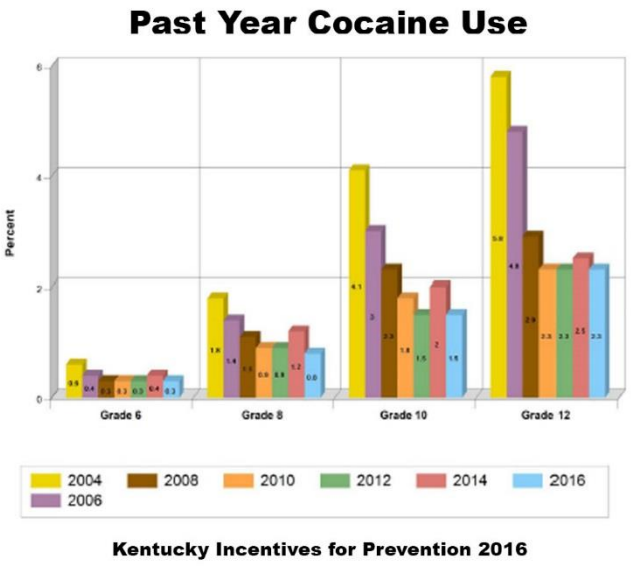
Past year marijuana use rates, as measured on the (KIP survey), steadily increase from 6th through 12th grades, with 1% of 6th graders reporting use within the last year compared to 27.5% of 12th graders. For this age group, however, use rates have been declining since 2010, falling from a high of 30.3%. Among 10th graders in Kentucky, 5.2% report they first smoked marijuana by the age of 12. Eighth-graders were nearly as high at 5%, followed by 12th graders at 4.6% and 6th graders at 1.4%. While the percentage of students reporting that access to marijuana has been decreasing since 2004, 60.3% of 12th graders and nearly 45% of 10th graders reported that it would be "sort of easy" or "very easy" for them to access the illicit substance. Personal disapproval of marijuana use decreases significantly from the 6th grader, where 97.1% of students said it was "wrong" or "very wrong" for someone to smoke marijuana to 12th graders where only 56.9% answered in the same manner. Additionally, personal disapproval ratings have been decreasing over the 10 years among 10th and 12th graders, indicating that they are perceiving it is less and less wrong for them smoke marijuana. Perception of parental disapproval of smoking marijuana has also been decreasing over the same time frame, although nearly 15% of 12th graders perceive their parents would not disapprove of marijuana use. However, this is down from a high of 7.3% of 12th graders in 2004 who said that their parents would not disapprove of marijuana use, an 8% decrease in the disapproval rating. Additionally, perception of peer disapproval of marijuana use has also decreased since 2012 (the first year the question was added to the KIP survey). The older the student the less peer disapproval they feel in regards to marijuana use. Between 2012 and 2016, peer disapproval for 6th graders was 96%. By the time those students got to 12th grade, the percentage who reported that their friends would say is was "wrong" or "very wrong" for them to smoke marijuana fell to 49.3%, a 48.6% decrease in disapproval rate from 6th to the 12th grade, reflecting the reports of increased use among 12th graders, compared to 6th graders. This number coincides with perception of peer use of marijuana, which ranges from 38.5% for 10th graders to 49.1% of 12th graders who report that at least one of their four best friends have used marijuana in the past year. While the percentage of 6th and 8th graders who report that their friends have used in the last year is much lower (3%, 18% respectively), the percentage of students perceiving that their friends are using has decreased over the last eight years. Just as disapproval ratings for marijuana use have fallen over the past decade so too have risk perception. Only 41% of 10th graders reported that the risk of harm was moderate or great if they tried marijuana once or twice, down from 43.9 in 2004. The perception of harm also decreases significantly from the 6th grade to the 12th. The perception of harm among 6th graders was nearly 70%, compared to less than 32% for 12th graders. And even when the amount of marijuana used increases to once or twice a week (compared to just trying marijuana once or twice in a lifetime), the percentage of 10th graders who perceived moderate or great risk was only 53%. The number was 10% lower for 12th graders at 43.1%, compared to 74.6% for 6th graders.

According to NSDUH data, past year marijuana use for all age groups is trending upward, with significant gaps between use rates of the 18-25 year olds and the rest of the population. For the 18-25 age range, NSDUH data shows that since 2010, the rate of past year marijuana use has climbed from a rate of 23.6 to 28.7. Data from the Treatment Episode Date Set (TEDS) shows that admissions for marijuana use increased between 2013 and 2015, climbing 14% in that time frame. Prevention efforts will focus on continuing the decrease of use among middle and high school students while also addressing the increasing use among 18-25 year olds, as well as increased consequences of use requiring hospitalization.

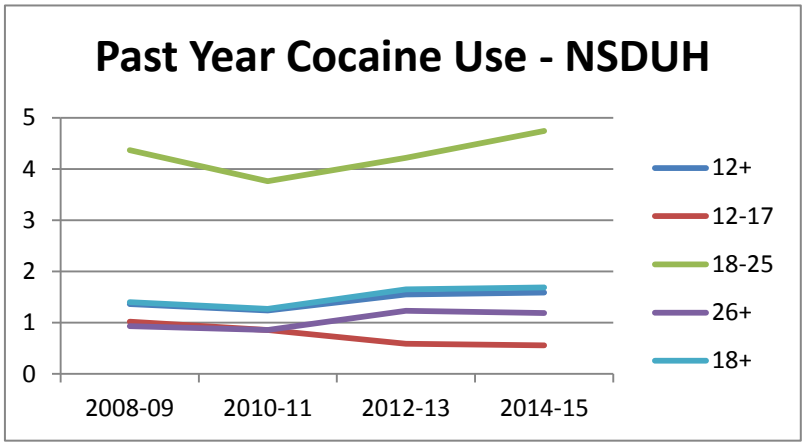


Cocaine

Similar to marijuana, cocaine use over the last 12 years has been steady/decreasing among middle and high school students, with a gradual increase by grade level as measured by the KIP. Among 18-25-year-olds, however, use has increased significantly since 2010. KIP data shows that about 2.3 percent of 12th graders report past year cocaine use. NSDUH data shows that 4.74% of 18-25 year olds reported cocaine use in 2015, with a significant uptick in usage from 3.76% in 2010. Personal disapproval of cocaine – i.e. the percentage of students answering "wrong" or "very wrong" to the question, "How wrong do you think it is for someone your age to use cocaine? Ranged from 93.9% for 12th graders to 98.4% to 6th graders. Percentage of parental disapproval to cocaine use ranged from 97.4% for 12th graders to 99% for 6th graders. Yet, nearly 8% of 12th graders said at least one of their four best friends had used cocaine in the last years. That percentage was 5.5 for 10th graders; 3.3 for 8th graders and 1.2 for 6th graders. Four Rivers region in far Western Kentucky had the highest rate of 10th graders reporting cocaine use (1.4%) while Kentucky River had the lowest at .1%. The overall 10th grade rate was .7%. The TEDS shows that admissions for cocaine use and medical consequences resulting from that use has remained steady over the last few years. Bridging the gap in prevention efforts for this young adult age group is imperative in decreasing the rate of cocaine use among 18-25 years. NSDUH data shows indicates that cocaine use has been

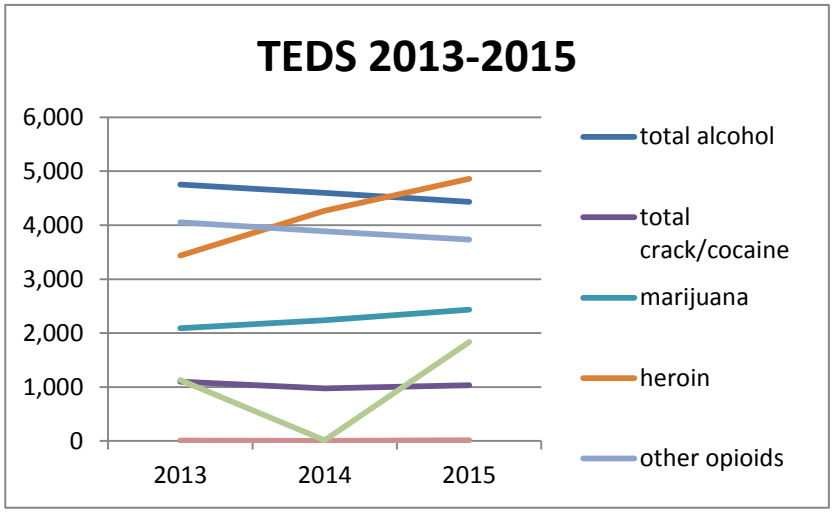


relatively steady across all age groups, except for those in the 18-25 year-olds range, where a 26% -increase in use has been noted since 2010.



Methamphetamines

TEDS data from 2013-2015 shows a significant increase in hospital admissions in Kentucky as a result of amphetamines, including methamphetamine. The increase mirrors the increase noted for heroin admissions as well. Among youth, methamphetamine use has remained steady since 2008 with an average of 1% of youth reporting past year methamphetamine use and about a half percent reporting 30-day use. Personal disapproval of methamphetamine use is high across the grades, ranging from 95.6% among seniors to 98.4% among sixth graders. Perception of parental disapproval of meth use is even higher, ranging from 97.6% for 12th graders to 99% of 6th graders. In comparison, 4.8% of 12th graders said at least one of their four best friends had used the illicit substance in the past year; 1% of 6th graders did. The Communicare and Pennyroyal regions in Western and west Central Kentucky have the highest rates of 10th grade methamphetamines use at .7% (compared with a statewide 10th-grade rate of .5%). The lowest rate was in the Northern Kentucky region with .3% of 10th graders reporting 30-day use. The Western Kentucky regions higher use rates coincide with anecdotal evidence from key stakeholders that methamphetamines are becoming an increasing problem in the region.



Opioids/Heroin/NMUPD

Substance abuse, particularly the diversion and abuse of prescription drugs along with heroin and illicit fentanyl, remains one of the most critical public health and safety issues facing Kentucky. Over the past decade, the number of Kentuckians who die from drug overdoses has steadily climbed to more than 1,400 (2016 overdose deaths) each year, exacting a devastating toll on families, communities, social services and economic stability and growth. Death numbers are expected to reach 1,600 or higher in 2017 based on the current trends, according to the

Kentucky Office of National Drug Control Policy (ODCP). The largest number of deaths related to opioids and heroin in Kentucky were among those ages 35-44, followed by those aged 45-54. Ninety-two youth under the age of 25 died by overdose.
According to 2016 findings in the Overdose Fatality Report released by the KY ODCP recently, heroin was present in approximately 34% of OD deaths in which autopsy and toxicology reports are available. This is up from 28% in 2015. Additionally, the report shows that fentanyl, either in combination with heroin or alone, was involved in 47 percent of overdose deaths, up from 34% in 2015. Heroin was present in 34% of all cases autopsied by the Kentucky Medical Examiner's Office in 2016. The top five counties for heroin-related overdose deaths were Jefferson, Fayette, Kenton, Campbell and Boone, representing the three largest urban areas in the state. These five also represented the top five counties for fentanyl-related deaths. The top five counties for overdose deaths per capita were Leslie, Bell, Powell, Gallatin and Campbell, all of which – except Campbell – are considered rural.

The prescription drug monitoring program in Kentucky is referred to as the Kentucky All Schedule Prescription Electronic Reporting (KASPER) system. In 2016, the total number of opioid and benzodiazepine prescriptions dispensed in Kentucky was 4,495,050 opioid prescriptions (101 prescriptions/100 persons), according to the 2017 Needs Assessment compiled for implementation of the Kentucky Opioid Response Effort. The highest numbers of opioids were dispensed in Jefferson, Fayette and Kenton counties, which corresponds with the highest number of OD deaths in the state. The counties with the highest opioid dispensing rates were Owsley, Floyd and Clay, all in the Eastern portion of the state. The Kentucky opioid overdose emergency department visit rate was 84.5 visits/100,000 population in year 2015. Individuals aged 25-34 comprised the largest percentage of individuals treated for opioid overdoses in Kentucky emergency departments (EDs) (38%), followed by those aged 35-44 (20%), and those under the age of 25 (19%). TEDS data shows a 29% increase in patients admitted as a result of the consequences of heroin use between 2013 and 2015. Admissions for other opioids decreased by 8.5% in the same time frame.

KIP results show that 2% of 10th graders report that they first used a prescription drug (such as OxyContin, Percocet, Vicodin, etc.) without a doctor's prescription before the age of 12. This rate has been steady for 10th and 12th graders since 2012 when the question was added to the KIP survey, but has increased significantly for 6th and 8th graders in that time frame, rising from 2% to 2.5% for 8th graders (25% increase) and from 1.3% to 1.8% for 6th graders (38% increase). Past year prescription drug use, as reported on the KIP has shown a steady decrease since 2004, dropping 65.6% among 10th graders, 65% among 12th graders, 63% among 8th graders and 58% among 6th graders since 2004. Thirty-day use of prescription drugs has similarly declined in that time frame, falling 72% among 10th graders, 71.5% among 12th graders, 66.6% among 6th graders and 64% among 8th graders. These declines speak to the significant prevention efforts that have been in place across the state over this time frame and serve as effectiveness indicators of strategies implemented to address the non-medical use of prescription drugs in that time frame. However, past-year and 30-day painkiller usage, specifically, OxyContin, Percocet, Vicodin and Codeine) has increased in the same time frame (see table for specifics). Additionally, 5.1% of 10th and 12th graders reported in 2016 they had taken any prescription drug as measured on at least one of the four prescription drug questions on the survey (answered "yes" to any four separate prescription drug questions).

Personal disapproval of prescription drug use without a doctor's prescription was high across the grades, with 97.1% of 6th graders and 91.3 of 12th graders reporting they felt it was "wrong" or "very wrong" to use prescription drugs without a doctor's orders. This rate has remained steady since 2012 when the question was added to the KIP survey. Perception of parental disapproval of prescription drug use without a doctor's prescription is similarly high with percentages ranging from 96.6% of 12th graders reporting they thought their parents felt it was "wrong" or "very wrong" for them to use prescription drugs without a doctor's prescription to 98.4% of 6th graders. Perception of peer disapproval was lower, however, with just 79% of 12th graders and 80.9% of 10th graders reporting they felt their friends would think it "wrong" or "very wrong" to use prescription drugs without a doctor's order. These rates, however, have remained consistent across the period, 2012-2016. The perception of peer use, however has decreased significantly since 2012, especially among 10th and 12th graders. The percentage of 10th graders reporting that they had at least one of their four best friends taking a prescription drug without specific direction from a doctor fell 35.9% between 2012 and 2016 and the percentage of 12th graders answering the same way dropped 40%. Risk perception increased among younger students but decreased among older students in the 2012-2016 time-frame. Sixth-graders reporting they felt that using a prescription drug without a doctor's orders was a "moderate" or "great risk" climbed 9.5% while the percentage of 8th graders answering similarly increased .8%. Conversely, the percentage of 10th and 12th graders who reported moderate or great risk fell 3.8% and 4.5% respectively.

Percentage of Change in Painkiller Usage 2004-2016		
Grade Level	**% of change Past Year Painkiller Usage 2004-2016**	**% of change 30 Day Painkiller Usage 2004-2016**
6th	475%	300%
8th	155%	190%
10th	45%	54.5%
12th	38.7%	50%

Students were first asked about their heroin usage in 2014 with 1% of 12th graders reporting they had used heroin in the past year. That percentage fell to .6% in 2016. The same percentage of 10th graders reported use in 2016, down from the 2014 percentage of .9. Thirty-day heroin usage is even lower with .4% of 12th graders, .3% of 10th graders, and .2% of 8th and 6th graders reporting heroin use, representing just 328 students across the entire state of Kentucky. Risk perception regarding heroin use has remained relatively steady across the grade levels between 2014 and 2016, with between 77.2% (6th graders) and 83.8% (12th) reporting moderate or great risk in using heroin.

Unmet Service Needs and Critical Gaps:

ALCOHOL

A long recognized critical gap of Kentucky's prevention system is collecting local data on adult drinking trends and delivering prevention services to this population. The NSDUH data cited above only applies to the state. Since Kentucky has no local, or even regional data, it is difficult from an epidemiological standpoint to identify areas of the state where the need for alcohol prevention services are greatest.

SUBSTANCE 2: ILLICIT DRUGS

The needs assessment process conducted for this application indicates that a focus on addressing illicit drug use, especially among 18-25-year-olds, is imperative if the state is to reduce the impacts of this drug use among its residents. Even with limited data available for this age group, it is evident that there is increasing risk and use leading to more severe

consequences, including death, in subsequent age groups. Prevention efforts should begin with middle and high school students, since there is a general trend of increased use and decreased perception of risk as students get older, leading to an even greater increase when those students graduate and transition into college or work life in their young adult years. Illicit substances of focus identified in the assessment include opioids/heroin/non-medical use of prescriptions drugs (since a significant percentage of the prescription drugs abused are opioids), marijuana, methamphetamine, and cocaine. These illicit drug categories have increasing use with age, increasing hospital admissions, increasing long-term consequences as a result of use, and decreasing risk factors, including perception of harm. In addition to focusing prevention efforts on those in the 18-25 year age group, strategies will also be targeted to those geographic hotspots with the greatest use. This will vary by substance used and prevention efforts will need to be tailored to the specific circumstances occurring at the community level that supports use of the illicit drug.

Marijuana prevention efforts will focus on increasing the perception of risk of use as well as decreasing the perceived access of the drug. Additional focuses will be on decreasing early initiation of use, increasing peer and parental disapproval, and reducing use consequences that lead to hospitalization. Efforts focused on **cocaine** must address the significant increase of use by those in the 18-25-age-group and should include decreasing the perception of peer use among middle and high schools as well as finding additional ways to measure the impact of use in the young adult group. Prevention strategies focused on **methamphetamine** use must first more thoroughly assess the areas in the state that are anecdotally reporting an increase in use as evidenced by the increased consequences of use. Youth use for this substance is low, but young adult use represents a significant increase. And prevention efforts to address Kentucky's **opioid** crisis will be multi-pronged and collaborative in nature, leveraging all available resources in order to continue to assess the hot spots and target prevention capacities in those areas – either geographically or among target populations, such as pregnant and parenting women, those who are military-connected, and those in the middle years. Prevention efforts will be coupled with treatment and recovery efforts in order to reduce use and consequences of use and reduce deaths.

Workforce Issues are also identified as a significant gap in Kentucky. During SFY 2016 and SFY 2017, significant time and effort was poured into building the providers' (RPC) capacity regarding operationalizing the SPF in their communities. The Branch pushed out extensive technical assistance and CAPT was heavily used to increase the knowledge and skills related to the shared risk and protective factors that underlie substance use behaviors. During this period, the Branch was understaffed and a high degree of turnover began to occur with the provider network. The Branch being hiring personnel to address the capacity gaps that were becoming evident. The providers, however, were rapidly shrinking in numbers. Five (5) of the fourteen (14) providers lost their director. All fourteen (14) lost prevention staff, particularly staff who were certified prevention specialists. Three 93) of the newly hired directors had little to no prevention background; most directors hired as replacements were from the treatment side of the continuum. While there are some advantages to hiring a leader with a treatment perspective, it has caused a ripple among the network as it worried that prevention was losing its focus and drifting toward treatment. This hiring trend highlights a bigger systemic issue with the providers that Kentucky uses. The role played by Regional Prevention Centers within their host agency (CMHC) also reflects the mission drift discussed. RPCs live with a host agency (CMHC) that is required to be the behavioral health planning authority for their region. The business model used involves the necessity of bringing revenue into the host agency with its services. Treatment services are billable to various payers. Prevention services, with few exceptions, do not generate revenue with their host agency. This sets the RPCs apart from their CMHC

colleagues even further than the dichotomy between treatment and prevention creates. RPCs are faced with the pressure to prove themselves as useful, necessary and effective. These pressures result in small budgets, a culture of mistrust and a sense of fight or flight with the RPC staff. Unable to succinctly articulate the role that prevention plays within their host agency, RPCs report feeling isolated within their corporate structure. Part of the technical assistance targeted over the next two (2) years involves some marketing and promotion building training and support as the RPCs and all the prevention partner's work to create a consistent message of the work being done.

Addressing the Need:

To address underage drinking and binge drinking, each Regional Prevention Center will each have an underage drinking component in the annual work plan submitted to the Branch. Addressing critical gaps within the18-25 year-olds population in Kentucky is a challenge. Kentucky proposes to engage the SEOW to analyze existing county level data sources (admissions for alcohol treatment, DUI arrests, alcohol related traffic accidents and fatalities, rates of cirrhosis and other alcohol related health problems) to identify critical areas of need. This needs assessment will serve as the basis for future planning efforts to address alcohol use with the targeted adult population.

In order to address the substance use issues identified through prevalence and incidence data, as well as risk factors for substance use, Kentucky's prevention efforts over the next two years will focus on increasing capacity with a special emphasis on increasing the numbers and experience of the prevention workforce. Kentucky will focus on increasing skills and abilities of the workforce to understand and effectively intervene at the community level. Kentucky plans on increasing surveillance opportunities related to the identified substances of focus, especially as they affect the 18-25-year-old population in the state. Kentucky is creating a strategic plan to ensure a comprehensive delivery of interventions across the lifespan utilizing a mix of the six (6) CSAP strategies at all levels of the socio-ecological construct. Kentucky's prevention system has experienced a significant turnover in experienced leadership and field staff, necessitating additional training and technical assistance to increase the capacity of current staff, and recruitment of trained and trainable providers to fill vacant positions. Community-level needs assessments will be conducted across the state in order to fine-tune the delivery of prevention efforts to maximize resources and additional surveillance opportunities – especially focused on the 18-25-year-old population – will be identified or developed, allowing for a better understanding of the issues affecting the population which in turn lead to substance use and misuse. From these assessments, state and community level strategic plans will be developed which will guide efforts and ensure implementation drift does not occur, but rather focus interventions where most needed and where most opportunity for community-level behavior change exists. Addressing the capacity of the prevention system will allow for an intentional focus on prevention of the use and consequences of the illicit substances identified.

The Branch is continually providing technical assistance to the RPCs regarding timely and accurate data entry. In combination with the failure to accurately connect the data to problem statements, the PDS itself may be a barrier. Staff do work with the providers to problem solve the barriers they experience regarding accurate data entry into Kentucky's system and the Branch feels it can and will improve the issues by working through the SPF to craft effective work plans for community implementation. The programming issues and lack of a more user friendly platform for data input will be evaluated to determine if Kentucky's system can be improved or whether a new, proven data system can be acquired. The issues related to RPC identity and prevention messaging are larger, systemic issues that will have to be addressed in a progressive, consistent manner. While additional training and technical assistance will be

offered, the strategic planning process mentioned throughout this document will also be used to create a concrete set of steps to move the system toward full integration within its host agency's own set of priorities.

Data Sources Used:

- **Kentucky Incentives for Prevention (KIP) 2016** - Since 1999, the KIP Survey has been administered in Kentucky through the Substance Abuse Prevention Program in the Cabinet for Health and Family Services, through agreements with individual school districts across the state. The intent of the survey is to anonymously assess student use of alcohol, tobacco, and other drugs (ATOD), as well as a number of factors related to potential substance abuse (e.g., peer influences, perception of risk, school safety). The survey is now conducted bi-annually in the fall in even-numbered years (2014, 2016, etc.), with 6th, 8th, 10th, and 12th graders attending school in Kentucky communities. In 2016 the total sample size for 6th, 8th, 10th, and 12th grades was 111,700. The sample includes schools from 113 out of 120 Kentucky counties, and 149 out of 173 public school districts.
- **Treatment Episode Data Set (TEDS) 2013-2015** – The Treatment Episode Data Set is a national census data system of annual admissions to substance abuse treatment facilities. TEDS provides annual data on the number and characteristics of persons admitted to public and private substance abuse treatment programs that receive public funding. TEDS consists of data reported to state substance abuse agencies by the treatment programs, which in turn report to SAMHSA.
- **National Survey on Drug Use and Health (NSDUH)** - The National Survey on Drug Use and Health is an annual nationwide survey involving interviews with approximately 70,000 randomly selected individuals aged 12 and older. The Substance Abuse and Mental Health Services Administration (SAMHSA), which funds NSDUH, is an agency in the U.S. Department of Health and Human Services (DHHS). Data from the NSDUH provide national and state-level estimates on the use of tobacco products, alcohol, illicit drugs (including non-medical use of prescription drugs) and mental health in the United States. In keeping with past studies, these data continue to provide the drug prevention, treatment, and research communities with current, relevant information on the status of the nation's drug usage.
- **Kentucky Overdose Fatality Report 2016** – The Kentucky Overdose Fatality Report 2016 is compiled by Kentucky's Office of National Drug Control Policy and focuses on the impact of opioids on Kentucky's population. The report describes the numbers of opioid overdoses in the state as well as identifies demographic and geographic hotspots, to inform policy makes and prevention, treatment and recovery professionals in addressing the substance use issues affecting Kentucky's residents. The report utilizes information from the Kentucky Medical Examiners report, Kentucky Office of Vital Statistics, as well as other key data sources related to opioid consequences in the state.
- **Kentucky Opioid Response Effort (KORE) Needs Assessment** – The KORE Needs Assessment report was compiled in 2017 in response to the state's receipt of funding to address the opioid crisis in Kentucky. The assessment utilizes a number of key data sources, including the National Violent Death Reporting System, Kentucky Injury Prevention Research Center data collection, to outline the demographic and geographic populations of focus toward which grant efforts will be targeted. The needs assessment

provides a comprehensive narrative of opioid overdoses and their impact on the state's population.

- **Prevention Data System (PDS) –** Kentucky currently has its own data collection system that its providers are required to use. Regional Prevention Centers create data drive work plans that address the substances being used in their regions. They prioritize by substance and develop plans that encompass all levels of the social ecology, employ the six strategies endorsed by the Center for Substance Abuse Prevention and implement their strategies through universal, selective and indicated methodologies. It is through the PDS that the Branch is able to evaluate the work being done in each region and identify the impact and outcome results occurring at the community level. Through these data collection efforts, the Branch began identifying the gaps related to Kentucky's prevention workforce. With dedicated staff now available to mine the PDS, bad, missing and incomplete data rose to the top of the capacity concerns. Identified as problematic: data interpretation errors leading to poor problem statements and logic models, problem statements that did not match the needs assessment data, poor interpretation of PDS data points, gaps in data submission and inconsistency in coding. The PDS itself creates a gap in the system, as the RPCs report finding it difficult to navigate and somewhat counterintuitive. Visually is it not helping the RPCs connect their needs assessment to their logic models and work plans. While the Branch now has someone dedicated to the PDS, the structure and programming of the system is not within staff control. Changes are continually suggested, made and tested, but these efforts have not improved the gaps related to data entry.

Substance Abuse Treatment

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

Kentucky implemented the Affordable Care Act and expanded Medicaid coverage in 2014 to a larger population. Most critical to this population is the ACA parity requirement that ensures substance use disorder (SUD) 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 Community Mental Health Centers (CMHC) screen for substance use disorder at initial contact and provide care within twenty-four (24) hours or if no such facility has the capacity to admit the woman, interim services will be made available 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.

Kentucky has eleven (11) substance use programs designed specifically for pregnant women that receive public funding.

1. **KY-Moms: Maternal Assistance Towards Recovery (MATR)** prevention and case management program provides universal, selective, and indicated prevention education services, as well as identifies, assesses, and links pregnant and postpartum women to substance use and/or mental health treatment, recovery supports, and other community resources**.** Engaging women in intensive pregnancy case management provides an

opportunity to increase readiness for treatment. Evidence Based Practices (EBP) used include Screening, Brief Intervention, Referral and Treatment (SBIRT), Motivational Interviewing, Prime for Life (PRI) and Contingency Management program. KY-Moms MATR 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. KY-Moms MATR 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 substance use treatment, recovery supports and other community resources**.**

3. **PRIDE Program** provides prevention, case management and referral for treatment services for pregnant and parenting women in Lexington/Fayette County.

4. **Independence House** provides long term residential substance use treatment, intensive outpatient, medication-assisted treatment, and targeted case management services for women during pregnancy and post-partum. Located in Southeastern Kentucky, it serves women from all over the state and allows newborns to reside with mothers during treatment.

5. **Chrysalis House** is a residential and transitional housing treatment program 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 receiving treatment. Chrysalis House partners with the UK Polk Dalton clinic to provide obstetrics services, medication assisted treatment and healthcare referrals for pediatric services at UK hospital.

6. **Freedom House** provides a holistic and comprehensive program that is designed to treat the women's substance use disorder. Their program includes residential, transitional housing, intensive outpatient and medication-assisted treatment for pregnant and parenting women. The program accommodates infants and other children to reside with the mother during treatment.

7. **Serenity House:** Serenity House is an eight (8) bed residential treatment program for pregnant and parenting women with substance use disorders. Residents can stay at Serenity House up to nine (9) months during pregnancy and up to six (6) post-partum with their infant. Residents of Serenity House receive counseling for Substance Use Disorder (SUD) and co-occurring mental health disorders, Trauma informed programing, Parenting, Peer Support Services, Targeted Case Management, Hazelden Betty-Ford Comprehensive Opioid Response and 12 Step facilitation and self-help groups, and other supportive services. Residents obtain prenatal care and Medication Assisted Treatment (MAT) through partnerships with local providers as an essential part of their comprehensive treatment for opioid dependency. Serenity House offers an array of services that promote maternal bonding, recovery, health and wellness of both the mother and the infant.

8. **Centerstone:** Centerstone located in the Metro Louisville area operates The Women's Renaissance Center (WRC) in Shelbyville. This facility is a non-profit residential facility (8 bed) that provides comprehensive services to pregnant and parenting women and their children. WRC provides a multitude of services including medication assisted therapy,

trauma informed care, and parent-child interactional therapy as well as safe housing, food, and support in order to promote stability and safety during pregnancy and post-partum period of time. Their goal is to provide a warm, nurturing environment for at-risk women with a substance use disorder. Services include mental health, addiction treatment, life skills and parenting skills for a healthy safe pregnancy for mother and child. Centerstone also operates an Intensive Outpatient program for pregnant and parenting women, along with transitional housing and supportive services.

9. **Medication Assisted Treatment-Prescription Drug and Opioid Abuse: MAT-PDOA SMARTS – Supporting Mothers to Achieve Recovery through Treatment and Services (SMARTS):** The purpose of this grant is to expand treatment services and to increase capacity for evidence-based medication assisted treatment (MAT) and other recovery support services to pregnant and postpartum women with opioid use disorders through a partnership with two Community Mental Health Centers. Creating a new system of care with evidence-based, comprehensive, integrated, community coordinated service delivery elements for pregnant and parenting women up to 2 years post birth with opioid use disorder that addresses current service deficits and includes access to MAT; includes Hazelden Betty Ford Foundation's Comprehensive Opioid Response – Twelve Steps (COR-12) approach; and includes wrap-around services to assist these clients with meeting medical, social, childcare, housing, educational, and vocational needs that typically serve as barriers to treatment and recovery. Promoting community partnerships by facilitating meetings and work sessions to examine how to best provide these comprehensive services, promote community education, and maximize efficient use of resources. Providing extensive training and workforce development opportunities for both the medical and behavioral health workforce.

10. **ODCP Expansion Grants**:
    a. Transitions, Inc. provides residential treatment to pregnant and parenting women. The Women's Residential Addiction Program (WRAP) allows children (ages 12 and under) to accompany them to the facility. A comprehensive array of services are provided to residents in the WRAP program, these include; Medication Assisted Treatment through partnerships, healthcare referrals, transportation, Targeted Case Management, therapies, transitional housing, rental assistance, recovery supports and Individual Placement Supports (IPS) Supported Employment.
    b. LifeSkills, Inc. Park Place Recovery Center for Women is a 16 bed residential facility specifically designed for pregnant and parenting women struggling with SUD. Infants are kept with their mothers to promote bonding and attachment. Comprehensive services are provided for the family, including family therapy, help groups, trauma services, Person Centered treatment planning, group work and aftercare services. Medication assisted treatment is also included. Transitional services are provided to assist the family.
    c. St. Elizabeth Healthcare: The Baby Steps program helps navigate pregnant and parenting woman through the clinical process, access treatment and counseling, and referrals to social services where needed. The program provides woman with a point of contact for care prenatally and postnatal. The staff meets individually with clients to assess needs and assist in the navigation of services. Services are provided for a minimum of 12 months postnatal. The program objectives include increasing access to healthcare and social services through the guidance of the program staff, and providing treatment and counseling options prenatally, during delivery and postnatal for pregnant and parenting women with OUD.

d. Communicare: The Passages Eastern Care program is a recovery residence and intensive outpatient program for pregnant, post-partum and parenting women with opioid use disorder. Services include Medication Assisted treatment, individual and group therapy, peer support, case management and other comprehensive services to assist mothers and their families in recovery.
e. Kentucky River: Hollyberry House operates as transitional living apartments with intensive treatment options that provide 24-hour supports with parenting, addiction recovery, counseling for trauma or other co-occurring issues, and options for long-term linkage into effective recovery models, as well as support from early childhood specialty programs for NAS, would offer a holistic program that is sustainable with available resources. Hollyberry House is a Modified Treatment Community approach designed to assist pregnant and parenting women with substance use problems, and who lack the necessary support systems in their community to sustain recovery. Residents are able to have 2 preschool children stay with them in an effort to support the family unit and to assist the resident in caring for her children while sustaining recovery.

11. **Plan of Safe Care Initiative:** Kentucky is piloting a project to create a model of Plan of Safe Care that is multi-disciplinary and intended to support the mother and infant during the critical period after discharge from the hospital. It identifies services and supports that will be provided to the mother and infant and delineates who is responsible for ensuring that the mother enrolls in those services and supports. The plan recognizes the important role of trauma and adverse childhood experiences in this population. Stabilizing the mother in the post-partum period, providing ongoing supports for positive parenting and safe home environment for the infant, creates opportunities to reduce adverse childhood experiences for the infant, thereby improving long term outcomes for both, and reducing the risk of repeating the cycle of substance abuse as the infants grow into their teenage years.

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/transitional living programs and eighty-eight (88) intensive outpatient programs available (including private providers) that serve pregnant women. Twelve (12) of the residential treatment programs/transitional living programs that accept pregnant women, allow the woman's dependent children to live on-site with her during treatment.

The Pathways program at Polk Dalton Clinic in Lexington, KY (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. 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 (21) Narcotic Treatment Programs/Opioid Treatment Programs that accept pregnant women, along with approximately 726 Buprenorphine DATA 2000 waivered 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 2015 grant (PFS 2015), Kentucky All Schedule Prescription Electronic Reporting (KASPER) system, enactment of House Bill 1(HB1) and Senate Bill 192 (SB192), Medicaid expansion, Regional Prevention Centers (RPCs), KY Health Now, 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.

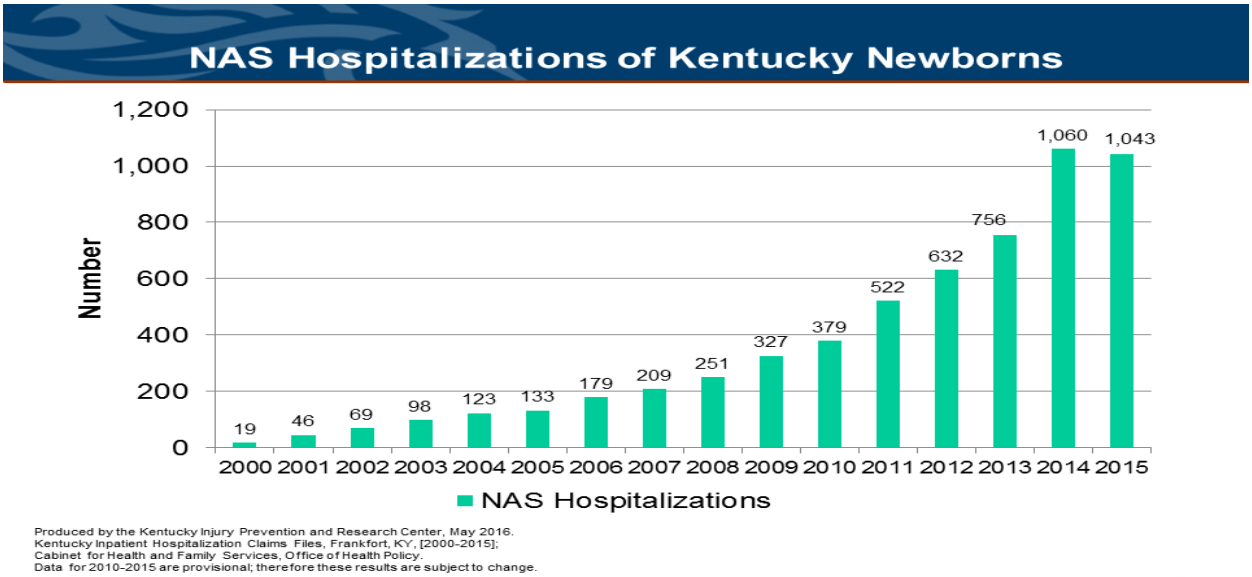
Multiple trainings have been hosted around the state providing hundreds of behavioral health professionals, health care professionals; community based service providers, and other community agencies with specific training and information on opioid use disorder, neonatal-abstinence syndrome (NAS), trauma, American Society of Addiction Medicine (ASAM), Motivational Interviewing (MI) and other Evidence-Based Practices. In an effort to address NAS, KY Department of Behavioral Health, Developmental and Intellectual Disabilities has worked in collaboration with the following agencies and organizations; the Kentucky Perinatal Association, Norton Healthcare, the University of Louisville, the University of Kentucky Division of Neonatology, and the Kentucky Chapter of ACOG.

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 inhance 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.

- Despite recent increase in the availability of services for pregnant and parenting women, the opioid epidemic has placed a burden on KY's system of care. There is a continued need to increase and improve services for this population.
- Kentucky lacks statewide criteria for screening pregnant women for substance use. As a result, many women are not being identified and/or referred to treatment. Early identification and treatment of pregnant women who use substances can reduce the risks of exposure to drugs and alcohol, including Fetal Alcohol Disorder and NAS. 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 Neonatal Abstinence Syndrome (NAS) and screen infants appropriately.
- There continues a need to reduce stigma associated with pregnant women and substance use disorder. In an effort to reduce stigma, ongoing training and education to professionals and community partners is needed.
- From 2000 to 2015, 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 nineteen (19) NAS babies hospitalized in the state, by 2015, 1043 babies were reported hospitalized with NAS.



- 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.

Addressing the Need:

- 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; prevention, outpatient, residential services, case management, peer support, 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 safe sleep practices and reduction 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.
- Enhance KY-Moms: Maternal Assistance Towards Recovery prevention and case management services, focusing on the use of Evidence Based Practices and Evidence Informed Practices, 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.
- 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.
- Continue to collaborate with community partners on a statewide Plan of Safe Care protocol.

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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.

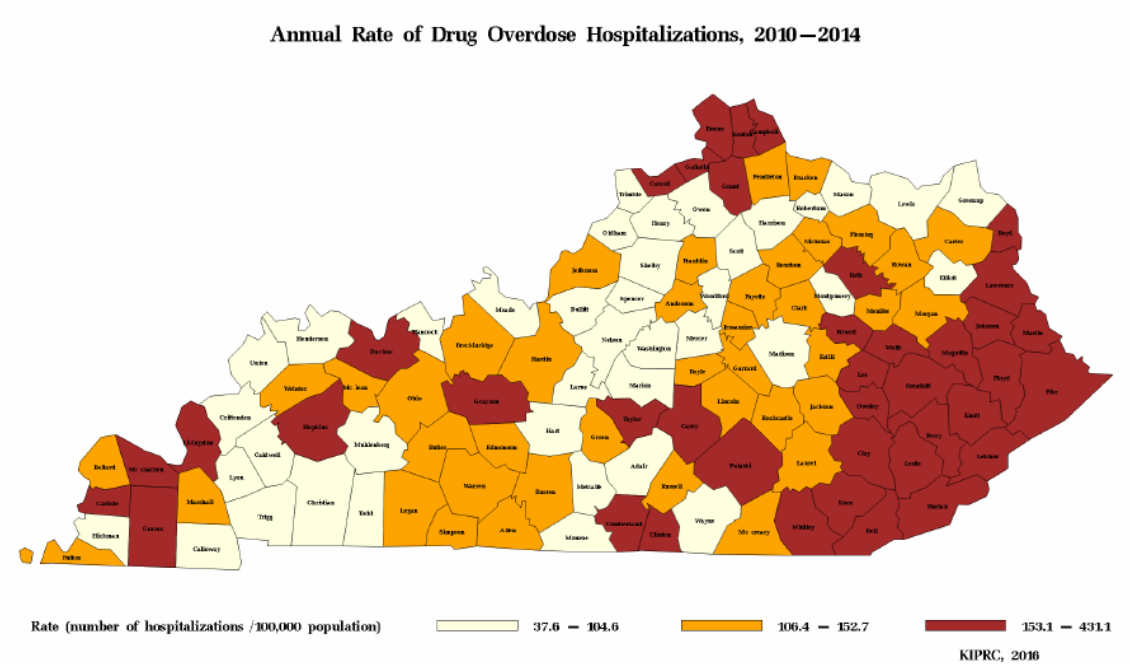
With the rise of opioid addiction, there has been an increase in reporting of substance exposed infants with significant increase in infants identified with NAS as a result of opioid use during pregnancy. Front line DCBS staff struggle with how to best work with this population of families, considering the sharp increase of opioid 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 rats 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).

- More than nine 10 people who used heroin also used at least one other drug (CDC Vital Signs)
- Among new heroin users, approximately three out of four report having abused prescription opioids prior to using heroin.
- 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 14th consecutive year (CDC press release)*

- Heroin overdose deaths in Kentucky increased by 124% from 2012 to 2015
- Kentucky's rates of drug overdose deaths increased by 32% from 2012 to 2016 (2016 ODCP Report)
- Kentucky ranks 2nd in the nation at 29.9 drug overdose deaths per 100,000 (2015) (CDC)
- Since 2008, more Kentuckians have died from drug overdoses than motor vehicle accidents
- Females remained at higher risk for drug overdose hospitalizations (148.6/100,000) compared with males (108.4/100,000) in 2014.



DBHDID participated in the SAMHSA Policy Academy in 2014 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.

As a result of the work associated with the Policy Academy, KY applied for and was awarded the SAMHSA Medication Assisted Treatment-Prescription Drug and Opioid Abuse: MAT-PDOA SMARTS Grant. With this grant, KY expanded treatment services and increased capacity for evidence-based medication assisted treatment (MAT) and other recovery support services to pregnant and postpartum women with opioid use disorders, through a partnership with two Community Mental Health Centers. Expansion of SMARTS will be implemented in three additional CMHC regions.

Kentucky has expanded Medicaid coverage to a larger population. 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 the mother to receive SUD treatment services, but the whole family is now able to receive services to treat and heal the whole family.

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:

- Need for additional treatment programs that incorporate services for families with children.
- Increased need for support services specific to families with children including; childcare, supported housing, supported employment, peer support, transportation, and life skills.
- Enhance communication and collaboration between DCBS, CMHCs and other community partners.
- More training and supervision toward workforce development in EBP is needed to ensure the provision of appropriate treatment particularly for individuals with opioid use disorders.
- Integration with primary care providers to identify, refer, and follow-up individuals at risk, including pregnant women.

Addressing the Need:

- Enhance the use of EBP across the system of care.
- Integrate substance use disorder and mental health services with primary care services.
- Continue to provide training and encourage the use of Person-Centered Recovery planning.
- Increase and enhance Recovery Support services.
- Expand the availability of after care and follow up services.
- Increase awareness of the availability of services and enhance the referral network.
- Encourage and facilitate collaboration among community partners.
- Increase Universal Screening by medical providers and other referring community partners using SBIRT Principles
- Continue to enhance the current system of care.
- Enhance childcare and transportation services to increase accessibility
- Create a web-based treatment locator program
- Provide education on substance use during pregnancy, NAS, Plans of Safe Care, and medication-assisted treatment.
- Include injury prevention education and strategies as part of SUD treatment and NAS discharge to prevent injuries and fatalities to infants.
- Continue to provide technical assistance to support the 2018/2019 priorities.

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 Adolesce Med, 1995. (149(4): 386-92.
- http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6417a2.htm?s_cid=mm6417a2_w
- http://www.cdc.gov/nchhstp/stateprofiles/pdf/Kentucky_profile.pdf
- https://www.cdc.gov/drugoverdose/data/statedeaths.html
- http://www.mc.uky.edu/kiprc/programs/kdopp/reports/Drug-Overdose-Hospitalizations-2000-2014.pdf

Persons who are Intravenous Drug Users (IDU)

Prevalence Data:

Reports of injection drug use are rising among individuals in the state substance abuse treatment sample. However, according to the CDC the Appalachian regions of the state are experiencing lower opioid injection drug use but a higher rate of other opioid use. 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 use disorder in the Community Mental Health Centers (CMHCs) during SFY 2014, 4,335, or 23%, reported having used IV drugs.

Kentucky has seen an increase in individuals seeking service at CMHCs who have a diagnosis associated with opioid use disorder. Between 2012 and 2015 there was a 23% increase and a 12% increase from 2012– 2016.

Overall, between 2012 and 2016 there were a total of 41,373 individuals identified who sought addiction treatment in Kentucky and had a history of intravenous drug use. Between 2012 and 2016, Kentucky experienced an increase in this population of 50.6%. This data only includes individuals who sought services at the CMHC's.

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 14th consecutive year (CDC press release).

- Kentucky's number of drug overdose deaths increased by 32% from 2012 to 2016.
- Approximately 34% of overdose deaths involved the use of heroin in 2016, up from 28% in 2015.
- Kentucky ranks 2nd in the nation at 29.9 drugs overdose deaths per 100,000 (2015)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 more than 50% from 2014 to 2015.
- In 2014, Kentucky had the nation's highest rate of acute hepatitis C

HIV

- Kentucky has relatively low rates of HIV/AIDS, but a much higher rate of Hepatitis C. Approximately 9% of all new HIV infections occur among injection drug users,
- Of the 220 counties across the US identified as highly vulnerable to an HIV outbreak, 54 are in KY.

Kentucky currently has twenty-two (22) licensed Narcotic Treatment Programs (NTP), two (2) publicly funded and twenty (20) independently owned that provide Medication Assisted Treatment (MAT) that use Methadone in combination with Behavioral Health to treat Opioid Use

Disorder (OUD) Six of the independently owned NTPs have obtained licensure to bill Medicaid for Behavioral Health services associated with Methadone treatment. Kentucky regulates and monitors its NTPs more stringently than many states, and as a result, the programs provide good quality care, both medical and psychosocial.

Over the past three (3) years, MAT services have become widely available across the state. All fourteen CHMC Regions currently provide access to MAT services either directly or through MOA with community partners. DBHDID contract with CMHC requires them to inform clients with OUD that MAT services are available and to make referrals as available.

Unmet Needs and Critical Service Gaps:

- Although MAT services are more widely available, there are still many programs that are abstinence only and do no offer a continuum of services.

- With the significant increase in individuals experiencing overdose due to Opioid use there is a need to provide immediate intervention that connects the client to SUD services. There is currently no systematic or widespread process to establish the link between overdose medical services and treatment.

- Although there has been a significant increase in the availability of services to address OUD treatment needs across the state, the dramatic increase in opioid use, including intravenous heroin use, has put a strain on the existing service network.

- With the expansion of Medicaid, more individuals who previously were unable to afford services now have coverage and can access services from a variety of providers. However, Kentucky remains a mostly rural and mountainous state, with many of the services clustered in the urban and more populated areas. Access to services for many in the state remains difficult due to poverty, transportation and location of services.

- Data collection for services continues to be incomplete. DBHDID has traditionally collected data from the CMHC client/event data set and Medicaid collects data for services covered under that program. However, for programs that only accept private pay or are covered under private insurance, DBHDID does not have access to that information.

Addressing the Need:

- Continue to ensure that all CMHCs screen for IV drug use on initial contact and refer clients for appropriate services.
- Increase the availability of peer support services with Specialized training in opioid use disorder (OUD) state wide
- Increase availability of Needle Exchange programs
- Provide peer support and referral services to Needle Exchange programs to link individuals to treatment
- Develop referral protocols and model programs for clients who present with overdose to emergency rooms
- Increase the availability of Evidence Based OUD services including MAT.

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
- Kentucky Injury Prevention and Research Center.
- 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
- http://www.mc.uky.edu/kiprc/

Individuals with Tuberculosis

Prevalence Rate:

Kentucky continues to show a declining rate of TB, as reported by the Kentucky Department for Public Health (DPH). A total of sixty-seven (67) cases of TB were reported for 2015, which is a rate of 1.5 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.

Unmet Needs and Critical Service Gaps:

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.

Addressing the Need:

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 Community Mental Health Centers (CMHC) and annually at the licensed Opioid Treatment

Programs (OTP). Review teams, which include a peer reviewer from the field, examine client service records for documentation of a referral for TB screening, 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 use treatment staff and that continuing education is provided offering the most current information on infectious diseases.

***Data Sources Used**:*

- Kentucky Department for Public Heath, http://chfs.ky.gov/NR/rdonlyres/620D69CA-AB10-4D36-8453-BCC771165F4A/0/2015CaseRatesByCountyFINAL.pdf

Persons with or at risk for HIV/AIDS and who are in treatment for substance abuse

Prevalence Data:

According to the Kentucky HIV/AIDS Surveillance Report dated 06/30/2016, there were 351 new HIV infections diagnosed among Kentucky residents in calendar year 2014, a diagnosis rate of 8.0 per 100,000 people. This is comparatively lower than the US estimated rate of 13.8 per 100,000 for 2014. Cumulatively, 94 pediatric cases of HIV disease have been diagnosed in Kentucky since 1982, with only two (2) pediatric HIV diagnoses in 2016.

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.

Unmet Needs and Critical Gaps:

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/AID 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.

Addressing the Need:

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 use prevention and treatment professionals along with continuing education focused 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.

***Data Sources Used**:*

- Department for Public Health, http://chfs.ky.gov/NR/rdonlyres/DCA0FF73-C42B-41FD-AC90-733939C239FD/0/AnnualReport_2016.pdf

Adolescents with Substance Use Disorders or Co-occurring Substance Use and Mental Health Disorders

Prevalence Data/Unmet Needs and Service Gaps:
Some Kentucky specific data reveals:

- Approximately 21.5% of Kentucky high school 11th grade students are current smokers. (YRBS, 2014)
- Among youth, 23.1% of Kentucky 11th graders report drinking 5 or more drinks in the past month. (YRBS 2014).
- Among those 18 and older, Kentucky reports 17% using marijuana and 7% any illicit drug use other than marijuana. (KIP, 2013-14). Among youth, 21% of Kentucky 10th graders report using alcohol in the past month compared to 23.5% nationally (KIP, 2014; MTF, 2015).
- 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).
- Kentucky's percentage of nonmedical use of pain relievers among adolescents aged 12–17 was similar to the national percentage in 2013–2014. with approximately 4.3% reporting use compared to 4.7% nationally (NSDUH, 2013-14).
- In Kentucky, among individuals aged 12 or older with illicit drug dependence or abuse, about 17,000 individuals (18.1%) per year from 2010 to 2014 received treatment for their illicit drug use within the year prior to being surveyed.

It is important to note that 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. (KIPRC 2016). It is also important to note that Kentucky has earmarked some of the Kentucky Opioid Response Effort (KORE) funding

toward transition age youth and adolescent funding. This is indicative of transformation in thinking and leadership support for adolescent treatment services in the state.

Results of the 2010-11 National Survey on Drug Use and Health (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.

Table 1: 2010-2011 National Survey on Drug Use and Health - Kentucky		
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 past year	30	36
Serious thoughts of suicide in the past year	Not reported	30

The Kentucky Youth Treatment 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 Kentucky Incentives for Prevention (KIP, 2014) survey, 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)

Kentucky has worked diligently over the past two decades to provide a more comprehensive array of behavioral health services for children and youth that adhere to the system of care values and principles. However, attention to the needs of adolescents and young adults with substance use and co-occurring disorders has become more apparent of late. Through the efforts of a Children's Mental Health Initiative (CMHI) aimed at co-occurring disorders, implementation of the Reclaiming Futures model in two communities, the State Adolescent Coordination grant, and the Substance Abuse Treatment Enhancement and Dissemination (SAT-ED) cooperative agreement, Kentucky has incrementally built an infrastructure to support the population of focus. DBH has a full-time staff member that serves as the Adolescent Treatment/Youth Coordinator. This position has been instrumental in facilitating infrastructure and service delivery efforts aimed at the population of focus.

Identified barriers in Kentucky to improving adolescent substance use services traditionally 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 use disorder services that would allow youth to obtain substance use 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 approval by CMS, there was also the opening of the Medicaid behavioral health provider network that made available a wider variety of geographically accessible treatment options.

With the benefit of the SAMHSA SAT-ED grant and an 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), Global Appraisal of Individual Needs (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 (PRTF) 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 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.

Currently Kentucky is a recipient of a follow up grant to the SAT-ED, the State Youth Treatment Implementation grant, (SYT-I). With that grant, Kentucky will expand access to developmentally appropriate, evidence based assessment, treatment, and recovery support services for adolescents and transition-age youth. More specifically, Kentucky proposes to expend funds for infrastructure improvement and direct treatment to improve access to high quality services that will improve outcomes for adolescents and transition-age youth (ages 12-25) who have substance use disorders and/or co-occurring substance use and mental health disorders and their families/primary caregivers.

Addressing the Need:

Through training and collaborative efforts with agencies across the commonwealth, many providers and social service agencies are now screening and assessing for youth substance use issues. However, the method of screening is not standardized across the state. Continued work is needed to encourage use of an evidence based screening and assessment tool for initial screening/assessment process (i.e. GAIN Family of instruments), with a standard way to screen and communicate results across agencies including schools and in our transitional age population, including our military families and young adults.

Kentucky has been able to address and support evidence based treatment and assessment however, the need to continue the use of these with fidelity continues to be a struggle, especially due to staff movement and turnover rate. Moreover, there is a tendency to for staff to be trained but not continue the use of the practices or use with fidelity to the model. Kentucky is working to continue to support infrastructure in using evidence based treatment and assessment by offering trainings in evidence based practices that have components of both coaching and fidelity as well as train the trainer options so that the infrastructure maintains its strength. Kentucky will 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 for child/adolescent mental health providers as well as for substance abuse providers who treat adolescents.

Through blended funding, we will also continue to support the infrastructure concerning building the policy and practices that are best suited for adolescent and young adult treatment. By better understanding the needs of the state through utilizing mapping of services and finances, funding can be restructured to offer more treatment and aftercare specifically geared toward adolescents and transitional age youth in need of behavioral health services and to identify service gaps and offer ideas to expand the continuum of services and supports.

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.

- 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. (2013-2014). Kentucky Incentives for Prevention (KIP) Survey. Louisville, KY.
- 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
- Monitoring the Future, 2015 https://www.drugabuse.gov/related-topics/trends-statistics/monitoring-future/monitoring-future-survey-overview-findings-2015
- Kentucky Injury Prevention and Research Center (KIPRC, 2016) : https://odcp.ky.gov/Documents/2015%20KY%20ODCP%20Overdose%20Fatality%20Report%20Final.pdf

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.

Footnotes:

Quality and Data Collection Readiness

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 contracted providers serving individuals in the community and in the state-owned and state-operated facilities., The community-based data and facility data share common data elements thus serve the BHDID on project-based analyses.

Community-Based Data
The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (BHDID) monthly collects data 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 MH-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.

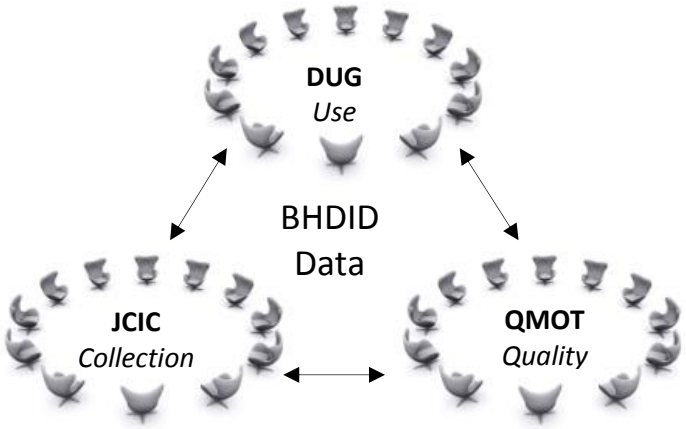
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

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.

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 is challenged by collecting justice involvement data which, beyond the self-report data that we collect, requires data-sharing memorandum of agreements with other state agencies. Such agreements are difficult to maintain due to inconsistent political climate which determines whether the agreements can be established. A second area of challenge for our state is the collection of school attendance data. The difficulty exists since such data is maintained at the local school / county, data quality among Kentucky's 120 counties appears to be inconsistent, and aggregated data is not readily available from the state-level Department for Education.

Our state hosts three data-related standing teams that involve state and community partners. Each committee has a key role in defining data elements, processes to ensure accurate, complete and timely data collection and defining indicators measures of quality. Contributions from all three teams often leads to successful implementation of data collection, issue resolution, and measure development.



The Data Users Group (DUG) is the team provides recommendations and direction for the collection, analysis, architectural design & structure, use of data and information relevant to desired outcomes management across the Department. The Team evaluates data and issues related to data collection, data analysis, data quality, data architecture and structure that support the provision of quality services and explores areas for improvement.

Recommendations by the Quality Management & Outcomes Team (QMOT) 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. The team evaluates outcomes that support the provision of quality services and explores areas for improvement.

The Joint Committee for Information Continuity (JCIC) is the team makes recommendations concerning information management to the Department. The committee facilitates the development of data-related contract items between the Department and CMHCs. As a central function, the committee provides direction and assistance in the continued development an information system to manage a public behavioral health system.

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 clarity the draft measures. It would be helpful to have a technical assistance webinar that reviews details of each measure and clearly explains SAMHSA's established expectations

which often seem vague (e.g., when will states be required to report CLD data in a TEDS-like methodology?). Also, it would be helpful to hear from our federal partners about any expected changes in structure or organization of SAMHSA data contractors to whom states directly send data. We request that SAMHSA regularly keep states updated on any possible changes to these contractors and perhaps include states experiences (feedback) on how well they work before making changes.

Specifically regarding the justice-involvement measure, the current political environment appears to allow formal agreements of sharing data with justice-serving state agencies. During this window of opportunity, the BHDID is attempting to establish data-sharing processes that can be maintained regardless of political climate. Specifically, the BHDID is attempting to attain data on arrests associated with the 202A evaluation for mental illness.

Specifically regarding the school attendance measure, the BHDID currently has no plan to change the method of current data-collection nor to add a new methodology to collect data directly from the Department of Education. Current collection includes 1) the BHDID maintains a self-report school-attendance data field in the Community Mental Health Center data set and 2) a set of evaluation data collected within a program that serves a sub-group of youth having Severe Emotional Disorder who receive higher intensity level of care. With awareness of the issue, the BHDID will continue to watch for windows of opportunity as they arise.

Please indicate areas of technical assistance needed related to this section. Please answer the questions as it relates to the state's ability to collect client level data. If technical assistance is needed in this area, please identify so.

First, convening states together via webinars, conference calls, or in-person meetings has proven a powerfully effective way to resolve data-collection and data-reporting issues. Facilitated meetings among states on specific issues shared by all allows states to share solutions and achieve confirmation of some problems inherent to the data required by federal partners. Having those discussions facilitated by the federal partner opens up understanding of barriers to reporting the required data.

Secondly, in our state, the BHDID receives data directly from fourteen Community Mental Health Centers (CMHC) by way of contract requirement. Each CMHC operates as a quasi-governmental agency so they contract with various data-management vendors and electronic medical record vendors. The primary authority needed to ensure quality of data collected and timeliness of issue resolution rests between the CMHCs and their vendors; so the State has little control if vendors are unable to resolve data reporting issues for the CMHCs with whom they contract. The fact that vendors often do not highly prioritize state data reporting remains an ongoing issue. It would be helpful to learn from SAMHSA or other states ideas on how this issue can be successfully resolved. Further in the larger picture, states and federal agencies are affected by the lack of data quality accountability within private agencies; particularly those agencies that become electronic health vendors for community providers thus indirectly responsible for reporting to state agencies. It would be helpful if federal partners that require state data reporting would advocate for regulating data quality that holds accountable private electronic health record vendors working with state behavioral health data. Often the lack of quality control on private electronic health record vendors becomes the barrier to data quality for the community partner, the state and thus the federal partner.

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 number of Adults with SMI, served by 14 CMHCs, who receive peer support services by 1% from SFY 2017 to SFY 2019.

Strategies to attain the objective:

CMHCs are required by contract to employ Adult Peer Support Specialists to serve Adults with SMI.
Continue to provide training and technical assistance to ensure that CMHCs understand how to recruit, retain and support peer support specialists in the workplace and how to appropriately document and bill for services.
Continue to provide awareness activities and training regarding Recovery principles and guidance on the process of fully including peer specialists in the service delivery array.
Continue to provide training and technical assistance regarding the supervision of peer specialists.
Technical assistance to CMHCs regarding accurate coding procedures for reporting peer support services in client/event data set.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Peer Support Services for Adults with SMI

Baseline Measurement: Total unduplicated number of Adults with SMI who received peer support services, from the 14 CMHCs in SFY 2017.

First-year target/outcome measurement: Increase by .50% the total unduplicated number of Adults with SMI who receive peer support services, from the 14 CMHCs, during SFY 2018.

Second-year target/outcome measurement: Increase by .50% the total unduplicated number of Adults with SMI who receive peer support services, from the 14 CMHCs, during SFY 2019.

Data Source:

MIS Client/Event Data Set used by DBHDID 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 peer support services during the SFY (July 1 - June 30).

Data issues/caveats that affect outcome measures::

During SFY 2017, peer support as a service was captured in the data system as one code, regardless of age of recipient. For SFY 2018, peer support as a service will be captured by separate codes for Adult Peer Support and Youth Peer Support.
Also, it should be noted that peer support as a service can be provided in Kentucky to anyone with a mental health diagnosis, not only individuals with SMI. But this indicator will focus only on measuring Adults with SMI who receive that service.

Priority #: 2

Priority Area: Early Serious Mental Illness/First Episode of Psychosis

Priority Type: MHS

Population(s): ESMI

Goal of the priority area:

Increase access to evidence based practices for individuals with early serious mental illness/first episode of psychosis.

Objective:

Fully implement Coordinated Specialty Care (CSC) as an evidence based practice to serve individuals with early serious mental illness/first episode of psychosis, in at least three (3) outpatient sites from SFY 2017 until the end of SFY 2019.

Strategies to attain the objective:

Provide training and technical assistance to all outpatient sites funded to provide CSC to this population.
Continue to have consultation from national experts in the field.
Continue biannual meetings with all key contacts from CMHCs regarding this population, to further education on this evidence based practice and this population.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Coordinated Specialty Care (CSC) as an evidence based practice to individuals with ESMI/First Episode of Psychosis.
Baseline Measurement:	Total number of outpatient sites that have fully implemented Coordinated Specialty Care to serve individuals with ESMI/First Episode of Psychosis.
First-year target/outcome measurement:	By the end of SFY 2018, will have at least one (1) outpatient site offering fully implemented CSC to individuals with ESMI/First Episode of Psychosis.
Second-year target/outcome measurement:	By the end of SFY 2019, will have a total of at least three (3) outpatient sites offering fully implemented CSC to individuals with ESMI/First Episode of Psychosis.

Data Source:

DPR Form 113H/CMHC Contract Reporting Requirement
MIS Client/Event Data Set used by DBHDID and 14 CMHCs.

Description of Data:

Form 113H requires quarterly reporting on the status of the core components of Coordinated Specialty Care (CSC) including:
1. Must list the FTE status of each CSC team member, including service role on the team for each core service component (e.g. team leader/outreach; case manager; peer support; supported employment/education; medication management; and therapy.
2. Initial contact with all referrals to CSC program must occur within 48 hours.
3. Access to a prescriber is required within one week of admission into CSC program.
4. Staff to client ratio of 1:10 or less (e.g. if 3.0 FTE on CSC team, then can only serve 30 clients or less)

Data issues/caveats that affect outcome measures::

Coordinated Specialty Care is a new service for Kentucky. Implementation is in its infancy.
Form 113H is a new reporting form that began in SFY 2018.

Priority #: 3

Priority Area: Children with Severe Emotional Disturbance (SED)

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Increase Access to Evidence Based Practices for Children/Youth with SED

Objective:

Increase the total unduplicated number of Children with SED who receive peer support services by 1% from SFY 2017 to SFY 2019.

Strategies to attain the objective:

CMHCs with Transition Age Youth specialized programming are required by contract to have peer support services available to children and youth being served.
Continue to provide training and technical assistance to ensure that CMHCs understand how to recruit, retain and support Youth Peer Support Specialists in the workplace and how to appropriately document and bill for services.
Continue to provide awareness activities and training regarding resiliency and recovery principles and guidance in the process of fully including peer specialists in the service delivery array.
Continue to provide training and technical assistance regarding the supervision of peer specialists.
Technical assistance to CMHCs regarding accurate coding procedures for reporting peer support services in client/event data set.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Peer Support Services for Children and Youth with SED.
Baseline Measurement:	Total unduplicated number of Children and Youth with SED who received peer support services, from the 14 CMHCs, in SFY 2017.
First-year target/outcome measurement:	Increase by .50% the total unduplicated number of Children and Youth with SED who receive peer support services, from the 14 CMHCs, during SFY 2018.
Second-year target/outcome measurement:	Increase by .50% the total unduplicated number of Children and Youth with SED who receive peer support services, from the 14 CMHCs, during SFY 2019.

Data Source:

MIS client/event data set used by DBHDID and the 14 CMHCs.

Description of Data:

Data report to show the total number of unduplicated Children and Youth with SED served by the 14 CMHCs, who received peer support services in the SFY.

Data issues/caveats that affect outcome measures::

During SFY 2017, peer support as a service was captured in the data system as one code. For SFY 2018, peer support as a service will be captured by separate codes for Adult Peer Support and Youth Peer Support.
Also, it should be noted that peer support as a service can be provided in Kentucky to anyone with a mental health diagnosis, not only children with SED. But this indicator will focus only on measuring Children and Youth with SED who receive that service.

Priority #: 4

Priority Area: Primary Substance Use Prevention

Priority Type: SAP

Population(s): PP

Goal of the priority area:

Reduce the Incidence of Underage Drinking

Objective:

Decrease 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 minors (children/youth under age 21). Work to establish additional Social Host Ordinances across the Commonwealth. Implement strategies such as "I Won't Be the One" to reduce underage social access to alcohol by minors. Improve early prevention screening and assessment of children/youth in school settings.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number of 10th graders who report drinking alcohol in the past 30 days.

Baseline Measurement:	The 2016 KIP Survey results indicate 19.4% of 10th graders that answered that they have had, at least once, 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 1% the number of 10th graders that answered at least once that they have had an alcoholic beverage in the past 30 days.

Data Source:

Kentucky Incentives for Prevention (KIP) Survey 2018

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 the 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.

Data issues/caveats that affect outcome measures::

The KIP survey is only provided every two years.
Results of the KIP survey are available the year after the survey is completed.

Priority #: 5

Priority Area: Pregnant Women/Women with Dependent Children who have Substance Use Disorders (SUDs)

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Increase access to treatment for Pregnant/Postpartum Women and Women with Dependent Children with SUDs

Objective:

Increase the total unduplicated number of Pregnant/Postpartum Women and Women with Dependent Children with SUDs who receive Specialized Case Management Services by 2% from SFY 2017 to SFY 2019.

Strategies to attain the objective:

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

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increase by 2% the total number of unduplicated PWWDC who receive specialized case management services from the 14 CMHCs from SFY 2017 to SFY 2019.
Baseline Measurement:	The total numbr of unduplicated PWWDC who received specialized case management services from the 14 CMHCS in SFY 2017.
First-year target/outcome measurement:	Increase by 1% the total number of unduplicated PWWDC who receive specialized case management services from the 14 CMHCs during SFY 2018.
Second-year target/outcome measurement:	Increase by 1% the total number of unduplicated PWWDC who receive specialized case management services from the 14 CMHCs during SFY 2019.

Data Source:

MIS client/event data set used by DBHDID and the 14 CMHCs.
Additional data reporting 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 specialized case management services from the 14 CMHCs in each SFY.

Data issues/caveats that affect outcome measures::

Priority #: 6

Priority Area: Persons who inject drugs

Priority Type: SAT

Population(s): PWID

Goal of the priority area:

Reduce the outbreak of Hepatitis by increasing the availability and awareness of syringe exchange programs statewide.

Objective:

Monitor the number of syringe exchange programs across the Commonwealth of KY

Strategies to attain the objective:

Collaborate with the Office of Drug Control Policy, the Harm Reduction Coalition and the Department for Public Health to monitor educate communities and encourage the increase of local ordinances to create local syringe exchange programs.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of syringe exchange programs (SEPs) in place across the Commonwealth

Baseline Measurement: There are currently 30 SEPs statewide in KY

First-year target/outcome measurement: Increase the number of SEPs from 30 to 32 by the end of state fiscal year 2018

Second-year target/outcome measurement: Increase the number of SEPs from 30 to 35 by the end of state fiscal year 2019

Data Source:

KY Department for Public Health Surveillance data, KY Office of Drug Control Policy, KY Harm Reduction Coalition, and DBHDID

Description of Data:

The KY Department of Public Health monitors the number of SEPs statewide and also posts to their web site the days/hours of operation for each. The ODCP and the KY Harm Reduction Coalition and the KY DBHDID work to educate individuals and communities about the cost, benefits, myths and best practice guidelines for initiating and maintaining SEPs.

Data issues/caveats that affect outcome measures::

Syringe exchange programs (SEPs) have existed and been studied extensively in the United States since 1988. SEPs are community-based programs that provide access to sterile needles and syringes free of cost, facilitate safe disposal of used needles and syringes and offer safer injection education. SEPs in Kentucky also provide linkages to critical services and programs, including substance use disorder treatment programs; overdose prevention education; screening, care and treatment for HIV and viral hepatitis; prevention of mother-to-child transmission; hepatitis A and hepatitis B vaccination; screening for other sexually transmitted diseases and tuberculosis; partner services; and other medical, social and mental health services.

In direct response to Senate Bill 192 enacted during the 2015 regular legislative session, the Kentucky Department for Public Health has published guidelines for local health departments implementing harm reduction and syringe exchange programs.
NO SABG FUNDS WILL BE USEDTO SUPPORT THE SEPs.

Priority #: 7

Priority Area: Individuals who receive Substance Use Disorder (SUD) services and have or are at risk for Tuberculosis (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:

Ensure all clients presenting for substance use services are adequately screened for TB.

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:	Screen persons who present for substance use services, at the fourteen CMHCs, for TB.
Baseline Measurement:	All fourteen CMHCs have written policy and procedure regarding the screening for TB for all individuals seeking services for substance use disorders.
First-year target/outcome measurement:	Ten of fourteen CMHCs will submit their written policies and procedure regarding the screening for TB for all individuals seeking services for substance use disorders.
Second-year target/outcome measurement:	Twelve of fourteen CMHCs will submit their written policies and procedure regarding the screening for TB for all individuals seeking services for substance use disorders.

Data Source:

CMHC to submit through the Plan and Budget process requested P&P for TB screening.

Description of Data:

Written P&P submitted by CMHCs

Data issues/caveats that affect outcome measures::

N/A

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	$32,122,428		$0	$26,420,186	$26,294,600	$0	$0
a. Pregnant Women and Women with Dependent Children**	$8,050,424		$0	$2,000,000	$4,747,026	$0	$0
b. All Other	$24,072,004		$0	$24,420,186	$21,547,574	$0	$0
2. Primary Prevention	$8,436,600		$0	$2,942,000	$1,214,284	$0	$0
a. Substance Abuse Primary Prevention	$8,436,600		$0	$2,942,000	$1,214,284	$0	$0
b. Mental Health Primary							
3. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)							
4. Tuberculosis Services	$0		$0	$0	$228,770	$0	$0
5. Early Intervention Services for HIV	$0		$0	$0	$0	$0	$0
6. State Hospital							
7. Other 24 Hour Care							
8. Ambulatory/Community Non-24 Hour Care							
9. Administration (Excluding Program and Provider Level)	$120,000		$0	$0	$3,000,000	$0	$0
10. SubTotal (1,2,3,4,9)	$32,242,428	$0	$0	$26,420,186	$29,523,370	$0	$0
11. SubTotal (5,6,7,8)	$0	$0	$0	$0	$0	$0	$0
12. Total	$40,679,028	$0	$0	$29,362,186	$30,737,654	$0	$0

* Prevention other than primary prevention

** The 20 percent set-aside funds in the SABG must be used for activities designed to prevent substance misuse.

Footnotes:

Other Federal Funds include discretionary grants awarded by SAMHSA for Suicide Prevention, Partnerships for Success 2015, the Cooperative Agreement to Benefit Homeless Individuals (CSAT portion ONLY), the Medication-Assisted Treatment grant, Kentucky Youth Treatment-Implementation, and the Kentucky Opioid Response Effort.

State Funds includes Pregnant and Women with Dependent Children funding received from the Commonwealth's Department of Early Childhood Development, along with funding to be used specifically to address Neonatal Abstinence Syndrome, and Drug Settlement dollars.

State funding for tuberculosis services includes a mean cost of $5 per client assessment. Using unduplicated client counts totaling 22,877, it is estimated that we will assess at least that many persons per year in the upcoming two fiscal years at a cost close to what is being assumed at present.

Kentucky is not an HIV-designated state, and is not required to track expenditures for Early Intervention Services for HIV.

KENTUCKY PLANS TO CONTINUE TO ALLOCATE AT LEAST 21% OF THE TOTAL BLOCK GRANT AWARD IN ORDER TO INSURE THAT THE REQUIRED SET-ASIDE IS MET.

Tables 5a and 5b of the Combined Behavioral Health Assessment and Plan have been adjusted to reflect a reduction of $53,000 that will be used for Information Systems and Research and Evaluation, as reported on Table 6. The additional $12,000 in funding will come from the anticipated annual administrative costs as shown in Table 2. This slight reduction in planned funding will not adversely affect our set-aside funds for activities designed to prevent substance misuse.

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All Other							
2. Primary Prevention		$0	$0	$0	$0	$0	$0
a. Substance Abuse Primary Prevention							
b. Mental Health Primary*			$0	$0	$0	$0	$0
3. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)**		$696,000	$0	$0	$0	$0	$0
4. Tuberculosis Services							
5. Early Intervention Services for HIV							
6. State Hospital			$35,900,000	$11,900,000	$82,600,000	$2,600,000	$0
7. Other 24 Hour Care		$0	$17,500,000	$200,000	$6,273,100	$200,000	$0
8. Ambulatory/Community Non-24 Hour Care		$6,074,600	$1,113,900	$2,779,600	$38,728,400	$0	$0
9. Administration (Excluding Program and Provider Level)		$189,600	$116,400	$51,400	$2,492,600	$0	$0
10. SubTotal (1,2,3,4,9)	$0	$189,600	$116,400	$51,400	$2,492,600	$0	$0
11. SubTotal (5,6,7,8)	$0	$6,770,600	$54,513,900	$14,879,600	$127,601,500	$2,800,000	$0
12. Total	$0	$6,960,200	$54,630,300	$14,931,000	$130,094,100	$2,800,000	$0

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMH or children with SED

** Column 9B should include Early Serious Mental Illness programs funded through MHBG set aside

Footnotes:

It is assumed that the instructions above should read: Column 3B should include ESMI set aside.

KY understands that the FY 2018 President's proposed budget allocation amounts are to be used, however KY had already allocated funding at the start of its State Fiscal Year- July 1st and KY generally takes advantage of the ability to spend federal funds over a two-year period and thus projections take into account FFY 2017 funds that will be used in SFY 2018 and FFY 2018 funds will be used in SFY 2019.

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
Pregnant Women	0	306
Women with Dependent Children	0	3247
Individuals with a co-occurring M/SUD	0	11828
Persons who inject drugs	0	5091
Persons experiencing homelessness	0	1693

Please provide an explanation for any data cells for which the stats does not have a data source.
Footnote for "Estimated in Need": The BHDID currently does not have a source for determining the "number estimated in need". We request TA/Guidance from SAMHSA for identifying a data source. Footnote for "Number in Treatment": This table reflects clients reported to BHDID via CMHC Client/Event Data for SFY 2016. Data reported in this table are subset of that reported on SABG Table #2 (persons having SUD served by the CMHCs). Data reported in this table represent all clients served having SUD which is a higher and more accurate number than the clients meeting the somewhat strict KY definition of TEDS criteria.

Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Expenditure Category	FFY 2018 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment	$16,061,214
2 . Primary Substance Abuse Prevention	$4,218,300
3 . Early Intervention Services for HIV*	$0
4 . Tuberculosis Services	$0
5 . Administration (SSA Level Only)	$60,000
6. Total	$20,339,514

* For the purpose of determining the states and jurisdictions that are considered “designated states” as described in section 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 45 CFR § 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 the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be are required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/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 a state’s AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. 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 will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to

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do so.

Footnotes:

Tables 5a and 5b of the Combined Behavioral Health Assessment and Plan have been adjusted to reflect a reduction of $53,000 that will be used for Information Systems and Research and Evaluation, as reported on Table 6. The additional $12,000 in funding will come from the anticipated annual administrative costs as shown in Table 2. This slight reduction in planned funding will not adversely affect our set-aside funds for activities designed to prevent substance misuse.

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Strategy	IOM Target	FY 2018
		SA Block Grant Award
Information Dissemination	Universal	$652,405
	Selective	$7,901
	Indicated	$4,365
	Unspecified	
	Total	$664,671
Education	Universal	$411,378
	Selective	$8,900
	Indicated	$10,029
	Unspecified	
	Total	$430,307
Alternatives	Universal	$175,876
	Selective	
	Indicated	$488
	Unspecified	
	Total	$176,364
Problem Identification and Referral	Universal	$160,911
	Selective	$3,433
	Indicated	$716
	Unspecified	
	Total	$165,060

Community-Based Process	Universal	$1,223,842
	Selective	$3,676
	Indicated	$648
	Unspecified	
	Total	$1,228,166
Environmental	Universal	$368,343
	Selective	
	Indicated	
	Unspecified	
	Total	$368,343
Section 1926 Tobacco	Universal	
	Selective	
	Indicated	
	Unspecified	$10,000
	Total	$10,000
Other	Universal	
	Selective	
	Indicated	
	Unspecified	$1,175,389
	Total	$1,175,389
Total Prevention Expenditures		$4,218,300
Total SABG Award*		$20,339,514
Planned Primary Prevention Percentage		20.74 %

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

Footnotes:

Tables 5a and 5b of the Combined Behavioral Health Assessment and Plan have been adjusted to reflect a reduction of $53.000 that will be

used for Information Systems and Research and Evaluation, as reported on Table 6. The additional $12,000 in funding will come from the anticipated annual administrative costs as shown in Table 2. This slight reduction in planned funding will not adversely affect our set-aside funds for activities designed to prevent substance misuse.

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Activity	FY 2018 SA Block Grant Award
Universal Direct	$2,992,755
Universal Indirect	$1,185,389
Selective	$24,398
Indicated	$15,758
Column Total	$4,218,300
Total SABG Award*	$20,339,514
Planned Primary Prevention Percentage	20.74 %

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

Footnotes:
Tables 5a and 5b of the Combined Behavioral Health Assessment and Plan have been adjusted to reflect a reduction of $53,000 that will be used for Information Systems and Research and Evaluation, as reported on Table 6. The additional $12,000 in funding will come from the anticipated annual administrative costs as shown in Table 2. This slight reduction in planned funding will not adversely affect our set-aside funds for activities designed to prevent substance misuse.

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

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

Footnotes:

The Behavioral Health Prevention & Promotion Branch's targeted populations for the 2018 Combined Behavioral Health Assessment and Plan include the Alcohol priority of 0 – 18 year-old underage drinkers and 18 -24 year-old binge drinkers. Within the Illicit Drug priority, the 18 – 25 year-old population is targeted, without a students in college focus. In addition, Kentucky continues learn about the service member, veteran and family member population as it relates to substance use and suicide.

Planning Tables

Table 6 Categories for Expenditures for System Development/Non-Direct-Service Activities

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Activity	A. MHBG	B. SABG Treatment	C. SABG Prevention	D. SABG Combined*
1. Information Systems			$15,000	
2. Infrastructure Support	$60,000			
3. Partnerships, community outreach, and needs assessment	$20,000	$20,000		
4. Planning Council Activities (MHBG required, SABG optional)	$60,000	$5,000	$0	
5. Quality Assurance and Improvement	$50,000			$200,000
6. Research and Evaluation	$50,000	$50,000	$50,000	
7. Training and Education	$220,000	$100,000		
8. Total	$460,000	$175,000	$65,000	$200,000

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

Footnotes:

Tables 5a and 5b of the Combined Behavioral Health Assessment and Plan have been adjusted to reflect a reduction of $53,000 that will be used for Information Systems and Research and Evaluation, as reported on Table 6. The additional $12,000 in funding will come from the anticipated annual administrative costs as shown in Table 2. This slight reduction in planned funding will not adversely affect our set-aside

funds for activities designed to prevent substance misuse.

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

1. The Health Care System, Parity and Integration

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[25] 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.[26] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[27]

Currently, 50 states have organizationally consolidated their mental and substance use disorder 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.[28] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[29] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[30]

Health care professionals and persons who access M/SUD treatment services 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.[31] SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[32] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. 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 M/SUD 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 EHRs and telehealth are examples of important strategies to promote integrated care.[33] 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, treatment, 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 homes[34] and ACOs[35] 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. SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[36] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[37]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[38] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[39] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who

experience health insurance coverage eligibility changes due to shifts in income and employment.[40] 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 in finding a provider.[41] 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 work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[42] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

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. The 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. The SSAs and SMHAs should collaborate with their states? 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. Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, 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.[43] SAMHSA recognizes that certain jurisdictions receiving block grant funds ? including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[44] 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 and substance use disorders.

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Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

   Both the service system traditionally serving adults with serious mental illness and children with severe emotional disturbances, as well as the service system traditionally serving those with substance use disorders, have gaps in skills related to training, technical assistance and coaching on integrated treatment. There is also a gap regarding intensive outpatient treatment for individuals with co-occurring disorders in Kentucky.
   To address the need for workforce development in this area, DBHDID has contract with Case Western Reserve University to provide IDDT training to ACT teams in Kentucky,

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

   As a result of several years of fidelity assessments, utilizing the Dual Diagnosis Capability in Addiction Treatment (DDCAT) and Dual Diagnosis Capability in Mental Health Treatment (DDMHT) tools, it became clear that there was a gap in essential support groups for individuals with co-occurring disorders. These fidelity assessments occurred through a team of integration specialists developed by DBHDID, through work with a national consultant and a Transformation Transfer Initiative (TTI) grant. In addition, fidelity self-assessments were made a requirement for individual contracted agencies.

   • Work with peers in recovery, advocacy groups, and others across the state, to spread the development of Double Trouble in Recovery (DTR) support groups. DTR is an evidence based model for peer led group support for individuals with co-occurring mental health and substance use disorders. Peer support through mutual support and mutual aid groups is one of SAMHSA's ten (10) guiding principles of recovery. At present, the Veteran's Administration in Kentucky, and at least nine (9) regions provide DTR as a support for individuals. More DTR availability is occurring with continued support from DBHDID;
   • Work with the Institute for Excellence, and others, to provide national consultants and a learning collaborative around

Motivational Interviewing for all regional staff across the state;
• Provide workshops at Kentucky School for Alcohol and Other Drug Studies (which has traditionally been designed for substance use disorders only) that focus on co-occurring topics and integrated treatment;
• Include contract requirements for CMHCs to include hiring at least 2.0 FTE peer support specialists with lived experience in substance use disorders and/or co-occurring disorders, and for agencies to provide fidelity self-assessments of co-occurring capability by utilizing the DDCAT/DDMHT tools;
• Include administrative staff in traditional "mental health" branches in DBH who have experience in administering substance use and co-occurring programs; and
• Restructure the plan and budget statutory process to include plans for all treatment, including integrated treatment.
Providers serving children and youth have received training and technical assistance from DBHDID to effectively screen, assess and provide treatment for youth with co-occurring mental health and substance use disorders. A number of evidence based programs have been implemented across the Commonwealth including the use of the GAIN, Sources of Strength and Seven Challenges. Enhancing the knowledge and skills of professionals serving youth in behavioral health settings as well as school, child welfare and juvenile justice has been a strong focus of DBHDID's efforts to address the increasing needs of children and youth with co-occurring disorders.

3. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? ( ) Yes ( ) No

   and Medicaid? ( ) Yes ( ) No

4. Who is responsible for monitoring access to M/SUD services by the QHP?

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? ( ) Yes ( ) No

6. Do the behavioral health providers screen and refer for:

   a) Prevention and wellness education ( ) Yes ( ) No

   b) Health risks such as

      i) heart disease ( ) Yes ( ) No

      ii) hypertension ( ) Yes ( ) No

      viii) high cholesterol ( ) Yes ( ) No

      ix) diabetes ( ) Yes ( ) No

   c) Recovery supports ( ) Yes ( ) No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? ( ) Yes ( ) No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? ( ) Yes ( ) No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

   Same day billing prohibition for Medicaid

10. Does the state have any activities related to this section that you would like to highlight?

    As a result of several years of fidelity assessments, utilizing the Dual Diagnosis Capability in Addiction Treatment (DDCAT) and Dual Diagnosis Capability in Mental Health Treatment (DDMHT) tools, it became clear that there was a gap in essential support groups for individuals with co-occurring disorders. These fidelity assessments occurred through a team of integration specialists developed by DBHDID, through work with a national consultant and a Transformation Transfer Initiative (TTI) grant. In addition, fidelity self-assessments were made a requirement for individual contracted agencies.

    It also became apparent that Kentucky had workforce development needs for the behavioral health service system that provides services to individuals with co-occurring disorders. Both the service system traditionally serving adults with serious mental illness and children with severe emotional disturbances, as well as the service system traditionally serving those with substance use disorders, have gaps in skills related to training, technical assistance and coaching on integrated treatment. For example, ACT teams in Kentucky need to fully implement integrated principles of co-occurring disorder treatment into their service package. Individuals being served by ACT teams have very intense treatment needs and many require integrated treatment in order to be successful.

    It is desirable for all behavioral health clinicians serving adults and youth to be co-occurring capable but the reality is that many were trained in one or the other and must seek additional training to improve their knowledge and skills. Whether in a setting that is primarily mental health or primarily substance use, program staff will be serving individuals who have co-occurring

disorders and must be prepared to screen, assess and treat appropriately. Kentucky has been offering training to Peer Specialists and others . During the last few years, the DBHDID has been training peers in recovery from substance use disorders as well.
• Work with peers in recovery, advocacy groups, and others across the state, to spread the development of Double Trouble in Recovery (DTR) support groups. DTR is an evidence based model for peer led group support for individuals with co-occurring mental health and substance use disorders. Peer support through mutual support and mutual aid groups is one of SAMHSA's ten (10) guiding principles of recovery. At present, the Veteran's Administration in Kentucky, and at least nine (9) regions provide DTR as a support for individuals. More DTR availability is occurring with continued support from DBHDID;
• Work with the Institute for Excellence, and others, to provide national consultants and a learning collaborative around Motivational Interviewing for all regional staff across the state;
• Provide workshops at Kentucky School for Alcohol and Other Drug Studies (which has traditionally been designed for substance use disorders only) that focus on co-occurring topics and integrated treatment;
• Include contract requirements for CMHCs to include hiring at least 2.0 FTE peer support specialists with lived experience in substance use disorders and/or co-occurring disorders, and for agencies to provide fidelity self-assessments of co-occurring capability by utilizing the DDCAT/DDMHT tools;
• Include administrative staff in traditional "mental health" branches in DBH who have experience in administering substance use and co-occurring programs; and
• Restructure the plan and budget statutory process to include plans for all treatment, including integrated treatment.
Providers serving children and youth have received training and technical assistance from DBHDID to effectively screen, assess and provide treatment for youth with co-occurring mental health and substance use disorders. A number of evidence based programs have been implemented across the Commonwealth including the use of the GAIN, Sources of Strength and Seven Challenges. Enhancing the knowledge and skills of professionals serving youth in behavioral health settings as well as school, child welfare and juvenile justice has been a strong focus of DBHDID's efforts to address the increasing needs of children and youth with co-occurring disorders.

Please indicate areas of technical assistance needed related to this section

Footnotes:

2. Health Disparities - Requested

Narrative Question

In accordance with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities[45], Healthy People, 2020[46], National Stakeholder Strategy for Achieving Health Equity[47], 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, sexual/gender minorities, orientation 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, etc.) 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)[48].

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS 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 HHS Secretary's top priority in the Action Plan is to "assess 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."[49]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[50]. 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[51]. 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 populations 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 and is 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.

[45] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[46] http://www.healthypeople.gov/2020/default.aspx

[47] http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf

[48] http://www.thinkculturalhealth.hhs.gov

[49] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[50] http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208

[51] http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, LGBT, and age?

   a) Race — Yes / No

   b) Ethnicity — Yes / No

   c) Gender — Yes / No

   d) Sexual orientation — Yes / No

   e) Gender identity — Yes / No

   f) Age — Yes / No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? — Yes / No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? — Yes / No

4. Does the state have a workforce-training plan to build the capacity of behavioral health providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? — Yes / No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) standard? — Yes / No

6. Does the state have a budget item allocated to identifying and remedialing disparities in behavioral health care? — Yes / No

7. Does the state have any activities related to this section that you would like to highlight?

   The Department for Behavioral Health, Developmental and Intellectual Disabilities' (BHDID) Behavioral Health Equity Action Planning Workgroup (workgroup) has made progress in identifying and addressing racial and ethnic disparities during SFY 2016 and SFY 2017. At this time, the workgroup is focusing its efforts on identifying and reducing disparities for children, adolescents and young adults utilizing public behavioral health services. The following is a list of the workgroup's past, current, and planned initiatives.
   Past Initiatives (Completed During the Past Year)
   -The Behavioral Health Equity Action Planning workgroup was formed in 2016 to analyze behavioral health data for racial and ethnic disparities, report outcomes to the interested stakeholders (e.g., Juvenile Justice Oversight Council, Juvenile Justice Advisory Board (JJAB), JJAB Subcommittee for Equity and Justice for All Youth, and the Disproportionality and Disparities Standing Committee of the State Interagency Council) and to engage in action planning to increase behavioral health equity.
   -BHDID collaborated with the Kentucky Administrative Office of the Courts and the Chair of the Subcommittee on Equity and Justice for All Youth, Pastor Edward L. Palmer, to provide two Implicit Bias trainings to staff from BHDID, BHDID facilities, and CMHCs.
   -The theme of the 2016 System of Care Academy was "Reducing Disproportionate Minority Contact and Health Disparities across the System of Care" and featured two plenaries and a Disproportionate Minority Contact track with six workshops addressing the important topic sponsored by the Department for Juvenile Justice.
   -The 2016 Kentucky School for Alcohol and Other Drug Studies offered workshops to outreach, engagement, retention and intervention strategies to improve health outcomes for populations at risk for disparities.
   -BHDID consulted with members of the Kentucky Behavioral Health Planning and Advisory Council. The following are their responses to discussion topics:
   -What do you think are subpopulations/groups in Kentucky who are vulnerable to behavioral health disparities?
   -with limited English proficiency;
   -Individuals with low socio-economic status (difficult to afford medications);
   -Those who cannot communicate clearly through speech;
   -Individuals with language barriers including individuals who are deaf or hard of hearing;
   -Individuals in rural areas;
   -Individuals from racial/ethnic minority groups;
   -Individuals with disabilities;
   -Veterans, active military, guardsmen, and their family members;
   -Older adults;
   -Individuals who are gender or sexual orientation diverse (LGBTQ);
   -Youth and young adults in the foster care system;
   -Individuals who are not familiar with behavioral health resources; and
   -Vietnamese and Cambodians in Louisville.

-What initiatives do you recommend to address behavioral health disparities in Kentucky?
-Look at the data first;
-Create jobs (peer support specialists – youth and adults who have experience who can use their skills to help others);
-Have "culturally sensitive" employees to help minorities in health care settings;
-Have individuals available to support those who are experiencing communication challenges;
-BHDID should consider looking at the 51 counties that has the federal designation of Appalachian counties that the Department for Public Health has found to have high rates of chronic disease; and
-BHDID should consider including an epidemiologist in its work to reduce disparities.
-What technical assistance do you think the state of Kentucky should request from SAMHSA related to behavioral health disparities?
-Telehealth (videoconferencing with doctor or other therapist);
-Video in sign language for individuals who are deaf or hard of hearing; and
-Materials in Spanish for the Latino community.
-Please share any other comments related to Kentucky's behavioral health system of care or health disparities.
-There is reluctance by older adults and Veterans to use CMHC services in Kentucky;
-Behavioral health providers must consider and integrate into treatment individuals' co-occurring physical health disorders;
-Parity must be extended to services reimbursed by Medicare. For individuals age 65 and older who are on Medicare Advantage, the copay is $15 when they go to their primary care provider and $40 when they go see a therapist; and
-NAMI Kentucky has had experienced increased requests to speak to older adults so their organization feels the need is great.
Current Status and Initiatives
-BHDID is a member of the Juvenile Justice Oversight Council, Juvenile Justice Advisory Board, Subcommittee for Equity and Justice for All Youth, Differential Treatment Workgroup, and the Disproportionality and Disparities Standing Committee.
-BHDID collects client-level data monthly, including fields for gender, race, and ethnicity from the following entities:
-Fourteen community mental health centers;
-Two state-owned psychiatric hospitals;
-Two state-contracted psychiatric hospitals;
-Four intermediate care facilities for individuals with intellectual disability; and
-Two non-profit agencies contracted to provide specialized services to individuals with substance use disorders.
-The workgroup is analyzing statewide and regional program performance data, disaggregated by race, ethnicity, gender and disability to determine if there are differences in access, use and outcomes.
-The workgroup is reviewing the client and event data systems to determine needed improvements (e.g., a "juvenile justice involvement" field for the client-level data system).
-BHDID's Kentucky Youth Treatment grant is providing specialized outreach and engagement into substance abuse services for African American youth and youth who identify as LGBT.
-BHDID is providing training and conference opportunities that include topics related to trauma informed care and outreach, engagement, retention and intervention strategies to improve health outcomes for populations at risk for disparities.
-The workgroup is identifying national data of behavioral health disparities for children and adolescents.
-BHDID provides a Behavioral Health Disparities Impact Statement for all grant submissions to the Substance Abuse and Mental Health Services Administration.
-BHDID maintains dialogue with the CMHCs about their initiatives to outreach to priority and vulnerable populations and to reduce barriers to treatment.
-BHDID is a contributor to the Department for Public Health Office of Health Equity's biennial Kentucky Minority Health Status Reports.
Planned Initiatives
The workgroup has discussed the following initiatives and may work on the following in the future:
-BHDID will connect with the Kentucky Equal Employment Opportunity Commission to determine collaboration opportunities.
-The workgroup will continue data analysis and provide recommendations for system enhancement.
-The workgroup will seek information on best practices to guide strategic planning.
-The workgroup will review CMHC plan and budget documents and contract language to determine need for modification.

Highlights from the Deaf and Hard of Hearing Services Program
BHDID has worked to address disparities for those who are Deaf, Hard of Hearing, or Deaf-Blind since 1992. The Department employs one FTE Program Administrator for DHHS and allocates block grant and state general fund dollars for language access needs. Significant gaps in services still exist for those seeking culturally, linguistically, and clinically competence care. Below are efforts made from SFY2015 to SFY2017 to address prevention, mental health promotion, and behavioral health treatment. A biennial report is also available by contacting the Program Administrator.
General
-CMHC Point People for Deaf and Hard of Hearing Services worked within their regions to implement a Right To Free Language Access form in medical records. Language access policy updates were contractually required.
-Nine (9) additional American Sign Language (ASL) interpreters completed the Mental Health Interpreter Training Program in Alabama.

Children with SED
Children who are Deaf, Hard of Hearing, or Deaf-Blind must have early intervention in order to develop a solid foundation in communication and a strong attachment to a caring adult. Too often, the lack of comprehensive, coordinated services for children

and their families leads to educational deprivation, language dysfluency, behavioral health issues, and / or substance abuse.
The KY DBHDID is committed to creating access to children's services for those who are Deaf, Hard of Hearing, and Deaf-Blind. During the FY2015-FY2017 biennium, the following actions were taken:
-Continuation of a DHHS track at the System of Care Academy bringing together service providers from across state agencies;
-Collaboration with the Department for Community Based Services (DCBS) to improve the Standards of Practice for frontline workers and to enhance specialized training available on obtaining and working with interpreters and connecting families to specialized resources;
-Participation of the Program Administrator in the Early Hearing Detection and Intervention (EHDI) State Advisory Committee focusing attention on the need for family-driven services;
-Hosting of multiple training opportunities on Trauma Informed Care at Kentucky School for the Deaf and in the community given by Deaf experts and partially funded by the KY Initiative for Collaborative Change; and
-Sponsorship of the annual Family Learning Vacation for families of children who are Deaf or Hard of Hearing.

Still, families with children who reach the SED threshold often face heartbreaking choices. There are few foster homes and no residential treatment programs fully accessible for Deaf children or youth in Kentucky. Sometimes families face the heartbreaking "choice" of giving up custody in order for their child to receive care. This must stop.
Adults with SMI
The Kentucky Commission on the Deaf and Hard of Hearing (KCDHH) estimates the total number of Deaf or Hard of Hearing residents at 737,712 based on the 2010 census. 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). Using this methodology, it is estimated that 19,181 individuals in Kentucky have SMI and are Deaf, Hard of Hearing, or Deaf-Blind. CMHC Data Set information show that, in FY2015, 2037 individuals were identified with SMI and as having a hearing loss. This correlates to a penetration rate of 10.6% of people receiving the services they need. However, researchers estimate SMI prevalence 3-5X greater for the deaf community (Tate, 2012). Using data such as that above, Cumberland River Behavioral Health identified an unmet need and worked with DBHDID to recruit and hire a Deaf individual to serve as a targeted case manager. In her first six months, she has worked to engage individuals who had been deemed "noncompliant" and spent time educating CRBH staff and community service providers on ADA access and nuances of working with members of the Deaf community.

Individuals with Substance Use Disorders
Between FY2015 and FY2017, the number of Deaf, Hard of Hearing, or Deaf-Blind individuals served in CMHCs for substance abuse issues more than doubled from 2015 to 415. Two major societal influences inform the data interpretation:
-Coverage for substance abuse treatment under Medicaid and other insurance providers increased access to care.
-A drastic increase in the number of people on a state, regional, and national level addicted to opioids increased the need for services.

Over the next biennium, we must be vigilant to ensure that "access" includes developing and sustaining substance abuse treatment services inclusive of the communication needs of people who are Deaf, Hard of Hearing, or Deaf-Blind. Kentucky currently has no Certified Alcohol and Drug Counselors (CADCs) who are Deaf, Hard of Hearing, or sign-fluent and knowledgeable about adapting treatment for the population.

Please indicate areas of technical assistance needed related to this section

-Enhancing managed care organizations' capacity to provide language access.

Footnotes:

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, the purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ? Cost, (V = Q ? C)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of behavioral health systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance misuse 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 IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. NREPP assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a program's conceptual framework. For each intervention reviewed, NREPP publishes a report called a program profile on this website. You will find research on the effectiveness of programs as reviewed and rated by NREPP certified reviewers. Each profile contains easily understandable ratings for individual outcomes based on solid evidence that indicates whether a program achieved its goals. 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 General[52], The New Freedom Commission on Mental Health[53], the IOM[54], and the NQF[55]. 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."[56] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, 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, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. 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 Protocol Series (TIPS)[57] are best practice guidelines for the SUD treatment. The 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 SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)[58] 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 M/SUD services.

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[52] 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

[53] 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.

[54] 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.

[55] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[56] http://psychiatryonline.org/

[57] http://store.samhsa.gov

[58] http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? ☐ Yes ☐ No

2. Which value based purchasing strategies do you use in your state (check all that apply):

   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 and non-financial incentives for providers or consumers.

   d) ☐ Provider involvement in planning value-based purchasing.

   e) ☐ Use of accurate and reliable measures of quality in payment arrangements.

   f) ☐ Quality measures focus on consumer outcomes rather than care processes.

   g) ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).

   h) ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

   Does the state have any activities related to this section that you would like to highlight?

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

   N/A

Footnotes:

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcome across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

States may implement models that 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, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). NIMH sponsored a set of studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP the RAISE model). The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a CSC model, and have been shown to improve symptoms, reduce relapse, and improved outcomes.

State shall expend not less than 10 percent of the amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? ( ) Yes ( ) No

2. Has the state implemented any evidence based practices (EBPs) for those with ESMI? ( ) Yes ( ) No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

Kentucky is utilizing implementation science as outlined by the National Implementation Research Network throughout the execution of first episode of psychosis programming. Several evidence based practices are being utilized in the implementation of first episode of psychosis programming, including:
-Early Assessment and Support Alliance (EASA) Coordinated Specialty Care Model – Kentucky is following the EASA model of Coordinated Specialty Care (CSC). Kentucky is utilizing EASA for technical assistance regarding CSC programming, as EASA utilizes the team based CSC model of care within the Oregon community mental health centers, which is very similar to Kentucky. EASA is providing overall technical assistance for CSC within Kentucky, including guidance on program implementation, differential diagnoses, multi-family group psychoeducation, and ongoing, site-specific technical assistance;
-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-V Disorders (SCID-V), and the Structured Interview for Psychosis-Risk Syndromes (SIPS). This will provide CSC teams, as well as other outpatient clinic staff, 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 CSC teams as well as other outpatient clinicians, specific

skills 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; and
-Multi Family Psychoeducation – educational and supportive sessions with several families at one time, focusing on specific diagnostic categories.

3. How does the state promote the use of evidence-based practices for individuals with a ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

   Kentucky is utilizing implementation science as outlined by the National Implementation Research Network (NIRN) throughout the execution of first episode programming. In addition, CMHC provider contract language requires the use of evidence based practices for programs that are funded by DBH to serve this target population. CMHC contract language also requires identified key contacts from each CMHC to attend statewide meetings and trainings, many that include information regarding evidence based practices for this population.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with a ESMI? ( ) Yes ( ) No

5. Does the state collect data specifically related to ESMI? ( ) Yes ( ) No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? ( ) Yes ( ) No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

   Kentucky is implementing Coordinated Specialty Care an as evidence based practice for the 10% set-aside for ESMI. Kentucky is modeling it's programming after the Early Assessment and Support Alliance (EASA), which 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 atypical antipsychotic medications, cognitive behavioral therapy, family education and support, employment and education support, occupational therapy, targeted 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.

8. Please describe the planned activities for FFY 2018 and FFY 2019 for your state's ESMI programs including psychosis?

   At this time, all community mental health centers are required to designate two (2) key contacts (one from the adult mental health system of care and one from the children's mental health system of care) within their agency for first episode of psychosis programming. These individuals are responsible for disseminating information on first episode of psychosis as well as attend and participate in collaborative meetings and trainings. At present, there are eight (8) community mental health centers that provide Coordinated Specialty Care with funding from DBH. These programs are called iHOPE (Helping Others Pursue Excellence). EASA will provide each iHOPE Program with monthly consultation calls. State program administrators will also provide bimonthly onsite technical assistance for iHOPE teams. EASA will also provide statewide training for clinical staff on Coordinated Specialty Care, the Structured Clinical Interview for DSM 5 (SCID-5) and Differential Diagnosis. Ongoing coaching will be provided regarding Cognitive Behavioral Therapy for Psychosis as well as the Structured Interview for Psychosis-risk Syndromes. All regions will be expected to participate in statewide training and workshops on evidence based practices for first episode programming. During SFY 2017, the fidelity process regarding iHOPE programs will be developed, in collaboration with EASA. In October of 2017, fidelity baseline assessments will be conducted with the iHOPE programs that are in their second year of implementation during SFY 2017. As iHOPE programs develop they will be guided by this fidelity process.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

   Each community mental health center is required to submit quarterly client and program data regarding the 10% set aside. In addition, CMHCs are required to submit monthly event data on each individual served as well as annual client level data for each individual served. Kentucky has made several changes to data collection processes, in an effort to capture more inclusive data for this population. However, more work needs to be done on specific outcome data such as school tenure, employment stability, and other measures.

10. Please list the diagnostic categories identified for your state's ESMI programs.

    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, and other diagnoses that include psychosis as identified in the DSM-5. (Delusional Disorder, Brief Psychotic Disorder, Schizoaffective Disorder, Schizophreniform Disorder, Unspecified Schizophrenia Spectrum and Other Psychotic Disorder, Other Schizophrenia Spectrum and Other Psychotic Disorder, Major Depressive Disorder with psychotic features (single or recurrent), Bipolar I with psychotic features (manic or depressed), Post Traumatic Stress Disorder). Kentucky is focusing on youth and young adults who have experienced a first episode of psychosis within the last year.

    Does the state have any activities related to this section that you would like to highlight?

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

Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

1. Does your state have policies related to person centered planning? Yes No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

DBHDID has been working to implement person centered planning in the behavioral health arena for the last three (3) fiscal years. DBHDID recognizes the value of engaging individuals who receive behavioral health services and assisting them in identifying desired outcomes. DBHDID also recognizes the value of having legal guardians, caregivers and other natural supporters assist individuals with achieving those outcomes.

In August of 2013, the Cabinet for Health and Family Services entered into an Interim Settlement Agreement with Kentucky Protection and Advocacy regarding adults with SMI living in personal care homes in Kentucky. As a part of that effort, person centered planning was named in the agreement as a necessary support for individuals moving into communities of their choice. This agreement was renegotiated and the Amended Settlement Agreement was signed in October of 2015. Person centered planning remained an initiative in that subsequent agreement due to being a vital support necessary to the transition of adults with SMI. During SFY 2014, DBHDID worked with national consultants (Diane Grieder, M.Ed., and Janis Tondora, Psy.D.) to provide two (2) day face to face trainings in the eastern and western part of the state. These trainings included individuals identified as possible trainers and coaches for individuals CMHCs and other behavioral health partner agencies across the state. These trainings included an overview of the person centered planning model for behavioral health along with hands on practice, in small groups, of writing actual plans. It was identified early on in the process of bringing person centered planning to Kentucky, that behavioral health organizations sometimes don't engage in this process due to the time required and reimbursement issues. Therefore, medical necessity documentation was intertwined in the person centered planning training and all CMHC regions had staff trained in how to provide a person centered process and write a person centered plan that included medical necessity. These face to face trainings were followed by case consultation webinars/conference calls, where CMHC staff would present a case assessment, narrative summary and subsequent person centered plan and the consultants would provide feedback and guidance for making the process and the plan better. Each agency had several rounds of these calls. In addition, identified trainers from each agency receiving some coaching calls regarding how to implement necessary changes in their own agency and how to train other staff in the person centered planning model.

In addition, Kentucky was one of twenty-four (24) states that received a planning grant for Certified Community Behavioral Health Clinics (CCBHC) in 2016. As a part of that grant planning process, person centered planning was targeted as an intense pilot project for six (6) CMHC regions in Central Kentucky. These six (6) regions identified change teams, supervisory/coaching staff, as well as upper management leadership to serve in various roles in the implementation process for their agency. The national consultants again were utilized, first to provide a site review of the six (6) pilot regions to review some treatment plans and to look at current processes. Then DBHDID assigned program administrators as liaisons for each region, and arranged case consultation monthly webinars for each region as well as monthly supervisory calls for identified supervisors from each region, and bimonthly webinars for statewide leadership, including DBH leaders and DBHDID Commissioner and staff. In addition, during SFY 2017, the consultants provided face to face training for supervisors/coaches, targeting information on how to supervise other staff in providing person centered planning. A large focus for the end of SFY 2017 was having agencies develop implementation plans for how to disseminate person centered planning amongst all behavioral health programming in their agencies.

The steps that were taken in SFY 2017 regarding the pilot regions included the following:
-PCRP kickoff introduction in June of 2016;
-2-day training in September 2016 for targeted staff from each region;
-Assignment of DBH Program Administrator liaisons for each region;

-Monthly case consultation calls to change team identified by each region;
-Monthly supervision technical assistance webinar for all regions; and
-Bimonthly state workgroup technical assistance webinar for leadership of DBH and regions.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

DBHDID developed the term person centered recovery plan (PCRP) and requires all CMHCs, via contract, to provide person centered recovery planning to all adults with SMI served. In addition, all adults with SMI moving out of personal care homes into community based living must have a person centered transition plan to assist with ensuring successful transition. CMHC contracts define a person centered transition plan as “short-term plan directed by the recipient with specifically defined action steps, timelines, and responsible parties to assure a smooth transition into community based living”. CMHC contracts define person centered recovery plan as “a treatment/recovery plan that is developed collaboratively with an individual, based on the strengths of each individual and clearly identifies planned interventions, both billable and not, and the frequency and purpose of each treatment intervention”.

CMHC contracts also provide for “service planning” a new service as of 2014 in Kentucky. This service is defined via contract as “assisting the recipient in creating an individualized plan for services needed for maximum recovery of symptoms associated with a mental health disorder and restoration of a recipient to the best possible functioning level”. Service planning allows for multiple sessions that might be necessary when engaging and developing a collaborative, individualized plan of care through a person centered process.

For children with SED and individuals with SUD, CMHC contracts also require service planning with all individuals served. For children with SED service planning in a person centered planning manner has been occurring for many years. Typically, service planning sessions are facilitated by targeted case managers for children with SED and have the purpose of identifying necessary services and providers with the collaboration of the child being served as well as caregivers and others. Other provider staff may facilitate this discussion and assist with planning of necessary services and supports.

4. Describe the person-centered planning process in your state.

DBHDID is collaborating with the national consultants again for SFY 2018. This fiscal year the focus will be to bring the PCRP model to prescribers and to peer support specialists, so that all providers can understand the behavioral health model and understand their role in that process. In addition, SFY 2018 will bring an effort to pull in other CMHC regions that were originally trained in the PCRP model, but not part of the SFY 2017 pilot project, and give them a refresher and some technical assistance to troubleshoot barriers with fully implementing the model in their agencies. The beginning of SFY 2018 will highlight a leadership summit, where national consultants will facilitate a discussion with DBHDID leadership, including the Commissioner level staff, Managed Care Organization staff, Department for Aging and Independent Living staff, and Department for Medicaid Services Staff. This leadership summit has the goal of fostering understanding and support for the PCRP effort in Kentucky and for assisting with full implementation of this very important initiative.

Does the state have any activities related to this section that you would like to highlight?

In collaboration with the national consultants, DBHDID developed a quality indicator tool that outlines all the necessary pieces of the PCRP model for behavioral health providers. Included in this tool are questions about the assessment process, the narrative summary process and the plan itself. In SFY 2018, DBHDID will begin to assess the process of PCRP with regards to fidelity to this quality indicator tool. Details of this process are currently being developed. Due to person centered planning being an actual process and the plan being only one of the products that can be measured, the development of a fidelity-type tool has been tricky. Kentucky will continue working with national consultants on this process. In the fall of 2017, the consultants will be training the program administrators identified as liaisons in this process.

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

Footnotes:

6. Self-Direction - Requested

Narrative Question

In self-direction - also known as self-directed care - a service user or "participant" controls a flexible budget, purchasing goods and services to achieve personal recovery goals developed through a person-centered planning process. While this is not an allowable use of Block Grant Funds,the practice has shown to provide flexible supports for an individual's service. The self-direction budget may comprise the service dollars that would have been used to reimburse an individual's traditional mental health care, or it may be a smaller fixed amount that supplements a mental health benefit. In self-direction, the participant allocates the budget in a manner of his or her choosing within program guidelines. The participant is encouraged to think creatively about setting goals and is given a significant amount of freedom to work toward those goals. Purchases can range from computers and bicycles to dental care and outpatient mental health treatment.

Typically, a specially trained coach or broker supports the participant to identify resources, chart progress, and think creatively about the planning and budgeting processes. Often a peer specialist who has received additional training in self-direction performs the broker role. The broker or a separate agency assists the participant with financial management details such as budget tracking, holding and disbursing funds, and hiring and payroll logistics. Self-direction arrangements take different forms throughout the United States and are housed and administered in a variety of entities, including county and state behavioral health authorities, managed care companies, social service agencies, and advocacy organizations.

Self-direction is based on the premise that people with disabilities can and should make their own decisions about the supports and services they receive. Hallmarks of self-direction include voluntary participation, individual articulation of preferences and choices, and participant responsibility. In recent years, physical and mental health service systems have placed increasing emphasis on person-centered approaches to service delivery and organization. In this context, self-direction has emerged as a promising practice to support recovery and well-being for persons with mental health conditions. A small but growing evidence base has documented self-direction's impact on quality of life, community tenure, and psychological well-being.

Please respond to the following items:

1. Does your state have policies related to self-direction? ( ) Yes ( ) No

2. Are there any concretely planned initiatives in our state specific to self-direction? ( ) Yes ( ) No

   If yes, describe the currently planned initiatives. In particular, please answer the following questions:

   a) How is this initiative financed:

   b) What are the eligibility criteria?

   c) How are budgets set, and what is the scope of the budget?

   d) What role, if any, do peers with lived experience of the mental health system play in the initiative?

   e) What, if any, research and evaluation activities are connected to the initiative?

   f) If no, describe any action steps planned by the state in developing self-direction initiatives in the future.

   Does the state have any activities related to this section that you would like to highlight?

   Kentucky does not have any programs utilizing self directed care for mental health and/or substance use programming.

   Please indicate areas of technical assistance needed to this section.

Footnotes:

Environmental Factors and Plan

7. Program Integrity - Required

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 U.S.C. §§ 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 U.S.C. § 300x-55(g), 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 made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify 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 use disorder prevention, treatment and recovery 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 MHBG and SABG. 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 M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have 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 respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? ( ) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with programs requirements, including quality and safety standard? ( ) Yes ( ) No

Does the state have any activites related to this section that you would like to highlight?

The Division of Program Integrity (DPI) is designed to oversee critical organizational functions, including the following:

Regulation/legislative review;
Business information/intelligence gathering, analysis and reporting;
Contract monitoring;
Risk management; and
Training support and facilitation.
Within this Division are two branches—the Data Analytics Branch and the Program Support Branch:

Data Analytics Branch: Provides oversight of application development and integration; business informatics; facility information system management, and the Electronic Medical Records project. The branch also provides technical support to the DBHDID and serves as the point of contact for development of technical solutions and interaction with the Commonwealth Office of Technology.

Program Support Branch: Composed of four primary work units: Contract Monitoring, Education/Event Coordination, Risk Management, and Legislation/Regulations. Each work unit is led by a Team Leader, and staff works with other Divisions to ensure the delivery of high-quality products, accountability, and transparency. Activities and services include:

Contract monitoring database administration and reporting;
Training and event facilitation, including curriculum development;
Continuing education units (CEUs), publications, equipment, webinars, and video conferencing;
Risk management database administration and reporting;
Residential and community mortality review;
Certified investigator training; and
Kentucky Administrative Regulations and legislation review, updates and drafting.

Please indicate areas of technical assistance needed to this section

N/A

Footnotes:

8. Tribes - Requested

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[59] 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 approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

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.

[59] http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

   N/A

2. What specific concerns were raised during the consultation session(s) noted above?

   N/A

   Does the state have any activites related to this section that you would like to highlight?

   N/A

   Please indicate areas of technical assistance needed to this section

   N/A

Footnotes:

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 - Required SABG

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states 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 misuse. The program must include, but is not limited to, the following strategies:

- *Information Dissemination* providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
- *Education* aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- *Alternative programs* that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- *Problem Identification* and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
- *Community-based Process* that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- *Environmental Strategies* that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? ( ) Yes ( ) No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) ( ) Yes ( ) No

   - [ ] Data on consequences of substance using behaviors
   - [ ] Substance-using behaviors
   - [ ] Intervening variables (including risk and protective factors)
   - [ ] Others (please list)

   -Prescription Drug Monitoring Programs (PDMP) data from Kentucky All Scheduled Prescription Electronic Reporting System (KASPER)
   -Behavioral Health Data (past year depressive episodes, self harm, suicidal ideation, suicide attempts)
   -Children who have family member or someone close to them who have served in the military
   -School safety, bullying, gambling

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

   - [ ] Children (under age 12)
   - [ ] Youth (ages 12-17)
   - [ ] Young adults/college age (ages 18-26)
   - [ ] Adults (ages 27-54)
   - [ ] Older adults (age 55 and above)

- Cultural/ethnic minorities
- Sexual/gender minorities
- Rural communities
- Others (please list)

Kentucky National Guard Members

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

- Archival indicators (Please list)
- National survey on Drug Use and Health (NSDUH)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Youth Risk Behavioral Surveillance System (YRBS)
- Monitoring the Future
- Communities that Care
- State - developed survey instrument
- Others (please list)

Kentucky All Schedule Prescription Electronic Reporting (KASPER)
Kentucky Violent Death Reporting System
CDC Wonder
Kentucky State Police Data
Kentucky Center for School Safety
Kentucky Poison Control
Kentucky Injury Prevention & Research Center

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds? Yes No

If yes, (please explain)

If no, (please explain) how SABG funds are allocated:

The needs assessment data is used primarily to determine priorities and allocate discretionary funding such as the Partnership for Success (PFSII) and currently the PFS2015. The majority of the Block Grant funding is allocated to Kentucky's 14 Regional Prevention Centers (RPC). Each RPC is required to conduct biannual needs assessment of every county within their region. Local priorities are identified for each county. Allocations are then made to the RPC based on each county's local needs assessment data. Kentucky has thus far not required the RPCs to allocate SABG primary prevention funds abased on a state needs assessment.

Does the state have any activities related to this section that you would like to highlight?

The Division of Behavioral Health Prevention & Promotion Branch will hold a strategic planning summit on August 14 and 15, 2017. The goal of the summit is to create an outline for a comprehensive substance abuse prevention strategic plan for the entire state prevention system. This plan will encompass a vision and mission statement and incorporate state-level capacity building and workforce development-related goals, as well as an updated needs assessment. Once this plan is in place, we will be in a position to allocate SABG funds based on the planning priorities that surface in the needs assessment.

Please indicate areas of technical assistance needed related to this section

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states 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 misuse. The program must include, but is not limited to, the following strategies:

- *Information Dissemination* providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
- *Education* aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- *Alternative programs* that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- *Problem Identification* and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
- *Community-based Process* that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- *Environmental Strategies* that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce? (j) Yes (j) No

   If yes, please describe

   All Regional Prevention Center staff are required to be Certified Prevention Specialists within three (3) 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 Alcohol, Tobacco and Other Drug (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.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce? (j) Yes (j) No

   If yes, please describe mechanism used

   -Training: 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. In addition, we collaborate with key stakeholders to embed prevention specific topics into other training venues, for example, the division's annual System of Care conference. Training needs of prevention providers are assessed on an annual basis and a plan is developed to ensure that delivery of trainings match the needs of the community-level providers. We also access national level technical assistance through the Southeast Center for the Application of Prevention Technologies (CAPT), including the Substance Use Prevention Skills Training (SAPST), online courses and webinars. The focus throughout SFY 2016 and SFY 2017 has been on operationalizing the Strategic Prevention Framework within communities. This focus will continue in order to increase and then maintain capacity of providers to deliver programming with fidelity to the Strategic Prevention Framework (SPF) model.
   -Kentucky School prevention programming included: Kentucky's Response to the Opioid Epidemic; The new Cannabis Culture: Can Prevention Prevail?; Using Systems Thinking to Create Vibrantly Effective Prevention Systems; How to Market Prevention to Community Stakeholders and Legislators; Kentucky Prevention Board Ethics; Grants: Funding the Work: Successful Grant Seeking and Writing; Communication Skills for the Prevention Professional
   -Prevention Academy consists of the delivery of the SAPST during the first week followed by a second week covering current topics, populations and substances of focus in the state

-CAPT trainings delivered specifically for Kentucky include: Shared Risk and Protective Factors for Collaborative Efforts; Involving Youth in Your Substance Abuse Prevention Program; What is the SPF? An Introduction to SAMHSA's Strategic Prevention Framework; Go Get It! Finding Existing Data to Inform Your Prevention Efforts; Focusing on Focus Groups: An Implementation Guide for Substance Abuse Prevention Practitioners; Ethics in Prevention: A Guide for Substance Abuse Prevention Professionals
-External Technical Assistance: Kentucky's prevention branch utilizes the expertise and resources made available through the Southeast Resource team of the CAPT. The CAPT is providing TA focused on:
-Guidance on re-energizing the Master Trainer system
-Understanding the role of prevention in the continuum of care and developing a prevention elevator speech
-Increasing capacity of prevention providers to provide training and technical assistance to community-level stakeholders
-Create a mentoring system for providers
-Increase facilitation skills for collaborative efforts while maintaining the prevention position
-Analyzing and using data to tell the story of prevention in Kentucky
-Working with military populations
-Continued efforts around shared risk and protective factors
-Defining evidence-based programs

-Internal Technical Assistance: In addition to utilizing technical assistance from the Southeast Resource team of the CAPT, Kentucky state-level staff provide one-on-one technical assistance with providers and utilize that one-on-one TA to determine system-wide training and technical assistance needs. Identified gaps drive the requested services from CAPT (as noted above) as well as TA delivery offered by state staff.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? ( ) Yes ( ) No

If yes, please describe mechanism used

All Regional Prevention Centers are required to assess community readiness as part of their biannual needs assessment process and during the update process in the following year. The readiness assessment utilizes the Tri-Ethnic Center Community Readiness Model and center staff have received training in the assessment process. Additional analysis support is provided through the evaluation contract for the prevention portion of the Block Grant, REACH Evaluation. The readiness components are included in the RPCs work plan and work plans are monitored by state staff.

Does the state have any activities related to this section that you would like to highlight?

-The state's current prevention data system (PDS) serves as a barrier to timely and accurately data entry by prevention providers. While the state has designated a person to be responsible for addressing the issues related to the PDS, programming issues and a lack of a user-friendly platform make it difficult to ensure that the data entered reflect the reality of prevention delivered at the community level.
-Significant turnover in community-level providers, including and especially among individuals in leadership roles, has resulted in a degradation of the prevention delivery system in Kentucky. State staff are evaluating different components of the system in light of this workforce capacity issue in order to ensure that the highest likelihood of success is possible. Training and technical assistance is focused on rebuilding the infrastructure of the prevention delivery system to rebuild the system with fidelity to the SPF process.

Please indicate areas of technical assistance needed related to this section

-Developing/choosing a PDS that supports decision making for community-level implementation
-Attracting and retaining qualified prevention providers
-Identifying alternative/additional sustainable funding sources to support workforce recruitment and retention (i.e. higher salaries to increase tenure and experience of candidates).

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states 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 misuse. The program must include, but is not limited to, the following strategies:

- *Information Dissemination* providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
- *Education* aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- *Alternative programs* that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- *Problem Identification* and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
- *Community-based Process* that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- *Environmental Strategies* that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years? ( ) Yes ( ) No

   If yes, please attach the plan in BGAS by going to the Attachments Page and upload the plan

   Kentucky's PFS2015 strategic plan is currently the state plan being used since it involves all fourteen (14) of the RPCs and is based on a statewide needs assessment conducted by the SEOW. The priorities of the PFS2015 plan are opioid misuse/abuse, heroin, a special focus on the Service Member, Veteran, Families (SMVF) population and suicide among the population at large. The RPCs are responsible for drafting regional work plans to address these priorities. Moving forward, Kentucky is in the planning stage of developing a statewide prevention strategic plan, involving a cross section of the substance use prevention partners in the state. The Prevention Branch will begin the process in August 2017, by creating the first stage of the statewide plan. Identifying the Branch priorities, strengths, gaps and needs is vital to the creation of a comprehensive plan. Prevention partners are being recruited to participate in the larger planning process that will be occurring in the next two years.

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) ( ) Yes ( ) No ( ) N/A

3. Does your state's prevention strategic plan include the following components? (check all that apply):

   a) [ ] Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
   b) [ ] Timelines
   c) [ ] Roles and responsibilities
   d) [ ] Process indicators
   e) [ ] Outcome indicators
   f) [ ] Cultural competence component
   g) [ ] Sustainability component
   h) [ ] Other (please list):
   i) [ ] Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds? ( ) Yes ( ) No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate ( ) Yes ( ) No

strategies to be implemented with SABG primary prevention funds?

If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

The evidence-based work group is a subcommittee of the SEOW. While it has not been as active as it could be, it has been balanced by the work occurring around the evolution of Kentucky's Prevention Data System (PDS). As the PDS has grown, many challenges regarding terminology, service definitions and consistent documentation have been identified. A subset of the RPC Directors has been involved in the creation of a data dictionary and revising the old data manual used prior to the PDS. This process has been slow. As the Prevention Branch added staff over the last two years and was able to more fully assess the PDS' process and production of outcome data reports, these barriers have become clearer. As the workgroup continues to meet to solve the definitional questions, the SEOW will be involved in the approval process.The evidence-based workgroup is in the process of establishing criteria to determine which programs, policies and strategies will be considered evidence-based and reported as such in our PDS. An evidence-based program decision support tool has been developed to provide some context for how to set up a system to establish evidence-based criteria. The approval of the tool is pending.

Does the state have any activities related to this section that you would like to highlight?

Prevention Branch is scheduled to conduct a strategic planning summit in August. The ideas generated during this summit will be used to create a more SABG-based state strategic plan that will include long range capacity building and workforce development goals.

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

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states 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 misuse. The program must include, but is not limited to, the following strategies:

- *Information Dissemination* providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
- *Education* aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- *Alternative programs* that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- *Problem Identification* and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
- *Community-based Process* that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- *Environmental Strategies* that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:

   a) ☐ SSA staff directly implements primary prevention programs and strategies.

   b) ☐ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).

   c) ☐ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.

   d) ☐ The SSA funds regional entities that provide training and technical assistance.

   e) ☐ The SSA funds regional entities to provide prevention services.

   f) ☐ The SSA funds county, city, or tribal governments to provide prevention services.

   g) ☐ The SSA funds community coalitions to provide prevention services.

   h) ☐ The SSA funds individual programs that are not part of a larger community effort.

   i) ☐ The SSA directly funds other state agency prevention programs.

   j) ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

   a) Information Dissemination:

   Kentucky does not direct fund any strategies through its Block Grant dollars. The determination of strategies is made by the RPC 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. Kentucky is not able to 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 being funded by block grant dollars in various regions of the state.

   -Information Dissemination: Awareness campaigns on proper storage, monitoring and disposal of prescription medication, promotion of permanent prescription drop-box locations, brochures on prevention resources

   b) Education:

   -Education: Project Alert, Lifeskills, Too Good for Drugs, Prime for Life, Generation Rx, Tobacco Retail Underage Sales Training

c) Alternatives:

-Alternatives: Making Healthy Choices, Project Prom, mentoring programs

d) Problem Identification and Referral:

Problem Identification & Referral: TEG TAP, Zero Tolerance, Question, Persuade, and Refer (QPR)

e) Community-Based Processes:

-Community-Based Process: town hall meetings, training on smoke free policies, e-cigarettes, social host ordinances, creating regional law enforcement task forces to address Under Age Drinking, SPF-based training for community members, military culture training

f) Environmental:

-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, responsible beverage server training, alcohol and tobacco environmental scans

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means? ( ) Yes ( ) No

If yes, please describe

Does the state have any activities related to this section that you would like to highlight?

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

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states 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 misuse. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years? ( ) Yes ( ) No

   If yes, please attach the plan in BGAS by going to the Attachments Page and upload the plan

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

   a) [ ] Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
   b) [ ] Includes evaluation information from sub-recipients
   c) [ ] Includes SAMHSA National Outcome Measurement (NOMs) requirements
   d) [ ] Establishes a process for providing timely evaluation information to stakeholders
   e) [ ] Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
   f) [ ] Other (please list:)

   g) [ ] Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

   a) [ ] Numbers served
   b) [ ] Implementation fidelity
   c) [ ] Participant satisfaction
   d) [ ] Number of evidence based programs/practices/policies implemented
   e) [ ] Attendance
   f) [ ] Demographic information
   g) [ ] Other (please describe):

   -Activity Type
   -Intervention Type (universal direct, universal indirect, selective, indicated)
   -Staff Time
   -Partners

-CSAP strategy

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

a) ☑ 30-day use of alcohol, tobacco, prescription drugs, etc

b) ☑ Heavy use

☑ Binge use

☑ Perception of harm

c) ☑ Disapproval of use

d) ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

e) ☑ Other (please describe):

-risk factors (suspension, weapons, drug sales, car theft, aggression)
-age of onset
-school safety
-problems at school
-mental health
-accessibility
-lifetime use
-bullying
-violence

Footnotes:

Environmental Factors and Plan

10. Statutory Criterion for MHBG - Required MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

   The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) 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. DBHDID is Kentucky's designated State Mental Health Authority (SMHA). 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 disorders. Kentucky is divided into fourteen (14) geographic regions for the purposes of planning and providing publicly-funded community mental health, substance abuse and prevention services. Together, the 14 CMHCs 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 is an independent, non-profit organization; that is governed by a volunteer board of directors that broadly represents stakeholders and counties in the region; and is licensed by the Cabinet for Health and Family Services as a "Community Mental Health Center."

   Regional Boards are charged, statutorily, with providing at a minimum the following services:
   (a) Inpatient services (generally by referral);
   (b) Outpatient services;
   (c) Partial hospitalization or psychosocial rehabilitation services;
   (d) Emergency services;
   (e) Consultation and education services; and
   (f) Services for individuals with an intellectual disability.
   http://lrc.ky.gov/Statutes/statute.aspx?id=43455

   The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) administers a recovery oriented, comprehensive, community-based system of behavioral health care for adults with serious mental illness and their families through contracts with fourteen Regional Boards and a variety of other not-for-profit providers to offer a full continuum of mental health services and supports that address the needs of individuals with behavioral health conditions, including co-occurring disorders/co-morbid physical health conditions or developmental disabilities. DBHDID works with the Kentucky Department for Medicaid Services so that basic services, like outpatient clinic, targeted case management and rehabilitation services, are available and have similar requirements for Medicaid and non-Medicaid eligible individuals. DBHDID also funds a number of services and supports that are not Medicaid reimbursable (e.g., Supported Employment, Housing, Targeted case Management).

   CMHCs are required to specifically describe their current system of care for adults and to state their plans for development regarding key system components, within the annual Plan & Budget/contracting process. These components include:
   • Consumer and Family Support
   • Emergency Services
   • Behavioral Health Treatment Services, including Co-occurring Treatment for Mental Health and Substance Abuse, Substance Abuse Treatment, and Mental Health Services for Deaf and Hard of Hearing
   • Targeted Case Management Services
   • Rehabilitation Services (screening, Assessment, ACT, Peer Support, etc.)
   • Housing Options
   • Physical Health Interface
   • Continuity of Care
   • Homeless Outreach
   • Rural Outreach

Regional Boards also are required to describe their system of care for children, youth, young adults, and families as well as to state their plans for development regarding key system components, including:

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

DBHDID is committed to working collaboratively with CMHCs to continuously enhance continuity of care, service effectiveness and accountability. Training and technical assistance continues to be an important role of DBHDID to ensure provider competencies and to enable individuals to live, work and thrive in their own communities.

2. Does your state provide the following services under comprehensive community-based mental health service systems?

a)	Physical Health	Yes No
b)	Mental Health	Yes No
c)	Rehabilitation services	Yes No
d)	Employment services	Yes No
e)	Housing services	Yes No
f)	Educational Services	Yes No
g)	Substance misuse prevention and SUD treatment services	Yes No
h)	Medical and dental services	Yes No
i)	Support services	Yes No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	Yes No
k)	Services for persons with co-occuring M/SUDs	Yes No

Please describe as needed (for example, best practices, service needs, concerns, etc)

Yes responses to items a-k above does not mean that it applies statewide for all of them. Yes responses for items g) and j) above does not imply that MH Block Grant funds are used for these activities.

3. Describe your state's case management services

Targeted Case management was first provided in Kentucky through the fourteen (14) CMHCs beginning in 1985. In 1991, Kentucky Department for Medicaid Services received approval from CMS to add targeted case management for adults with SMI and children with SED as an optional Medicaid program.
In October of 2014, CMS approved a new state plan amendment for targeted case management for Kentucky. This new plan added some new categories for targeted case management including, targeted case management for individuals with substance use disorders and targeted case management for individuals with SMI, SED or SUD AND a co-occurring chronic physical health disorder. This state plan amendment and subsequent KY Medicaid regulations charged DBHDID with the responsibility for the credentialing of all new targeted case managers and supervisors. In response to the new state plan amendment in addition to a larger pool of Medicaid providers for behavioral health providers, the DBHDID restructured the process of certification trainings for several programs, including targeted case management.
Beginning in SFY 2015, the DBHDID provided curriculum rubrics and required potential training providers to submit curricula for approval, so agencies could begin providing certification trainings. Through DBHDID regulation, providers are required to follow the core components outlined in the curriculum rubrics, provide the required trainings following DBHDID approval, administer testing at the end of the training, and then submit to DBHDID the names and numbers of persons certified in each specific program (e.g. the names and numbers of certified targeted case managers for adults with SMI and for Children with SED).
Since that time, twenty-two (22) agencies have had curricula approved for the twelve (12) hour core curriculum, and fifteen (15) agencies have had the curricula approved for the six (6) hour additional training for SMI targeted case management, seventeen (17) agencies have had the curricula approved for the six (6) hour additional training for SED targeted case management, and twelve (12) agencies have had the curricula approved for the six (6) hour additional training for SMI/SED + a chronic, complex physical health condition.

Targeted case managers must have certification training within six (6) months of beginning to provide the service. Targeted case management supervisors are also required to attend the certification trainings. Provision for continuing education requirements are also included in the legislation.

Children/Youth with SED

The Kentucky IMPACT program was developed as a statewide service coordination model for children with SED in 1990 through work as a pilot program through one of the CMHCs, and was implemented in accordance with System of Care values and principles. IMPACT was established as a coordinated, interagency approach to service delivery for children/youth with SED and their families. The model provides services not traditionally available, such as mentoring, school-based services, and intensive in-home therapy, as well as flexible funding for informal supports such as community activities, family support, and after-school and summer activities. The overall goal of Kentucky IMPACT was to prevent children/youth with SED from being placed outside of their homes and to provide support and assistance to those who were transitioning from residential placements. Kentucky IMPACT has embraced the Wraparound philosophy since its inception. In fact, the Kentucky IMPACT program was one of the first statewide Wraparound initiatives in the country.

Historically targeted case management, delivered in accordance with the values of Wraparound, has been the key component of Kentucky IMPACT by which Wraparound for children and youth with SED has been implemented. Since the inception of Kentucky IMPACT, research related to Wraparound implementation has progressed dramatically. Until recently, Kentucky has not had the resources to keep up with the research progress. Deficient resources and high staff turnover had resulted in drift away from the Wraparound model. Recently, with support from the Kentucky Initiative for Collaborative Change (KICC) grant and collaboration between DBH Children's Services Branch and the Institute for Excellence in Behavioral Health, work toward better fidelity of this practice is occurring.

Kentucky DBH staff, stakeholders involved with KICC grant, and staff from Institute for Excellence are currently working with the National Wraparound Implementation Center to support the addition of High Fidelity Wraparound (HFW) to the existing Kentucky IMPACT program within the fourteen (14) CMHCs. The Kentucky IMPACT program maintains responsibility for the delivery and oversight of targeted case management services for children/youth with SED. Beginning in January of 2016, HFW was made available, through Kentucky IMPACT, to a limited number of children, youth and their families who met objective eligibility criteria. CMHCs have identified child/youth targeted case managers and their supervisors who attended initial training in the facilitation and supervision of HFW. Following this training, these facilitators and supervisors participated in a HFW learning collaborative that includes ongoing technical assistance, coaching and fidelity monitoring.

Trained HFW facilitators work with fewer children/youth than traditional targeted case managers. However, the children/youth who receive HFW have more complex needs and require more coordination among formal and informal services and supports. The lower caseload allows the HFW facilitators to spend more time with each family, supporting them in meeting their goals and becoming connected with community resources that will help them thrive. Children/youth are determined eligible to receive HFW via a multi-step process.

Child/youth and family functioning will be assessed across a variety of life domains on a regular basis to assist in determining the effectiveness of HFW in reducing behavioral health concerns and increasing connections within the community. Finally, a cost study is being conducted to determine the fiscal and human resources necessary to support HFW implementation.

Adults with SMI

Targeted case management is considered an essential Community Support Service because it coordinates an individual's service array, making maximum use of available formal and informal supports. Adults with serious mental illness who have the greatest difficulties accessing resources and those with more intense service needs are targeted for this service. Kentucky's adult mental health system of care embraces a strengths based model advocated by the University of Kansas (Dr. Charles Rapp) blended with the psychiatric rehabilitation model endorsed by Boston University (Dr. William A. Anthony).

Kentucky DBHDID supports targeted case management through the CMHCs in a variety of ways. DBH designates a statewide coordinator of targeted case management for adults with SMI, in addition, DBHDID approves curricula for agencies to provide certification training for targeted case managers, and provides additional training opportunities for case managers and case management supervisors.

Targeted case management services for adults with SMI and children with SED are available in all one hundred twenty (120) of Kentucky's counties. Eight (8) regions also provide targeted case management services for adults with SMI + a chronic, complex physical health condition. In SFY 2016, targeted case managers employed by CMHCs provided targeted case management to 6,075 (unduplicated) individuals with SMI. In April 2017, there were 331 Children's Targeted Case Managers ("IMPACT Service Coordinators") and an additional 33 High Fidelity Wraparound facilitators employed by the 14 CMHCs. Collectively they provided targeted case management services to (unduplicated) 9205 (unduplicated)children under age 18, in SFY 2018. It has become increasingly hard to receive Medicaid/MCO reimbursement for TCM for adults with SMI and children with SED.

4. Describe activities intended to reduce hospitalizations and hospital stays.

The Department believes that addressing the issue of continuity of care through a well-planned aftercare process is the key to ensuring a successful transition from the psychiatric hospital and other facilities to the community. Providing appropriate aftercare following a hospital stay or transition from a higher level of care is critical to reducing hospital readmission rates, enhancing community housing tenure and ultimately improving quality of life.

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 affected 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 133 people. As of SFY 2018, all but five (5) of

the original expressers had been transitioned. In October of 2015, the agreement was rewritten and resigned as the Amended Settlement Agreement (ASA). This agreement calls for the transition of 675 individuals with SMI from personal care homes into communities of their choice by October of 2018. An Independent Reviewer was hired to monitor the progress of the Settlement Agreement. The Settlement Agreement has led to additional funding allocations and additional continuity of care efforts in Kentucky.

KDBHDID addresses continuity of care for adults with SMI through several avenues. Through contracts with the fourteen (14) Regional Boards, KDBHDID requires the regions 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, contract language 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. There are also a series of various meetings designed to assist with continuity of care planning.
-Continuity of Care committee meetings occur at least 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. Agendas include system wide issues such as admission and discharge processes, follow up processes for outpatient appointments and medication access, strategies to reduce readmission rates, and general communication issues.
-Olmstead committee meetings occur monthly 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 and planning for transitioning to lower levels of care for individuals identified under the Olmstead Act. DBHDID provides funding to each state operated/contracted psychiatric hospital Catchment area. Olmstead funds are overseen by a Regional Board in each of the four (4) state psychiatric hospital Catchment areas. These flexible funds are designated for necessary goods and services for identified individuals that meet the Olmstead criteria:
-Have resided in the hospital over 90 days;
-Have had repeat admissions to the hospital over the course of one year and need flexible funding to remain in the community;
-Treatment professionals determine that community placement is appropriate;
-Community treatment is chosen via fully informed awareness; and
-Placement can be reasonable accommodated.
-Regional Transition committee meetings occur within each state operated/contracted psychiatric hospital, and include DBHDID, CMHC staff, Kentucky Protection and Advocacy, Department for Aging and Independent Living, Department for Community Based Services, Kentucky Long Term Care Ombudsman, Managed Care Organizations, the Independent Reviewer of the Amended Settlement Agreement, and other community stakeholders for that Catchment area. The purpose for these meetings is to discuss and plan for transitioning individuals that fit the ASA criteria:
-Adults with SMI who are transitioning from personal care homes or at risk of being readmitted to a personal care home.
-Adults with SMI who have been admitted to the state psychiatric hospital and fit the above criteria.

DBHDID has worked with each of the state operated/contracted psychiatric hospitals and their assigned Regional Boards to assist with the development of 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, additional behavioral health crisis services, such as mobile crisis, continued development of other community support services as effective alternatives to inpatient services for adults with serious mental illness, as well as opportunities for community partners to discuss pertinent strategies for creating "warm hand-offs".

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, peer support, and comprehensive community supports. 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, clarify authorization processes, and to improve relationships between stakeholders across the state.

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

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

There are several models of community-based crisis stabilization in place across the state. Services in these models include the following:
-Mobile Crisis Services
-Crisis Stabilization Unit
-Intensive In-home Services
-Walk-in Crisis Services
-Intensive Outpatient Services
-Crisis Case Management
-Crisis Therapeutic Foster Care and Other Residential Overnight Services
-Crisis Respite
-Crisis Transportation Services

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

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

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's behavioral health system

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	2.6% of Adult Pop. or 86,217	42,017 served in SFY 2016
2.Children with SED	5% of the Child Pop. or 51,169	26,925 served in SFY 2016

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

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.

Variable Criteria
Age Age 18 or older
Diagnosis Major Mental Illness
• 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:
• 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:
• 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 (2) year period of time

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 (SPMI).

The following table uses the federal SPMI prevalence rate of 2.6% and the 2010 census data to estimate the percentage of the targeted population serviced by the Regional Board during SFY 2016.

1 - Regional Boards
2 - Adult Census 2010
3 - Estimated Prevalence (2.6% of the Adult Census)
4 -Kentucky Adults with SMI Served in SFY 2016
5 - Penetration Rate - SMI Served

1 2 3 4 5
Four Rivers 161,545 4,200 3,483 83%
Pennyroyal 158,100 4,111 2,447 60%
RiverValley 161,977 4,211 2,264 54%
LifeSkills 217,231 5,648 1,874 33%
Communicare 200,640 5,217 3,394 65%
Centerstone 730,843 19,002 7,127 38%
NorthKey 326,235 8,482 3,154 37%
Comprehend 42,757 1,112 656 59%
Pathways 170,601 4,436 3,612 81%
Mountain 119,756 3,114 3,643 117%
Kentucky River 89,550 2,328 1,936 83%
Cumberland River181,110 4,709 2,843 60%
Adanta 160,202 4,165 2,313 56%
Bluegrass 595,449 15,482 3,271 21%
TOTAL 3,315,996 86,216 42,017 49%
Note: The data for SFY 2017 is not certified until October 2017 thus SFY 2016 data is used.

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

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 2015– 55,442 or 5% (of Kentucky's child population)
Kentucky MH Children Served SFY 2016– 50,339 or 5% (of Kentucky's child population)

Kentucky SED Children Served SFY 2015 – 29,267 or 57% (of the 5% SED population)
Kentucky SED Children Served SFY 2016 – 26,925 or 53% (of the 5% SED population)

1 - Regional Boards
2 - Child Census 2010
3 - Estimated Prevalence (5% of the Child Census)
4 - Kentucky Children with SED Served in SFY 2015
5 - Penetration Rate of Children with SED Served in SFY 2015
6 - Kentucky Children with SED Served in SFY 2016
7 - Penetration Rate of Children with SED Served in SFY 2016

1 2 3 4 5 6 7
Four Rivers 44,367 2,218 1,471 66% 1,460 66%
Pennyroyal 51,686 2,584 543 21% 413 16%
RiverValley 51,495 2,575 1,206 47% 1,278 50%
LifeSkills 66,964 3,348 1,072 32% 1,204 36%
Communicare 68,477 3,424 2,905 85% 2,462 72%
Centerstone 228,248 11,412 6,259 55% 5,634 49%
NorthKey 112,412 5,621 2,638 47% 2,542 45%
Comprehend 13,721 686 747 109% 642 94%
Pathways 48,935 2,447 2,268 93% 2,119 87%
Mountain 34,337 1,717 1,509 88% 1,780 104%
Kentucky River 25,212 1,261 1,243 99% 989 78%
Cumberland 55,508 2,775 3,002 108% 2,916 105%
Adanta 47,054 2,353 1,503 64% 1,217 52%
Bluegrass 174,955 8,748 2,901 33% 2,269 26%
TOTAL 1,023,371 51,169 29,267 57% 26,925 53%

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.
• KRS 200.503 http://www.lrc.ky.gov/Statutes/statute.aspx?id=43493

Narratve Question

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include: social services; educational services, including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services.

Criterion 3

Does your state integrate the following services into a comprehensive system of care?

a)	Social Services	Yes No
b)	Educational services, including services provided under IDE	Yes No
c)	Juvenile justice services	Yes No
d)	Substance misuse preventiion and SUD treatment services	Yes No
e)	Health and mental health services	Yes No
f)	Establishes defined geographic area for the provision of services of such system	Yes No

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

Describe your state's targeted services to rural and homeless populations and to older adults

1) Rural Populations

Narrative Question: Describe how your state targets services to rural populations.

Using the Rural-Urban Continuum Codes and the 2010 Census information, Kentucky has thirty-five (29%) counties considered metropolitan, forty-nine (41%) counties considered nonmetropolitan urban, and thirty-six (30%) counties considered completely rural. See table below:

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

Kentucky adult population distribution by CMHC region is shown in the chart 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. Centerstone 730,843 699,976 30,867
7. NorthKey 326,235 282,835 43,400
8. Comprehend 42,757 13,225 29,532
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

Kentucky adults with SMI who live in rural areas and were served by CMHC regions for SFY 2016 are listed in the table below:

Region Rural SMI Pop Rural SMI Served
1. Four Rivers 2,085 1,335 /64%
2. Pennyroyal 1,799 947/53%
3. River Valley 1,392 756/54%
4. Lifeskills 3,024 1,108 /37%
5. Communicare 3,185 2,268/71%
6. Centerstone 803 284/35%
7. NorthKey 1,128 511/45%
8. Comprehend 768 455/59%
9/10. Pathways 2,160 1,846/85%
11. Mountain 3,114 3,307/106%
12. Kentucky River 2,328 2,125 /91%
13. Cumberland River 4,709 2,798/59%
14. Adanta 3,670 1,944/53%
15. Bluegrass 2,300 900/39%
Total 32,465 20,584/63%
*Based on SFY 2016 data

The three most common barriers to mental health services in rural areas are isolation, transportation issues, and limited workforce. Isolation can partially be attributed to the geographical distance between neighbors and/or amenities, but may be more closely associated with the heightened stigma associated with mental health services in rural areas and the difficulty of ensuring confidentiality and anonymity in a small community.

One strategy to address isolation in rural areas is the recruitment and development of family support/peer support staff, to assist in decreasing stigma and enhancing needed outreach and support to individuals and families. Family peer support specialists are parents of children with severe emotional disabilities who have been trained to support other family members of these children. Kentucky also utilizes youth peer support specialists and adult peer support specialists in their continuum of behavioral health care, to enhance meaningful access, engagement and outcomes.

Transportation barriers remain one of the greatest concerns among providers, consumers and family members. The Human Service Transportation Delivery (HSTD) program pools existing public transportation funds including Medicaid non-emergency transportation. HSTD services are coordinated by the Kentucky Transportation Cabinet and provides non-emergency, non-ambulance medical transportation services to eligible Medicaid, Vocational Rehabilitation, and Department of the Blind recipients. A total of 12 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. Eight (8) of fourteen (14) Regional Boards report engaging in initiatives to better coordinate transportation services for adults with SMI in their regions. When no other source of funding is available, flexible funding for individuals eligible for targeted case management services may be utilized to pay transportation costs. Transportation remains, however, the number one barrier to accessing services in rural parts of the Commonwealth as reported by the CMHCs.

Rural communities often have fewer workforce and fewer resources to provide mental health services. It is important for rural mental health agencies to develop collaborative agreements with primary care physicians, senior citizen centers, church groups, government agencies, and other organizations. 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 created licensure categories for additional professionals 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.

The advantages of establishing telehealth capability across rural areas are well known. Due to difficulties in recruiting qualified medical and clinical staff to work in more rural areas, telehealth can be used to extend staff coverage from a central site to outlying rural clinics and other services sites. Most Regional Boards now report delivering or accessing services from the telehealth network. Nine (9) out of fourteen (14) CMHCs utilize telehealth equipment for providing some services as outlined below:

• Four Rivers Behavioral Health currently utilizes the telehealth network for psychiatric screening and services in three (3) counties and hired an Advanced Practice Registered Nurse (APRN) that is dedicated 100% for provision of telepsychiatry services.
• Pennyroyal Center utilizes telehealth for psychiatry services from all outpatient clinic locations. In addtion, emergency services are provided via telehealth to all clinic locations, all local hospitals who have MOAs with Pennyroyal Center, and all regional police departments who have MOAs with Pennyroyal Center.
• River Valley Behavioral Health utilizes telehealth via psychiatrists from the University of Louisville as well as APRN and other psychiatrists for medication management.
• Lifeskills utilizes the telehealth network to increase access of psychiatric services. Secure video connections are used to connect providers and individuals in real time.
• Communicare uses telehealth for psychiatry services and therapy services in all eight rural counties in their region.
• NorthKey utilizes telehealth for afterhour emegency room services and mental health evaluations. They are currently working on utilizing telehealth for some substance use services.
• Mountain Comprehensive Care Center utilizes telehealth for outpatient psychiatrist and medication management services in addition to crisis stabilization unit services and residential children's programs.
• Kentucky River Community Care, Inc., utilizes telehealth services with individuals in all offices across their region, as well as in Lexington, Louisville and London. They provide individual therapy, medication management and crisis services via this technology.
• Cumberland River Behavioral Health has telehealth available in each outpatient clinic across their region and offers telehealth between sites. They are also utilizing telehealth to assess new admissions into the adult crisis stabilization unit and to provide children's psychiatric services to one site in Manchester, Kentucky.
• The Adanta Group provides telehealth psychiatry services to rural counties in their region and provides telehealth psychiatry services via contract with the University of Louisville as well.

In May of 2009, the regulation regarding telehealth services was rewritten by Medicaid and submitted to CMS for approval. The original teleheath regulation approved only psychiatrists or advanced registered nurse practicitioners as providers. In March of 2011, the telehealth amendment was approved by CMS. Medicaid now provides 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, when provided to eligible individuals

through real-time telecommunications as part of a medically necessary service, under telehealth:
• Consultations;
• Mental health evaluations and management;
• Individual and Group therapy;
• Pharmacological management; and
• Psychiatric/Psychological/Mental Health diagnostic interview examination.

Regional Boards have begun to expand these reimbursable services into their array and it is hoped that more rural consumers will have better access to services and better continuity of care between providers.

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

2) Homeless Populations
Narrative Question: Describe how your state targets services to homeless populations.

DBHDID recognizes the importance of system coordination among the numerous agencies and programs involved with services to individuals who are homeless. At the state level, DBHDID participates in the Kentucky Interagency Council on Homelessness (KICH), a group of state and local providers, consumers and government officials, established to develop statewide systems and policies that forge partnerships among state agencies allowing communities to achieve local solutions to homelessness, in addition to establishing targets for permanent supported housing production.

The Council is updating its Plan to Prevent and End Homelessness, which is an expression of a collective commitment to actively seek long-term and sustainable solutions to homelessness, rather than continuing to simply manage episodes of homelessness as they occur. The significant focus of this plan is on investing local resources in a manner that better serves the homeless, and in so doing, eliminates homelessness in Kentucky. Some areas addressed in this Plan include:
• Access to mainstream services;
• Access to health insurance, including Medicaid;
• Assistance with disability applications through the SSI/SSDI Outreach, Access and Recovery (SOAR) initiative;
• Implementing a Move-Up strategy from Permanent Supportive Housing to subsidized housing;
• Serving victims of intimate partner violence experiencing homelessness; and
• Ending youth and family homelessness.

DBHDID, KICH and Kentucky Housing Corporation (KHC) continue to collaborate on the SOAR Initiative. They have developed a Case Management Manual for homeless service providers and a Homelessness Rights Manual (both available on the KICH website), and continually promote education and training for discharge planning in public institutions. Efforts are also underway to increase access and availability of housing options for individuals experiencing homelessness through the promotion of the “Housing First” model.

Most 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;
• Thirteen (13) regions participate in regional Continuum of Care meetings;
• Thirteen (13) regions do consultation with local shelters;
• Nine (9) regions have staff dedicated to homeless individuals;
• Nine (9) regions regularly visit local homeless shelters;
• Six (6) regions have a walk-in clinic; and
• Four (4) regions do street outreach.

DBHDID continues PATH Grant funding in SFY 2018 to the CMHCs that received contracts in the prior year. The seven PATH regions are:
• LifeSkills, Inc. - Provides outreach, case management and training in the Bowling Green / Warren County area.
• Centerstone (formerly Seven Counties Services, Inc.) - 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.
• NorthKey Community Care, - 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 urban areas.
• Pathways, Inc. - Provides outreach and case management in the Ashland / Boyd County area.
• Kentucky River Community Care - 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 Behavioral Health - Provides outreach, case management and housing support services in Laurel County.
• Bluegrass.org, - 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.
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, ensures that annual data collection requirements are met, and that fund allocation and contracts are in place. Support is also provided through notification of relevant training, updates on homelessness issues, and on -site technical assistance, as needed.
DBHDID is also involved with other homeless initiatives including:
• The Homeless Prevention Project, which assists persons being discharged from state facilities in accessing housing and mainstream services, in an effort to limit discharges to homeless shelters. Community partners include the Lake Cumberland Regional Board, the Department of Corrections, the Department for Community Based Services, the Louisville Coalition for the Homeless, and Families and Children Place. This project assists persons serving out of the prison system, persons being discharged from psychiatric institutions, and persons aging out of foster care.

• Collaboration with the KY Housing Corporation (KHC) in the operation of local homeless planning boards ("Continuum of Care Committees") in Kentucky's area development districts (which correspond to the fourteen CMHC regions). CMHCs 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.

• Funding an Outreach Worker with the St. Johns' Day Center in Louisville to provide on-site assessment and link individuals with services at Centerstone, the Regional Board for Louisville.

• A Rural Homeless Outreach program, funded with MH block grant funds, is operated by Mountain Comprehensive Care. The goal of this program is the identification of individuals with SMI who are homeless and linkage with mainstream mental health services. Consultation and training to homeless service providers is also provided under this initiative.

3) Older Adults
Narrative Question: Describe how your state targets services to older adults.

According to the United States Census (2016 American Community Survey 5-year estimates), Kentucky's population of individuals age sixty (60) and older is approximately 901,866 individuals, accounting for about 21% of Kentucky's total population. This is an increase from the 2010 census of 829,193 individuals or approximately 19.1%. According to the Center for Disease Control (CDC), this population will more than double in the coming years due to two factors, including aging baby boomers (persons born between 1946 and 1964) and longer life spans. In 2006, the first baby boomers began to cross the threshold into this population, accounting for the largest category of people. The last baby boomers will be over the age of eighty-five (85) in the year 2050.

Using the federal formula for severe and persistent mental illness, it is estimated that approximately 2.6% of adults in Kentucky, age sixty (60) and older, are diagnosed with a serious mental illness, such as depression, which is not a normal part of the aging process. Based on the 2010 Census population numbers, 2.6% of the population is approximately 21,558 individuals, however this number is estimated to be higher due to the population growth in this age group. In SFY 2016, Kentucky's 14 CMHCs served approximately 5,950 individuals over the age of sixty (60) with a serious mental illness (SMI), accounting for about 28% of the state's total SMI population of individuals over age sixty (60).

The diagnosis and treatment of mental illness can be more complex with older adults due the presence of another health diagnosis. For example, depression is more common in people who also have other illnesses (such as heart disease or cancer) or whose function becomes limited. The CDC reports that about 80% of older adults have at least one chronic health condition, 50% have two or more chronic health conditions, and major depression occurs in about 13% of the older adult population depending on their setting. Additionally, the CDC highlights an on-going concern of healthcare providers misdiagnosing depression, and other mental illnesses, due to a long standing belief and practice, that a decline in mental health is a natural part of the aging process. Many older adults 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 in Kentucky with behavioral health issues, as identified in the 2014 Behavioral Risk Factor Surveillance System (BRFSS) survey through the Centers for Disease Control (CDC), include:

• Nearly 24% of adults in have been told by a health professional that they have a depressive disorder which is higher than the national average;
• For adults, specifically age sixty-five (65) and older, 18.1% experience depression;
• Nearly 3% of older adults binge drink alcohol;
• Nearly 39% of older adults engage in little to no physical activities;

• Over 12% of older adults age use tobacco; and
• Older adults have an increased prevalence of arthritis, coronary heart disease, and diabetes (24.5%).

Older adults often have Medicare insurance coverage (only) and many of the behavioral health services they need are not part of the benefit package. For services that are provided, Medicare often will not reimburse for the professionals providing the services. There is a need for additional flexible funding to support the behavioral health services needed by older adults.
Kentucky is committed to addressing the need of expanded access to mental health treatment for older adults with SMI. 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 currently 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, Spaulding University, National Alliance on Mental Illness (NAMI), Medicaid Services, CMHCs, consumers, caregivers, and other interested stakeholders. For SFY 2018/2019, the Coalition strives to achieve the following on an ongoing basis:

• 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;
• Providing funding opportunities for members of the various statewide Mental Health and Aging Coalitions to participate in the learning opportunities regarding mental health and again of older adults; and
• Mental Health First Aid training.

In Kentucky there are fifteen (15) Area Development Districts (Area Agencies on Aging), which focus on the needs of Older Adults. The Area Agencies on Aging are under the umbrella of the Department of Aging and Independent Living (DAIL). DBHDID collaborates with DAIL and the CMHCs in a variety of ways, including:
• Staffing the statewide Mental Health and Aging Coalition to address the Coalition's mission of educating the public, healthcare professionals, consumers, caregivers, and other stakeholders, regarding issues related to the aging process and the mental health needs of older adults;
• Participating in training events regarding mental health and aging such as the annual Optimal Aging Conference and other local training events organized by the Area Development Districts. The 2017 Optimal Aging Conference was hosted by The University of Louisville's Institute for Sustainable Health and Optimal Aging as well as The Kentucky Association for Gerontology;
• Staffing the Behavioral Health Planning and Advisory Council;
• Staffing the Elder Abuse Committee; and
• Historically, partnering in grant applications regarding older adults and mental health.

A staff person from the Division of Behavioral Health serves as a designee for the DBHDID Commissioner on the National Association of State Mental Health Program Directors' (NASMHPD) Older Person's Division. Kentucky is a member of this national association that represents state mental health commissioners/directors and their agencies and provides support to inform, advocate for and provide a forum for the exchange of ideas and state agendas. The Older Person's Division keeps abreast of the national agenda and shares information with its membership through monthly conference calls and periodic in-person meetings.

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

1) Financial Resources
Per Section 1911 of the Title XIX Block Grants, the state will expend the grant funds only for the purposes of:
• Carrying out the plan submitted for the fiscal year;
• Evaluating programs and services carried out under the plan; and
• Planning, administering and educational activities related to providing services under the plan.

DBHDID allocates mental health block grant funds as well as substance abuse prevention and treatment block grant funds, to Regional Boards and to agencies that are either public or not-for-profit entities in accordance with federal block grant requirements. No funds are used to satisfy any requirement for the expenditures of non-Federal funds. The mental health block grant funds are utilized by DBHDID to provide direct services for adults with SMI and children with SED and to support statewide initiatives that promote the systems of care for these populations. A small portion of funds are also used to support data collection and analysis and the operation of the Kentucky Behavioral Health Planning and Advisory Council.
The following tables outline how mental health block grant funds are allocated for SFY 2018 and the same is planned for SFY 2019.
2) Staffing

3) Training of Mental Health Providers Necessary for the Plan

4) Training of Providers of Emergency Health Services regarding SMI and SED

The Department for Behavioral Health, Developmental and Intellectual Disabilities serves as a support agency for the Kentucky Emergency Support Function (ESF) 8 – Public Health and Medical Services group. ESF is led by the Department of Public Health, a sister agency to DBHDID, within the Cabinet for Health and Family Services. The ESF group assists with coordination of public health and medical related preparedness, response and recovery activities for any incident/event (emergency, disaster, exercise, or planned event) that requires state level coordination. One of the primary support organizations for the ESF is the Kentucky Community Crisis Response Board (KCCRB). This organization sits under the Kentucky Department for Military Affairs and was created under Kentucky Revised Statutes Chapter 36 and Chapter 42. KCCRB's Crisis Response Team (KCCRT) is activated by a Governor's Disaster Declaration in the case of natural or manmade disasters to provide psychological first aid. KCCRB provides Rapid Assessment & Response Teams deployed upon request to mitigate stress reactions to critical incidents and traumatic events. It is important to note that in many states, the responsibilities of KCCRB are housed within the mental health authority's office, thus Kentucky's system is rather unique since this responsibility lies elsewhere.

DBHDID requires the fourteen (14) Community Mental Health Centers (CMHCs) via contract, to maintain a community level behavioral health disaster plan regarding emergency preparedness that outlines expected regional response in the case of a crisis or disaster and that ensures collaboration with local community partners. Each CMHC is required to review their plan annually with the KCCRB and submit their plan electronically. In addition, each CMHC has designated an individual to serve as the point person for emergency preparedness in the region.

KCCRB is staffed by a multi-disciplinary team of trained individuals who volunteer their time to assist others who encounter a critical incident. Many of these volunteers are behavioral health professionals, and some are CMHC staff. As a part of the KCCRB effort, Psychological First Aid trainings are held across the state. Psychological First Aid is a SAMHSA endorsed program teaching first responders and others how to deal with individuals experiencing traumatic events. Individuals trained in Psychological First Aid learn to promote environments of safety, calmness, connectedness, self-efficacy, empowerment and hope in times of crisis. During SFY 2017, KCCRB reported 12 Psychological First Aid II trainings being held. Psychological First Aid I is now an online course. It is followed up by an 8 -hour face to face Psychological First Aid II course.

Mental Health First Aid (MHFA) training is another way the DBHDID is involved in providing training regarding behavioral health issues to emergency health providers by training first responders, other emergency health services providers, and other community members. MHFA is a public education program, which targets any member of the community, which helps with identification, understanding and responses to signs of mental illnesses and substance use disorders. It is managed by national entities and has rigorous requirements, including a week long training session, in order to be certified as a MHFA trainer. At the state level, each MHFA training is eight (8) hours and includes education on a five (5) step action plan where participants gain the knowledge and skills to assist an individual experiencing a mental health crisis by connecting him/her with the appropriate professional, peer, social or self-help care. The number of Mental Health First Aid trainers in Kentucky has ballooned over the last few years. The database from the National Council reports twenty-eight (28) instructors certified in Adult Mental Health First Aid, and two hundred, seventeen (217) instructors certified in Youth Mental Health First Aid in Kentucky. During SFY 2017, DBH contracted with

the National Alliance on Mental Illness (NAMI) affiliate in Lexington to provide Adult MHFA trainings across the state, and to begin a process of tracking both persons approved to provide the training, and the number of actual trainings occurring across the state. NAMI Lexington provided ten (10) Adult MHFA trainings during SFY 2017. The audience included first responders and emergency 911 call staff, state guardians, police officers and police dispatchers, and others. Some of these trainers work for Kentucky Partnership for Families and Children (KPFC), a behavioral health advocacy agency for children and families. KPFC trainers offered three (3) trainings in Youth MHFA during SFY 2017. NAMI Lexington has created a workgroup of MHFA trainers in Kentucky to work on coordination efforts and promotion. This group will be working toward the following:

- Increasing the number of Kentuckians certified as Mental Health First Aid trainers;
- Improving promotion of MHFA within the state;
- Providing a referral source for Kentucky MHFA instructors;
- Encouraging collaboration among Kentucky MHFA instructors;
- Becoming a resource for Kentucky MHFA instructors; and
- Surveying active Kentucky MHFA instructors for how best to support their efforts.

Footnotes:

Eighty-one percent **(81%)** of Kentucky's Mental Health Block Grant Funds are Allocated to the 14 CMHCs for Services and Supports to Adults with SMI and Children with SED, including Transition Age Youth.

CMHC	SMI-SED Emergency Services	Adults with SMI	Children with SED	First Episode Psychosis	TOTAL
1. Four Rivers	11,677	170,139	87,768	200,000	**469,584**
2. Pennyroyal	10,365	169,967	74,870	3,000	**258,202**
3. River Valley	10,453	186,882	86,894	3,000	**287,229**
4. Lifeskills	15,625	226,484	92,061	200,000	**534,170**
5. Communicare	15,083	198,047	102,418	100,000	**415,548**
6. Centerstone	29,632	708,257	187,268	50,000	**975,157**
7. North Key	13,048	293,649	120,171	3,000	**429,868**
8. Comprehend	7,271	35,045	79,533	3,000	**124,849**
9/10. Pathways	14,513	247,432	96,837	50,000	**408,782**
11. Mountain	12,675	204,467	93,670	100,000	**410,812**
12. Kentucky River	10,165	85,096	80,457	3,000	**178,718**
13. Cumberland River	13,541	261,676	106,474	125,000	**506,691**
14. Adanta	11,805	135,747	84,500	3,000	**235,052**
15. Bluegrass	21,541	170,465	151,315	100,000	**443,321**
TOTAL	**197,394**	**3,093,353**	**1,444,236**	**943,000**	**5,677,983**

Nineteen percent **(19%)** of Kentucky's Mental Health Block Grant Funds are Allocated to Support Statewide Projects or to support state level needs (e.g., data collection and analysis, consultation from Universities, etc.)

Statewide Project	Funding Allocation
Adult Mental Health Training and Technical Assistance	20,000
Recovery Initiative – Training and TA	40,000
Person Centered Recovery Plans – Training and TA	20,000
Supported Employment Fidelity Initiative	21,000
Crisis Intervention Training (CIT) –Training of Law Enforcement	90,000
Mental Health and Aging – Statewide Aging Coalitions	20,000
Children's Mental Health Training and Technical Assistance	20,000
State Interagency Council for Children Support	25,000
Statewide Deaf & Hard of Hearing Services	34,787
Eastern KY University	162,637
KY Housing Corporation – Supported Housing Specialist for SMI	13,333
KY Partnership for Families and Children	143,000

NAMI Lexington – Recovery Oriented Training	150,190
NAMI KY – Recovery Oriented Family Support	145,054
UK- Institute for Pharmaceutical Outcomes and Policy - Data support	100,000
UK-Human Development Institute -Supported Employment TA	263,059
BH Planning and Advisory Council - Operation of the Council	6,850
Wellspring - Supported Housing Initiative	50,000
TOTAL	**1,324,910**

Component 3: Training

Division of Behavioral Health Sponsored/Provided Training Events

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
Assertive Community Treatment (ACT) Team Leader Technical Assistance Meeting	ACT team leaders	Approximately 25	Quarterly 4 hours
ACT Leadership Training	Regional Board staff on ACT teams, DBH staff, other Regional Boards staff, other providers of behavioral health services	Approximately 50	2 Days As Needed
Adult Crisis Director's Meetings	Directors of adult crisis stabilization units	Approximately 30	Quarterly 4 hours
Amended Settlement Agreement Meetings	In Reach Coordinators, ACT team staff, Regional Transition Coordinators, DBH, others as appropriate	Unlimited	Quarterly 1 Day
Community Support Program (CSP) Directors Technical Assistance Meetings	CSP Directors	Approximately 25	Quarterly 3 hours
Community Transition Team (CTT) Meetings	Directors of 3 state contracted programs for transitional care of adults with SMI	Approximately 15	Quarterly 4 hours
Hearing Voices that are Distressing	Behavioral health providers and administrators and family members	Maximum of 40	As requested 3 hours
Integrated Dual Diagnosis Treatment (IDDT) Training	ACT team members Other providers	Approximately 40	3 Days Repeated in 3 locations across the state

Trainings Relevant to Adult Services			
Type of Training	**Intended Audience**	**# of Participants Anticipated**	**Frequency/ Length of conference**
IPS Supported Employment Conference	IPS Supported Employment staff from Regional Boards, other contracted entities, DBH staff, OVR.	Approximately 50	2 Days 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
Person Centered Recovery Planning (PCRP) Overview	Regional Board staff, DBH staff, other community partners	Approximately 50	1 Day Overview Training (Kickoff)
PCRP Supervisory Training	Regional Board staff, DBH liaisons identified during initial training efforts as supervisors/coaches	Approximately 30	2 Day Supervision Training
PCRP Case Consultation Webinars	Regional Board staff	Staff of one region	1 hour monthly calls
PCRP Supervision Webinars	Regional Boards staff identified as supervisors/coaches, DBH liaisons	Approximately 20	1 hour monthly calls
PCRP State Workgroup Webinars	Regional Board management staff, DBH commissioner level staff, DBH Division leadership staff, DBH liaisons	Approximately 20	1 hour bimonthly calls

BOLD *Denotes that Continuing Education Units (CEUs) may be 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

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.

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

ACT Leadership Training

Two-day training from national consultant on ACT regarding improving leadership skills in a number of critical areas such as resource management, practice competencies, and team building.

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.

Amended Settlement Agreement Meetings
Quarterly statewide meetings led by DBH staff to discuss issues related to the Amended 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, in reach, processes, etc.

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.

Community Transition Team (CTT) Meetings
These are meetings held quarterly consisting of staff from three (3) programs traditionally known as specialized personal care homes and now known as supportive housing programs and transitional personal care home. Peer group for networking various issues and resources related to adults with SMI transitioning to community living.

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.

Integrated Dual Diagnosis Treatment Training
Training regarding IDDT, an 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.

IPS Supported Employment Conference
DBH Adult Branch, in collaboration with the Office for Vocational Rehabilitation, hosts an annual, two-day training for staff in IPS Supported Employment programs, contracted fidelity monitors, contracted trainers and coaches, and others from across the state. Workshops regarding the Individual Placement and Support (IPS) Model of Supported Employment are provided.

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.

Person Centered Recovery Planning Overview
A 1-day training event on Person Centered Recovery Planning. Consultants Janis Tondora, PsyD., and Diane Grieder, M.Ed., provided an overview of person centered principles, medical necessity requirements, and identified local change teams, supervisor/coaches, and DBH liaisons for several Regional Boards.

PCRP Supervisory Training

A 2-day training for regional supervisors/coaches identified during the overview meeting, with consultants and DBH liaisons regarding supervision techniques and coach methods for strengths based coaching to the PCRP model.

PCRP Case Consultation Webinars
One-hour monthly technical assistance webinars with consultants, DBH liaison, and identified change teams within various regions. Staff present real cases and are given assistance in conceptualization and documentation of the PCRP model.

PCRP Supervision Webinars
One-hour monthly technical assistance webinars with identified regional supervisors/coaches, DBH liaisons and consultants. Discuss issues and barriers to provision of the PCRP model with regional middle management and identified supervisory staff.

PCRP State Workgroup Webinars
One-hour bimonthly webinars with management of Regional Boards, DBHDID Commissioner and Commissioner level staff, DBH leadership, DBH liaisons, and consultants to work through system level issues and support PCRP as a working model.

Trainings Relevant to Children's Services			
Type of Training	**Intended Audience**	**# of Participants Anticipated**	**Frequency/ Length of conference**
Behavior Institute, co-sponsor	Educators, administrators, agency service providers, and families	Approximately 1200	Biennially; 2.5 days
System of Care Academy	primary care providers, clinicians, practitioners, educators, child care providers, Family Resource Youth Service Center staff, juvenile justice staff, community based services staff, public health staff, families/youth, and community members	Approximately 350	Annually 3 Days
Plan of Safe Care	Behavioral Health service coordinators, clinicians, prevention specialists	1000	Offered Regionally and Annually
Trauma Informed Care Considerations for Children who are Deaf or Hard of Hearing	Teachers of the Deaf, Special Education teachers and administrators, Directors of Special Education, KY School for the Deaf staff, and Educational Interpreters	5-50 per session	1-1.5 hours at least twice per year and as requested
Resources for Serving Children who are Deaf or Hard of Hearing and Their Family Members	IMPACT Service Coordinators	20-30 per session	3 hour session as requested by CMHCs or SOC agencies

Trainings Relevant to Children's Services			
Type of Training	**Intended Audience**	**# of Participants Anticipated**	**Frequency/ Length of conference**
KY School for Alcohol and Other Drug Studies- adolescent treatment and recovery track	Mental health and substance use clinicians, case managers, peer specialists, prevention specialists, and others interested in working with young people	120 -150 in the track each year	Annual for 4 days
Law Enforcement Responses to Youth Experiencing the Onset of a Mental Disorder or a Mental Health Crisis	School Resource Officers, Police, Sheriff Deputies	25-30 per Session	1.5 Hours, Two Sessions per Year
Motivational Interviewing Basics Training	Clinicians, peer specialists, IPS employment specialists, case managers, supervisors). This training is required if you are interested in taking the Advanced Training.	40 per session	2 day training As needed
Motivational Interviewing Booster/Advanced Training	This training is for any staff who completed the MI Basics training and is interested in increasing their skill level in utilizing MI in their daily work. (clinicians, peer specialists, IPS employment specialists, case managers, supervisors).	40 per session	1 day booster training and/or 2 day advanced training As needed
Motivational Interviewing Supervisor Training	This training is for MI Supervisors who will be providing onsite coaching and skill building to staff within their agency who have completed the MI Basics, Booster Session and Advanced Training.	40 per session	1 day training As needed
Introduction to Wraparound	HFW Facilitators, HFW Supervisors, and directors as well as community partners that may participate in a child and family team process	45	3 days
Engagement in the Wraparound Process	HFW Facilitators, HFW Supervisors, directors as well as community partners who may participate in child and family team process	45	2 days
Advancing Wraparound Practice	For HFW Supervisors	30	2 days
School-Based Suicide Prevention	School Administrator, Educators, Staff	40	As requested

Trainings Relevant to Children's Services			
Type of Training	**Intended Audience**	**# of Participants Anticipated**	**Frequency/ Length of conference**
Transition Aged Youth Launching Realized Dreams (TAYLRD)	Child and Adult Case Managers	60	As requested 1 Day
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 community agencies	25	1 day, plus follow-up sessions, 2 per year
Child and Adolescent Needs and Strengths (CANS)	CMHC and PCC child clinicians who will be administering the CANS		1 day Offered as needed
Child and Adolescent Service Intensity Index (CASII)	CMHC child clinicians	30	1 day Offered as needed
Early Childhood Service Intensity Index (ECSII)	CMHC child clinicians	30	1.5 days Offered as needed
Structured Interview for Psychosis-risk Syndrome (SIPS)	The training is required for professionals who will be administering the SIPS tool with clients/patients such as psychiatrists, psychologists, nurses, social workers, case managers or other mental health workers, peer specialists.	60	3 days As needed
Early Interventions for First Episode Psychosis	Any community providers	50	3 hours As needed

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

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.

System of Care Academy 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.

Plan of Safe Care

Trauma Informed Care Considerations for Children who are Deaf or Hard of Hearing – The purpose of this workshop is to introduce providers to unique considerations in deaf-member families including higher risk for physical and sexual abuse, the presence of language and education deprivation, and language dysfluency. Strategies are provided for identifying behaviors that may be trauma-related, creating a more understanding environment, and referring for additional help.

Resources for Serving Children who are Deaf or Hard of Hearing and Their Family Members – Starting with scenarios

Kentucky School of Alcohol and Other Drug Studies

The Kentucky School of Alcohol and Other Drug Studies (KSAODS) is an annual week-long event where more than 800 Kentucky, Indiana and Ohio professionals from the alcohol and drug treatment, mental health, prevention and other related fields gather to hear from national and state leaders on the up-and-coming theories of practice in the behavioral health world. As of 2015, the School began to specifically offer an adolescent track of workshops that provide professionals working with youth and young adults who may have substance use issues or co-occurring substance use and mental health issues targeted information for that population.

Law Enforcement Responses to Youth Experiencing the Onset of a Mental Disorder or a Mental Health Crisis

This training is part of a 40-hour training to improve law enforcement officers' capacity to effectively engage individuals with diminished capacity. The training focuses on behavioral health disorders youth experience, developmental considerations, crisis warning signs, and how to engage youth and parents as allies.

Motivational Interviewing (Basic/Booster/Advanced/Supervisor)

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

Introduction to Wraparound

The purpose of this training is to gain an understanding of the critical components of the wraparound process in order to provide high fidelity wraparound practice and to practice these steps of the process to include eliciting the family story from multiple perspectives, reframing team missions, identifying needs, establishing outcomes, brainstorming strategies, and creating a plan of care and crisis plan that represents the work of the team and learn basic facilitation skills for running a wraparound team meeting.

Engagement in the Wraparound Process

The purpose of this training is to identify barriers to engagement, develop skills around engaging team members and the family, and utilize research-based strategies of engagement for increased positive outcomes for youth and their families.

Advancing Wraparound Practice: Supervision and Managing to Quality

The purpose of this training is to identify the essential elements of quality wraparound implementation, develop an increased understanding of the role of the supervisor in quality wraparound implementation, learn how to manage quality throughout the phases of wraparound implementation, learn how to utilize supportive tools to develop quality wraparound practitioners, individualized and strength-based service plans, and team processes, and learn how to transfer knowledge and skills to the workforce.

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.

TAYLRD
This training provides an overview of barriers, developmental issues, cultural issues and best practices when providing services and supports to transition age youth.

Trauma Informed Care Training
This training will provide an overview of trauma and the necessary components that support the provision of care that takes into consideration the trauma that individuals have experienced in their life.

Trauma Informed System of Care Training for Trainers
A cross-agency training to train community partner 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.

CANS
The CANS is the functional assessment used for children entering out-of-home care through DCBS. It is also the outcomes management tool that will be used for High Fidelity Wraparound

CASII
The CASII is required to determine medical necessity for the MCOs. It is also used as part of the eligibility determination process for High Fidelity Wraparound

ECSII
The ECSII is required to determine medical necessity for the MCOs. It is also used as part of the eligibility determination process for High Fidelity Wraparound

SIPS
The Structured Interview for Psychosis-Risk Syndromes (SIPS) is a reliable and internationally-used assessment tool to assist in the identification of early symptoms of psychosis. This training will provide the skills necessary to professionals who will be administering the SIPS tool.

Early Interventions for First Episode Psychosis
This training will provide an overview of prevalence, signs and symptoms of psychosis-risk and first episode psychosis in youth and young adults as well as provide information on best practices for this population.

Trainings Relevant for Both Adult and Children's Services			
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
Adapting Substance Use 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.
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
Cognitive Behavior Therapy for Consumers who are Deaf with Language and Learning Challenges	Therapists, case managers, rehabilitation counselors for the deaf, and others.	40	As needed.
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
Cognitive Behavior Therapy with Psychosis (CBTp)	Regional Board staff, DBH staff, state psychiatric facility staff, other providers of psychiatric services for youth and young adults	Approximately 50	3 Days As Needed
CBTp Supervision Training	Regional Board staff and other providers of psychiatric services who had been identified as supervisors/coaches during the 3 day training, DBH staff	Approximately 20	1 Day As Needed
Come Learn Presentations	DBHDID staff	Unlimited	Quarterly 1 hour

Trainings Relevant for Both Adult and Children's Services			
Type of Training	**Intended Audience**	**Number of Participants Anticipated**	**Frequency/ Length of conference**
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 Every Few Years
Crisis Intervention Team Training (CIT)	Law Enforcement Officers	Approximately 360 Total	12 per year 5 Days (40 hours)
Cultural Competency Training	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
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

Trainings Relevant for Both Adult and Children's Services			
Type of Training	**Intended Audience**	**Number of Participants Anticipated**	**Frequency/ Length of conference**
Feedback Informed Treatment	Regional Board staff, DBH staff, other providers of psychiatric services for youth and young adults	Approximately 20	1 Day As Needed
First Episode of Psychosis Overview of Early Interventions	Regional Board staff, DBH staff, state psychiatric facility staff, other providers of psychiatric services for youth and young adults	Approximately 50	2 Day Annually
First Episode of Psychosis Site Consultation TA calls	Regional Board staff from iHOPE programs	One program at a time	1 Hour Monthly
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 Behavioral 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

Trainings Relevant for Both Adult and Children's Services			
Type of Training	**Intended Audience**	**Number of Participants Anticipated**	**Frequency/ Length of conference**
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
Mental Health Interpreting Peer Supervision Groups	A supervision group for clinicians serving clients who are deaf or hard of hearing.	5-15	Monthly
Motivational Interviewing	Regional Board staff, other providers of behavioral health services, state psychiatric facility staff, DBH staff	Approximately 30	2 Days As Needed
Multifamily Group Therapy	Regional Board staff, DBH staff, other providers of psychiatric services for youth and young adults	Approximately 30	2 Days As needed
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
Structured Interview for Psychosis Risk Syndrome	Regional Board staff, DBH staff, state psychiatric facility staff, other providers of psychiatric services for youth and young adults, colleges and university staff, local hospitals	Approximately 60	3 Days Annually and as needed
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
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

Descriptions of Trainings Related to Both Adult and Children's Services

Access Options for Consumers with Hearing Loss
Training made available by DBHDID Deaf and Hard of Hearing Services (DHHS) staff to all providers as needed regarding access options.

Adapting Substance Use Treatment for Deaf or Hard of Hearing Consumers
Training made available by DBHDID DHHS staff specific to treating individuals with SUD and who are Deaf or Hard of Hearing.

American Sign Language Interpreter Peer Supervision Groups on Mental Health Interpreting
Training provided to certified, licensed interpreters and interns working in mental health settings across the state. Designed to address specific issues related to mental health while interpreting.

Assessing and Managing Suicide Risk: Core Competencies for Mental Health
Training for behavioral health clinicians in recognizing and managing risk for possible suicidal behaviors.

Cognitive Behavioral Therapy for Consumers who are Deaf with Language and Learning Challenges
Training to specifically educate how to adapt CBT for use with individuals who are Deaf and who may have learning challenges.

Cognitive Behavior Therapy for Perinatal Depression
Training for professionals specifically on adapting CBT for use with women who are experiencing depression in conjunction with pregnancy.

Cognitive Behavior Therapy for Psychosis (CBTp)
A 3-day training for clinicians regarding building skills to adapt CBT for use with individuals experiencing psychosis, in particular, with individuals experiencing very early symptoms of their first episode of psychosis. Douglas Turkington, M.D., from the United Kingdom, and Jesse Wright, M. D. of the University of Louisville provided this training. Clinicians from regional boards as well as other providers identified supervisory staff who receiving this training and agreed to go forward and coach others in their agency.

CBTp Supervision Training
A one-day follow-up training for identified supervisors/coaches from across the state. This training was led by Jesse Wright, M.D. from the University of Louisville. The focus was on supervision methods and tips and tools to guide this evidence based practice in local agencies.

Come Learn Presentations
One-hour educational presentations that are generally for DBH staff and designed as traditional "brown bag" opportunities to gain information on a variety of topics.

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 complex physical health conditions and their supervisors.

Crisis Intervention Team (CIT) Training
In collaboration with the National Alliance on Mental Illness (NAMI), KDBHDID provides training for law enforcement officers, via a contract with a retired police lieutenant, regarding how to better respond to encounters with individuals who may be experiencing a behavioral health crisis. This training is based on the evidence based Memphis Model of CIT.

Cultural Competency Training
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.

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.

Deafness 101
Overview of cultural and linguistic issues in serving individuals who are Deaf or Hard of Hearing.

Deafness 102
Additional training on how to adapt clinical practices to be culturally and linguistically affirmative for individuals who are Deaf or Hard of Hearing.

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.

Evidence Based Care for the Client at Risk of Suicide
Training for clinicians on skills for dealing with individuals at risk of suicide.

Feedback Informed Treatment
Training from Ryan Melton, Ph.D., from Portland State University, in methods and procedures for evaluating behavioral health treatment in a collaborative manner and adjusting methods in a data driven manner, in collaboration with the person being served.

First Episode of Psychosis Overview of Early Interventions
A two-day training from the Early Assessment and Support Alliance (EASA) from Portland State University regarding literature and best practices for early intervention in young people experiencing first episodes of psychosis. Includes screening and assessment methods, evidence based treatment and family support.

First Episode of Psychosis Consultation TA Calls
Monthly TA calls between EASA consultants and iHOPE (Helping Others Pursue Excellence) programs across the state. iHOPE are programs offering Coordinated Specialty Care, an evidence based practice for young people experiencing first episode of psychosis.

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.

Kentucky Registry of Interpreters for the Deaf (RID)
Training for interpreters for individuals who are Deaf or Hard of Hearing from across the state.

KDBHDID Orientation

Orientation is provided 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 Behavioral Health Planning and Advisory Council Member Orientation
A 4-hour orientation is provided annually for all new members of this Council, or new state representatives on this Council, or other interested parties. Led by members of the Council.

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 (Mental Health 101)
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.

Let's Talk Safety for Families: Access to Lethal Means
Training for family members and others in the general population about prevention of suicide.

Let's Talk Safety: Clinical Issues Associated with Access to Lethal Means
Training for clinicians about prevention of suicide.

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.

Motivational Interviewing
Trainings by a national consultant to introduce the concept of motivational interviewing and to allow participants to practice the techniques that are part of the methodology behind the concepts. These trainings are targeting staff in mental health, substance use, and other programming.

Multifamily Group Therapy Training
A two-day training by EASA from Portland State University in this evidence based family psychoeducation model, particularly effective when working with families of individuals experiencing their first episode of psychosis.

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.

Structured Interview for Psychosis Risk Syndrome (SIPS)
A 3-day training event for individuals wanting to be certified in using the SIPS assessment tool. Barbara Walsh of Yale University provides this certification training and teaches participants to score this

standardized assessment tool in order to accurately identify individuals most likely experiencing early symptoms of their first episode of psychosis.

Therapists' Retreat for those Serving Consumers with Hearing Loss
Networking and support opportunity that occurs four times per year.

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. 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 effective treatment.

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").

Environmental Factors and Plan

11. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i)	Screening	Yes	No
ii)	Education	Yes	No
iii)	Brief Intervention	Yes	No
iv)	Assessment	Yes	No
v)	Detox (inpatient/social)	Yes	No
vi)	Outpatient	Yes	No
vii)	Intensive Outpatient	Yes	No
viii)	Inpatient/Residential	Yes	No
ix)	Aftercare; Recovery support	Yes	No

b) Are you considering any of the following:

	Targeted services for veterans	Yes	No
	Expansion of services for:		
(1)	Adolescents	Yes	No
(2)	Other Adults	Yes	No
(3)	Medication-Assisted Treatment (MAT)	Yes	No

Criterion 2: Improving Access and Addressing Primary Prevention - See Narrative 9. Primary Prevention-Required SABG.

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? ( ) Yes ( ) No

2. Either directly or through and arrangement with public or private non-profit entities make pernatal care available to PWWDC receiving services? ( ) Yes ( ) No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? ( ) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? ( ) Yes ( ) No

5 Are you considering any of the following:

   a) Open assessment and intake scheduling ( ) Yes ( ) No

   b) Establishment of an electronic system to identify available treatment slots ( ) Yes ( ) No

   c) Expanded community network for supportive services and healthcare ( ) Yes ( ) No

   d) Inclusion of recovery support services ( ) Yes ( ) No

   e) Health navigators to assist clients with community linkages ( ) Yes ( ) No

   f) Expanded capability for family services, relationship restoration, custody issue ( ) Yes ( ) No

   g) Providing employment assistance ( ) Yes ( ) No

   h) Providing transportation to and from services ( ) Yes ( ) No

   i) Educational assistance ( ) Yes ( ) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

   Kentucky behavioral health system of care has incorporated multiple programs to address the needs of pregnant and parenting women. These programs address substance use disorder by developing a continuum of care consisting of residential services, transitional housing, intensive outpatient, peer support, case management.
   DBHDID staff convenes community level staff regularly and reviews the requirements and offers problem solving steps for ensuring compliance. DBHDID staff also visits programs at the local level periodically to provide training and technical assistance as time and resources allow.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

   a) 90 percent capacity reporting requirement — Yes / No

   b) 14-120 day performance requirement with provision of interim services — Yes / No

   c) Outreach activities — Yes / No

   d) Syringe services programs — Yes / No

   e) Monitoring requirements as outlined in the authorizing statute and implementing regulation — Yes / No

2. Are you considering any of the following:

   a) Electronic system with alert when 90 percent capacity is reached — Yes / No

   b) Automatic reminder system associated with 14-120 day performance requirement — Yes / No

   c) Use of peer recovery supports to maintain contact and support — Yes / No

   d) Service expansion to specific populations (military families, veterans, adolescents, older adults) — Yes / No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

   Contractual requirements include guidelines for providing education and referral sources for individuals identified at risk for diseases associated with intravenous drug use and their correlation with hepatitis, HIV and TB. The Department of Behavior Health includes the Program Integrity Branch to monitor provider compliance with program deliverables and performance indicators. Funding is contingent upon completion of performance indicators.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? — Yes / No

2. Are you considering any of the following:

   a) Business agreement/MOU with primary healthcare providers — Yes / No

   b) Cooperative agreement/MOU with public health entity for testing and treatment — Yes / No

   c) Established co-located SUD professionals within FQHCs — Yes / No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

   Persons Who Inject Drugs and Tuberculous

   • Contractual requirements include guidelines for providing education and referral sources for individuals identified at risk for diseases associated with intravenous drug use and tuberculous. The Department of Behavior Health includes the Program Integrity Branch to monitor provider compliance with program deliverables and performance indicators. Funding is contingent upon completion of performance indicators.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently maintain an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIC in areas that have the greatest need for such services and monitoring the service delivery? — Yes / No

2. Are you considering any of the following:

   a) Establishment of EIS-HIV service hubs in rural areas — Yes / No

b) Establishment or expansion of tele-health and social media support services — Yes / No

c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS — Yes / No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SABG funds are not expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)F)? — Yes / No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? — Yes / No

3. Do any of the programs use SABG funds to support elements of a Syringe Services Program? — Yes / No

If yes, plese provide a brief description of the elements and the arrangement

The Kentucky Department for Public Health has supported the development of needle exchange programs across the state. There are currently thirty (30) Needle Exchange Programs in Kentucky. Several of these programs provide outreach services and referral to treatment.

Criterion 8,9&10

Syringe System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — Yes / No

2. Are you considering any of the following:

   a) Workforce development efforts to expand service access — Yes / No

   b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — Yes / No

   c) Establish a peer recovery support network to assist in filling the gaps — Yes / No

   d) Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — Yes / No

   e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — Yes / No

   f) Explore expansion of service for:

      i) MAT — Yes / No

      ii) Tele-Health — Yes / No

      iii) Social Media Outreach — Yes / No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered and person-directed care? — Yes / No

2. Are you considering any of the following:

   a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — Yes / No

   b) Establish a program to provide trauma-informed care — Yes / No

   c) Identify current and perspective partners to be included in building a system of care, e.g. FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — Yes / No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449) — Yes / No

2. Are you considering any of the following:

   a) Notice to Program Beneficiaries — Yes / No

   b) Develop an organized referral system to identify alternative providers — Yes / No

   a) Develop a system to maintain a list of referrals made by religious organizations — Yes / No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — Yes / No

2. Are you considering any of the following:

   a) Review and update of screening and assessment instruments — Yes / No

   b) Review of current levels of care to determine changes or additions — Yes / No

c) Identify workforce needs to expand service capabilities — Yes / No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — Yes / No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — Yes / No

2. Are you considering any of the following:

a) Training staff and community partners on confidentiality requirements — Yes / No

b) Training on responding to requests asking for acknowledgement of the presence of clients — Yes / No

c) Updating written procedures which regulate and control access to records — Yes / No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure — Yes / No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — Yes / No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

For SFY 2018 and SFY 2019, DBHDID will be reviewing 23 Narcotic Treatment Programs annually, as well as 38 programs for expansion of substance use services on an annual basis, and at least 2 programs funded through the SMART grant to be reviewed annually.

3. Are you considering any of the following:

a) Development of a quality improvement plan — Yes / No

b) Establishment of policies and procedures related to independent peer review — Yes / No

c) Develop long-term planning for service revision and expansion to meet the needs of specific populations — Yes / No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, e.g., Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? — Yes / No

If YES, please identify the accreditation organization(s)

i) ◉ Commission on the Accreditation of Rehabilitation Facilities

ii) ◉ The Joint Commission

iii) ◉ Other (please specify)

Referrals

• Managed Care Organizations require American Society of Addiction Medicine (ASAM) criteria for Medicaid billable services. The Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) contracts with CMHCs to require the use of ASAM for level of care determination for services. DBHDID supported seven (7) trainings across the state on ASAM criteria. Additionally, DBHDID is supporting ongoing training efforts including Screening, Brief Intervention, Referral to Treatment (SBIRT), Trauma Informed Care, Comprehensive Opioid Response paired with 12-steps (COR 12), Motivational Interviewing, Targeted Case Management, and Peer Support.
The majority of the 14 CMHCs are accredited by either Joint Commission or CARF but it is not currently required by DBHDID.

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? Yes No

2. Are you considering any of the following:

   a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service Yes No

   b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing Yes No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opertunity to receive training on an ongoing basis, concerning:

   a) Recent trends in substance use disorders in the state Yes No

   b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services Yes No

   c) Preformance-based accountability Yes No

   d) Data collection and reporting requirements Yes No

2. Are you considering any of the following:

   a) A comprehensive review of the current training schedule and identification of additional training needs Yes No

   b) Addition of training sessions designed to increase employee understanding of recovery support services Yes No

   c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services Yes No

   d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort Yes No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:

   a) Allocations regarding women Yes No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

   a) Tuberculosis Yes No

   b) Early Intervention Services Regarding HIV Yes No

3. Additional Agreements

   a) Improvement of Process for Appropriate Referrals for Treatment Yes No

   b) Professional Development Yes No

   c) Coordination of Various Activities and Services Yes No

Please provide a link to the state administrative regulations, which govern the Mental Health and Substance Use Disorder Programs.

Group Home

Kentucky Division of Behavioral Health (DBH) has operated a revolving loan fund in partnership with Kentucky Housing

Corporation since the early 1990s. At that time, it was decided to utilize the Oxford House model, a now evidence based practice, for the purposes of establishing new recovery homes utilizing that loan fund. Since January 2016, DBH has contracted directly with Oxford House, Inc. for the purposes of expanding the recovery home network in the Commonwealth. During that time, Kentucky's network has grown from four (4) houses in Northern Kentucky providing thirty-two (32) recovery beds, to twenty-two (22) houses with one hundred, fifty-nine (159) beds across the state. Due to the recent increase in houses, we have increased the amount in the revolving loan fund to sustain rapid expansion of our recovery home network. While no Memorandums of Understanding (MOU)s have been instituted between providers and group homes, the contract with Oxford House, Inc. provides our state with Oxford House outreach workers who establish relationships with service providers to ensure linkage in our continuum of care.

Professional Development
DBHDID provides and sponsor a variety of trainings and technical assistance throughout the year including Kentucky School of Alcohol and Other Drugs, System of Care Academy, Faith Based Coalition Conference, Operation Immersion, Gambling Association Conference, and Prevention Academy.

Prevalence Data for Specific Population
Kentucky follows the Surgeon General's guidelines of a nine percent (9%) prevalence rate of substance use disorders in the population. According to the U.S. Census Bureau's 2016 population estimates, with a population of approximately 4.4 million people in the state, and, considering only those individuals ten (10) years of age or older, we estimate there are approximately 350,000 individuals in the Commonwealth that meet the criteria for a substance use disorder diagnosis.
Current unmet service needs in Kentucky include but are not limited to transitional housing, transportation to substance use disorder treatment services in rural areas, residential housing for pregnant and parenting women, treatment systems where SUD treatment is fully integrated with primary care, opioid overdose prevention, and medication assisted treatment programs that are effectively administered.

Regulations:

DBHDID -
Alcohol and Other Drug Entities Regulation:
http://www.lrc.state.ky.us/kar/908/001/370.htm
Also see: http://lrc.ky.gov/kar/TITLE908.HTM and scroll for
Chapter 1 Substance Abuse
300 Chemical dependency program evaluation
310 Certification standards and administrative procedures for driving under the influence programs
315 Zero tolerance program requirements
320 Confidential record of treatment for federally-assisted alcohol and other drug abuse programs
340 Narcotic treatment programs
370 Licensing procedures and standards for persons and agencies operating nonmedical- and nonhospital-based alcohol and other drug abuse treatment programs
380 Licensing procedures and standards for the operation of alcohol and other drug abuse prevention programs
400 Procedures for substance abuse prevention

Chapter 2 Mental Health
010 Local board authority
020 Personnel rules of local board
030 Board structure and operation; eligibility for state grants
040 Hospital district assignments
050 Formula for allocation of funds
060 Mental health and mental retardation manuals for funding instructions, program policies and standards, and reimbursement guidelines
065 Community transition for individuals with serious mental illness
090 Decriminalization of mental illness
220 Adult peer support specialist
230 Kentucky family peer support specialist
240 Kentucky youth peer support specialist
250 Community support associate; eligibility criteria and training
260 Targeted case manager: eligibility and training

Medicaid
Go to: http://www.lrc.state.ky.us/kar/title907.htm
and scroll for the following:
Chapter 15 Behavioral Health
• 005 Definitions for 907 KAR Chapter 15
• 010 Coverage provisions and requirements regarding behavioral health services provided by individual behavioral health

providers, behavioral health provider groups, and behavioral health multi-specialty groups
• 015 Reimbursement provisions and requirements for behavioral health services provided by individual behavioral health providers, behavioral health provider groups, or behavioral health multi-specialty groups
• 020 Coverage provisions and requirements regarding services provided by behavioral health service organizations
• 025 Reimbursement provisions and requirements regarding behavioral health services provided by behavioral health service organizations
• 040 Coverage provisions and requirements regarding targeted case management for individuals with a substance use disorder
• 045 Reimbursement provisions and requirements for targeted case management services for individuals with a substance use disorder
• 050 Coverage provisions and requirements regarding targeted case management for individuals with a mental health or substance use disorder and chronic or complex physical health issues
• 055 Reimbursement provisions and requirements regarding targeted case management for individuals with a mental health or substance use disorder and chronic or complex physical health issues
• 060 Coverage provisions and requirements regarding targeted case management for individuals with a severe mental illness and children with a severe emotional disability
• 065 Reimbursement provisions and requirements regarding targeted case management for individuals with a severe mental illness and children with a severe emotional disability
• 070 Coverage provisions and requirements regarding services provided by residential crisis stabilization units
• 075 Reimbursement provisions and requirements for behavioral health services provided by residential crisis stabilization units
• 080 Coverage provisions and requirements regarding outpatient chemical dependency treatment center services
• 085 Reimbursement provisions and requirements regarding

http://www.lrc.state.ky.us/kar/907/001/044.htm
http://www.lrc.state.ky.us/kar/907/001/045.htm
http://www.lrc.state.ky.us/kar/907/003/020.htm

Footnotes:

Kentucky's behavioral health system of care includes fourteen (14) Community Mental Health System providers as well as multiple licensed and credentialed private providers as specified on the DBHDID provider directory that provide access within the state to a full continuum of services, including screening, education, brief intervention, assessment, detox, outpatient, intensive outpatient, residential, and recovery supports. Kentucky is continuously identifying specific populations of need and provides targeted services. Those populations include Veterans, adolescents, pregnant and parenting women, homeless, and others as identified. Kentucky promotes the use of medication assisted treatment (MAT) as a valuable treatment tool through twenty-three (23) methadone clinics, and over seven hundred, fifty (750) DATA-2000 waivered physicians.

Environmental Factors and Plan

12. Quality Improvement Plan- Requested

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.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2016-FFY 2017? ( ) Yes ( ) No

Does the state have any activities related to this section that you would like to highlight?

The Division of Behavioral Health serves Kentuckians through community-based services for mental health and substance use disorders. The Division recently began revising its Quality Improvement Plan. The current plan has become outdated due to the Department's recent progress made in the areas of performance contracting and improving fidelity monitoring of evidence based practices. The revisions include aligning the outcomes and performance measurement system to the National Behavioral Health Quality Framework.

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

Kentucky would appreciate the opportunity to learn and share with other state behavioral health authorities about their Quality Improvement Planning process. As described in the "Quality and Data Collection Readiness" section of this application, KY has organized a collaborative among three teams which address data-related issues and we would like to be a part of a similarly organized team collaborative at the national level. Often key staff contributing to the Quality Improvement Plan are new to such roles yet bring skilled program administrator experience. Involving staff in a national collaborative to share and learn about Quality Improvement Plan development would empower and increase KY's ability to improve.

Footnotes:

13. Trauma - Requested

Narrative Question

Trauma [60] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening 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.

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. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with.

These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive behavioral health care. States should work with these communities to identify interventions that best meet the needs of these residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[61] paper.

60 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.*

61 *Ibid*

Please respond to the following items

1. Does the state have a plan or policy for behavioral health providers that guide how they will address individuals with trauma-related issues? ( ) Yes ( ) No

2. Does the state provide information on trauma-specific assessment tools and interventions for behavioral health providers? ( ) Yes ( ) No

3. Does the state have a plan to build the capacity of behavioral health providers and organizations to implement a trauma-informed approach to care? ( ) Yes ( ) No

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? ( ) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight.

   Since 2008 the Division of Behavioral Health has been facilitating trainings on Trauma Informed Care and on Seeking Safety, a manualized treatment for Co-occurring Substance Abuse and PTSD. All 14 CMHCs regularly require training for all new staff and provide continuing education for current staff. Many CMHCs have trained trainers of Trauma Informed Care and many participate on the state level workgroup to promote and refine this practice.

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

   N/A

Footnotes:

14. Criminal and Juvenile Justice - Requested

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 mental and substance use problems. Youth 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.[62]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[63]

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 M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or Marketplace; loss of eligibility for Medicaid 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.

The MHBG and SABG 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.

[62] Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.* Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide

[63] http://csgjusticecenter.org/mental-health/

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to behavioral health services? ( ) Yes ( ) No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, behavioral health provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? ( ) Yes ( ) No

3. Does the state provide cross-trainings 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 ( ) No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address behavioral health and other essential domains such as employment, education, and finances? ( ) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight?

   Since the implementation of multi-faceted decriminalization legislation in 1994, Kentucky has eliminated the use of jails and juvenile detention centers during acute psychiatric crises and during the involuntary hospitalization process. Instead, community mental health center (CMHC) staff evaluate individuals in safe, secure locations, such as emergency rooms, government buildings and homes. These efforts have:
   -Increased emergency responders' understanding of mental illness and substance use disorders;
   -Improved access to community-based evaluation and treatment;
   -Improved collaboration among local law enforcement officers, judges, mental health professionals, other community partners, and the general public; and
   -Reduced the trauma and stigma of involuntary hospitalization.

   Adult Diversion from the Justice System
   KDBHDID has intensified efforts to build an integrated service system for individuals with serious mental illness who are involved in the justice system, by collaboration between KDBHDID, law enforcement agencies, the Kentucky Department of Corrections,

CMHCs, and other stakeholders in our communities' "safety net" to serve persons with mental illness.

KDBHDID, in partnership with the CMHCs and other various stakeholders, provides training to a number of entities in order to ensure that individuals with a serious mental illness are diverted into treatment whenever possible rather than being arrested and booked into jail. One of these trainings is the jail triage program. During SFY 2003, KY legislators, spurred by an increase in jail suicides approved legislation related to the Jail Triage program. KDBHDID developed, implemented and monitored this training curriculum that included information on suicide prevention and recognizing the signs and symptoms of mental illness. Regional staff are trained with a "model curriculum" and expected to train the staff in their local jails. In addition to this training, CMHCs 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. Kentucky continues to look at technology and assessment protocols to strengthen the Jail Triage program. This programming is currently running well and anecdotal feedback from the jails is always highly positive. Jail triage funding did not increase over the years and innovation has been necessary to protect the gratifying success of the program and continued collaboration with jail staff. The Jail Triage program provides emergency mental health services to eighty-six (86) county jails in Kentucky. The relationship between CMHCs and local jails has continued through the delivery of 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 budgeted $1,100,000 for SFY 2017, and the program more than quadrupled in size and scope since SFY 2004. In SFY 2004 the program served a little less than (5,000) five thousand individuals in jails statewide. In SFY 2017 the program served approximately (21,500) twenty-one thousand five hundred clients in the jails. CMHCs 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. In Jefferson County, Louisville Metropolitan area, the CIT within the Police Department has been in place for over nine (9) years and has successfully diverted thousands of individuals into care. Over two thousand, two hundred and thirty-five (2,235) 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. In SFY 2017, three hundred, one (301) Kentucky Police Officers received the 40 hour CIT certification and there were seven thousand, eight hundred and twenty-four (7,824) statewide law enforcement responses to persons with either mental illness, substance use disorders, intellectual disabilities, or co-occurring disorders. There have also been over (35) thirty-five CIT "Train the Trainer" certifications awarded since the programs implementation. In July 2017, Lexington Metro Police began their own CIT certification for all new recruits with the goal of certifying their entire police force within five years. Twelve of fourteen CMHC regions to date have CIT Advisory Committees. CIT Advisory Committees involve mental health professionals, advocates, consumers, local law enforcement, local hospital staff, judges, county attorneys, peers, and other community partners in an effort to enhance community collaboration. The statewide objective going forward is to double the size of the CIT programs throughout the state, and to create regional CIT Advisory Committees in the two CMHC regions that do not currently have them.

KDBHDID in collaboration with The Department of Criminal Justice Training (DOCJT) began a new twenty-four (24) hour behavioral health training at the police basic academy in June 2017. The new program provides new police recruits with a basic knowledge of mental health, development disabilities, intellectual disabilities, and substance use disorders. The training block consists of two days (16 hours) of instruction and scenarios presented by two CIT "Train the Trainer" instructors. The remaining day (8 hours), consists of behavioral health professionals instructing new recruits about the clinical side of mental health disorders, substance use disorders, autism, brain injuries, developmental, and intellectual disorders. The new behavioral health training at DOCJT will provide all new Kentucky police officers a basic understanding of individuals with behavioral health issues and how best to communicate and work with them in the community. This block of training will be conducted about once per month and will reach about three-hundred and fifty (350) new police officers per year.

DBHDID also provides a 40-hour course for law enforcement titled; "Law Enforcement Response to Special Needs Populations", 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 learn about to best engage persons with a mental illness, intellectual disability, developmental disability, autism, deaf or hard of hearing, substance use disorder, and/or a co-occurring diagnosis. A peer support specialist and an individual in recovery participates as an instructor in this training.

Kentucky has also begun implementing mental health courts to divert many individuals into treatment and aftercare rather than long-term incarceration. Currently six (6) mental health courts exist and include; Jefferson County (Louisville), Fayette County (Lexington), Northern KY/Greater Cincinnati (Kenton, Campbell, and Boone Counties), Nelson County (Bardstown), Clark County (Winchester), and Hardin County (Elizabethtown). Persons with a serious mental illness (SMI) and involved in the criminal justice system are accepted in the mental health court program that provides an emphasis on treatment and recovery rather than incarceration. Assessment protocols and more formal treatment modalities are used to address co-occurring issues. Programming continues to include: Illness Management and Recovery (IMR), Integrated Dual Diagnosis Treatment (IDDT), peer support, 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 focuses on criminogenic factors that impact recidivism.

KDBHDID has also collaborated with the CMHC in the Louisville area (Centerstone Kentucky) on a re-integration project, partially funded by mental health block grant funds. This program allows for strategic planning and case management for inmates with

SMI who are exiting Kentucky prisons and returning to their communities. The Boundary Spanner project employs two re-integration case managers and a peer support specialist who work to form a bridge of services between the prison system and the individual's home community. This enables the connection to behavioral health services and provides a "warm hand off" to the local community mental health center.

Beginning in SFY 2017 KDBHDID collaborated with Centerstone Kentucky to develop the state's first Forensic Assertive Community Treatment (FACT) team. Based in Louisville the team works with individuals being released from the Louisville Metro Jail and/or the Kentucky Department of Corrections to provide discharge planning, housing, behavioral health services, medications, and supported employment. The FACT team wraps services around the individual in the community to prevent the cycle of re-incarceration. Currently the team has a case load of thirty (30) individuals with the goal of increasing the number of FACT team staff members as well as introducing FACT programs in other areas of the state.

Other projects that KBHDID 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. This program provides an individual with the ability to receive mental health and/or substance use treatment in the community as an alternative to jail or prison. Individuals are assisted throughout the process by court personnel, case managers, and probation/parole officials to ensure program participation. In most cases when an individual completes the program, the crimes are expunged from the individual's record.

KDBHDID's contract language with the CMHCs stipulates that 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 CMHCs. This allows individuals who are serving out or being released from the CPTU and PCU to be seen at a CMHC within fourteen (14) days of release for behavioral health services. By designating this group as a priority, a smoother transition into the community is ensured 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.

Children's Diversion from the Justice System
Kentucky has a unique juvenile justice system. Within the Judicial Branch of the Commonwealth, the Administrative Office of the Courts' Court Designated Worker (CDW) program is the "gatekeeper" to the court system. With the mission of preventing delinquency among Kentucky's youth, the CDW program provides education, treatment referral, and accountability through a statewide delivery of coordinated services. The Kentucky Department of Juvenile Justice (DJJ), one of five departments under the Kentucky Justice and Public Safety Cabinet within the Executive Branch, is responsible for statewide detention services, residential placement/treatment services, probation, community aftercare/reintegration programs and youth awaiting adult placement or court. Of Kentucky youth coming into contact with the juvenile justice system, 32% are committed to the DJJ, 28% are informally adjusted (diverted), and 40% of cases are probated (Kentucky Department for Juvenile Justice, 2006). Thus, the need for accessible and effective treatment is paramount throughout the system.

The need to enhance treatment options for adolescents with juvenile justice involvement has been especially pronounced. While some adolescents will engage in troubling behavior, appropriate and consistently-applied discipline can ensure youth have opportunities to learn from mistakes and become successful contributing adults. Unfortunately, Kentucky, like many states had responded to such troubling behavior by detaining youth, including those who commit status offenses, an approach shown to be ineffective and highly expensive (Nelson, 2008). In fact, Kentucky detained youth charged with status offenses at the second highest rate in the nation, even though the most populous county in the state does not use this practice (KYA, 2011). With national estimates of approximately 70% of youth with juvenile justice involvement meet criteria for a diagnosable mental health disorder and about 61% have a co-occurring substance use disorder (National Center for Mental Health and Juvenile Justice, 2006), adolescents with juvenile justice involvement presents a unique challenge to the system of care. Not only is the intensity of their needs likely to be greater, but proper response to their multiple needs requires increased collaboration, continuity of care, and the ability to recruit and retain providers who are equipped to treat multiple needs. Unfortunately, many of the youth had not receive much needed behavioral health treatment that could prevent initial involvement with the juvenile justice system or reduce the likelihood of recidivism. In 2012, The Department of Behavioral Health applied and received a Policy Academy grant. The John D. and Catherine T. MacArthur Foundation and the Substance Abuse and Mental Health Services Administration collaborated on an initiative entitled Improving Diversion Policies and Programs for Justice Involved Youth with Co-Occurring Mental Health and Substance Abuse Disorders: An Integrated Policy Academy/Action Network Initiative. Kentucky began to address some of the policy and practices within the juvenile justice system including its ability to address behavioral health issues by building from a previous site specific grant from the Robert Wood Johnson Foundation called Reclaiming Futures, a model for improving juvenile justice through community integration, into the pre-court diversion process so that youth with co-occurring mental and substance use disorders charged with status offenses receive a pre-complaint conference, screening and referral to appropriate community-based services.

The goal of the policy academy was to increase the number of youth with co-occurring mental and substance use disorders diverted out of the juvenile justice system to appropriate community-based services. Using SAMHSA's Policy Academy model, a core team consisting of senior level state and local policy makers were brought together to learn about the latest research and

effective diversion strategies for youth with co-occurring disorders in contact with the juvenile justice system. Kentucky worked to develop and implement front-end diversion strategies for youth with co-occurring disorders. Ongoing technical assistance was provided to support their efforts. Using the Foundation's Action Network model, which supports and links teams working on similar innovations in policy and practice, the state worked to identify and implement effective practices for screening and treating youth with co-occurring disorders. Guidance and support from national experts was provided to the state as well. Activities and accomplishments from this policy academy let to a Kentucky legislators initiated Task Force to look at possible revisions to the 1986 Unified Juvenile Code. The Kentucky team was able to provide information that enhanced and informed any rewriting of the juvenile code to align with proven frameworks for juvenile justice through the pilot site experiences and the core team addressed the State Interagency Council that is comprised of Commissioners of youth serving agencies to initiated conversations centered on the importance of youth and family engagement in juvenile services, streamlining services, early identification and provisions of services through utilization of standardized screening, and promotion of best practices for appropriate and effective behavioral health services. The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities applied for and received funding for the State Adolescent Substance Abuse Treatment and Enhancement Cooperative Agreement. Their application built on this initiative's work with regards to implementing the pre-complaint conferencing, screening and referrals within the CDW program, and improving access to evidence based practices and a most recent State Youth Treatment grant that has built from all the previous work. The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities has also worked collaboratively to provide Cross-system trainings for CDWs in Family Engagement and the Wraparound Process and continued work on supporting and training in motivational interviewing and screening youth using the Global Assessment of Individual needs screening instruments. The Department for Behavioral Health through various avenues including the adolescent state youth coordinator acting as a liaison, continues to work collaboratively with both the CDW and DJJ systems in order to provide training as requested, case consultation and to keep them in engaged in new research with regards to behavioral health treatment and services.

After successful adult corrections reforms in 2011 and due to the high number of lower-level youth offenders in the juvenile justice system and out-of-home placement, Kentucky adopted comprehensive legislation in 2014 (SB 200) that was projected to save the Commonwealth as much as $24 million over five years while protecting public safety, holding juvenile offenders accountable for their actions, and improving outcomes for the youth and their families (Pew Charitable Trusts, July 2014). KDBHDID is a member of the following advisory boards to assist with the implementation of SB 200.

Juvenile Justice Advisory Board

The Juvenile Justice Advisory Board (JJAB) is Kentucky's federally mandated State Advisory Group (SAG) on juvenile justice issues. Created in 1997, it has played a pivotal role in reforming Kentucky's juvenile justice stem and creating an effective, equitable system to prevent juvenile crime and delinquency. JJAB is composed of 22 members who represent juvenile justice, education, behavioral health, courts, youth advocates, and public advocacy. JJAB is responsible for providing a report to the Governor each year. JJAB has nine subcommittees that work to accomplish the objectives in its three-year plan.

One subcommittee of JJAB is the Subcommittee for Equity and Justice for All Youth (SEJAY). The purpose of this group is to provide review the states' initiatives to maintain delinquency prevention programs and system improvement efforts that are designed to reduce the disproportionate number of juvenile minority groups who come into contact with the juvenile justice system.

Juvenile Justice Oversight Council

In 2014, the Juvenile Justice Oversight Council (JJOC) was created to provide an independent review of Kentucky's juvenile justice system and provide recommendations to the General Assembly. The council is to actively engage in the implementation of the SB 200 juvenile justice reforms, collect and review performance measurement data, and continue to review the juvenile justice system for changes that improve public safety, hold youth accountable, provide better outcomes for children and families, and control juvenile justice costs. The chairs of the House and Senate Judiciary Committees serve as the co-chairs.

Children's Behavioral Health Crisis Services

KDBHDID, the State Interagency Council's Service Array Standing Committee, the Administrative Office of the Courts and CMHC children's crisis programs have been reviewing the children's behavioral health crisis system to determine ways to better serve children at risk of or involved with the justice system. The Service Array Standing Committee has provided a regional template of a youth crisis response flowchart that other CMHCs may customize and adopt. Children's residential crisis stabilization programs have reviewed their admission criteria and assessment processes to ensure accommodation of children and adolescents who are voluntarily seeking the service, can benefit from the short-term treatment service and meet admission criteria.

Other Activities

Kentucky also collaborated with juvenile justice to train not only juvenile justice workers but also communities and behavioral health providers in Principles of Effective Intervention. This initiative seeks to do the following:

-Embrace a community-based approach that limits out-of-home placemen;

-Promote evidence-based practices that follow a developmentally appropriate approach; and

-Assist states in maximizing cost savings and reinvesting savings to support system change.

KDBHDID has spent many years working collaboratively with the Department for Juvenile Justice and the Administrative Office of the Courts Family and Juvenile Services and the Court Designated Worker program—through programs like Reclaiming Futures and grant funding with both Kentucky Youth First, Kentucky Initiative for Collaborative Change (KICC) and KAT-ED we have cross

trained and continue as needed to work with in many ways with regards to SIAC and System of Care.

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

n/a

Footnotes:

Environmental Factors and Plan

15. Medication Assisted Treatment - Requested

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in 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 MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

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. In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? ( ) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly, pregnant women? ( ) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds? ( ) Yes ( ) No

   a) [ ] Methadone

   b) [ ] Buprenophine, Buprenorphine/naloxone

   c) [ ] Disulfiram

   d) [ ] Acamprosate

   e) [ ] Naltexone (oral, IM)

   f) [ ] Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately? ( ) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight?

   Since 1996, Kentucky has had comprehensive legislative regulations to address the implementation and continued quality assurance of Narcotic Treatment Programs (NTPs), specifically those providing methadone. The Division of Behavioral Health (DBH) employees the State Opioid Treatment Authority (SOTA) with the responsibility of ensuring regulatory compliance.

   Additionally, the Division of Behavioral Health (DBH) coordinates the annual Kentucky School for Alcohol and Other Drug Studies targeting providers of services throughout the Commonwealth's behavioral health continuum of care. As part of this annual event continuing education is provided regarding Medication Assisted Treatment (MAT) and other associated evidence based practices.

   DBH also supports specialized MAT services for pregnant and parenting women with a substance use disorder. These additional supports include:
   • The Supporting Mothers to Achieve Recovery through Treatment and Supports (SMARTS) programming which is supported by a SAMHSA federal grant that seeks to fully integrate behavioral health and medical treatment for both mother and baby, while promoting access to MAT for those with opioid use disorders. Included in this initiative is training in the use of the Comprehensive Opioid Response (COR) pared with Twelve Steps (COR-12) programs;
   • Utilizing funds through Kentucky's Office of Drug Control Policy (ODCP), DBH has facilitated a grant process for providers to expand services to those families affected by neonatal abstinence syndrome (NAS), encouraging innovative residential and recovery support service programs for pregnant and parenting women; and
   • DBHDID has encouraged and supported Community Mental Health Centers (CMHC) and other residential programs across the state to increase residential treatment capacity for pregnant and parenting women and their children that incorporates MAT services into their programs.

Please indicate areas of technical assistance needed to this section.

N/A

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved 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, and advocacy with state payers.*

Footnotes:

16. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD 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 recently released a publication, *Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies* that states may find helpful.[64] 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[65],

"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 following are an array of services and supports used to address crisis response. Please check those that are used in your state:

[64] http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848

[65] Practice Guidelines: Core Elements for Responding to Mental Health Crisis. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427

Please respond to the following items:

1. Crisis Prevention and Early Intervention
   - a) þ Wellness Recovery Action Plan (WRAP) Crisis Planning
   - b) þ Psychiatric Advance Directives
   - c) ¢ Family Engagement
   - d) þ Safety Planning
   - e) þ Peer-Operated Warm Lines
   - f) ¢ Peer-Run Crisis Respite Programs
   - g) þ Suicide Prevention
2. Crisis Intervention/Stabilization
   - a) þ Assessment/Triage (Living Room Model)
   - b) ¢ Open Dialogue
   - c) þ Crisis Residential/Respite
   - d) þ Crisis Intervention Team/Law Enforcement
   - e) þ Mobile Crisis Outreach
   - f) ¢ Collaboration with Hospital Emergency Departments and Urgent Care Systems
3. Post Crisis Intervention/Support
   - a) þ WRAP Post-Crisis
   - b) þ Peer Support/Peer Bridges

c) ☐ Follow-up Outreach and Support

d) ☐ Family to Family Engagement

e) ☐ Connection to care coordination and follow-up clinical care for individuals in crisis

f) ☐ Follow-up crisis engagement with families and involved community members

g) ☐ Recovery community coaches/peer recovery coaches

h) ☐ Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

The Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) has an expectation that all Kentuckians have access to a robust behavioral health crisis prevention and 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 Woods 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 hospitalization. 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 (CSUs) 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 CSUs in Jackson (Southeastern KY) and Prestonsburg (Eastern KY), respectively, and Bluegrass (Central KY) 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, twelve 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 programs in Kentucky. The information was used to secure funding to complete the crisis network.

2002 – DBHDID recruited stakeholders from across the state to developed its first state suicide prevention plan. These stakeholders continued to meet and became the Kentucky Suicide Prevention Group (KSPG), a grassroots organization dedicated to supporting suicide prevention, intervention, and postvention services throughout the state.

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 Services 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.

2004 - Kentucky hired its first Statewide Suicide Prevention Coordinator, Jason Padgett.

2005 – Children's residential crisis stabilization programs began using the Brief Psychiatric Rating Scale for Children (BPRS-C).

2006 – State general funding was appropriated to bring each CMHC up to $400,000 of for each adult and child crisis program. Additional funds were appropriated for the urban areas of the state (Louisville, Lexington and Covington). A line item in the state's budget to the Louisville area established the David J. Block Center Crisis Stabilization Unit.

2007 – Kentucky receives its first Garrett Lee Smith Suicide Prevention Grant.

2013 – The Suicide Prevention Consortium of Kentucky (SPCK) is a stakeholder group of suicide survivors, attempt survivors, mental health professionals, community leaders and all others who have an interest in suicide prevention in the Commonwealth of Kentucky. Its mission is to cultivate and coordinate suicide prevention resources for all Kentuckians to end deaths by suicide.

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 CMHCs. It reviewed and revised deliverables and re-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 crisis state general fund fiscal year allocation.
2017 – Kentucky convened its first Kentucky Zero Suicide Academy. Teams of senior leaders from fifteen behavioral health care organizations participated in this two-day academy learned how to incorporate best and promising practicing into their organizations and processes to improve safety and care for individuals at risk of suicide.
Guiding Principles
-Respect
Emergency services programs and staff respect the needs and wishes of each person and/or family experiencing a behavioral health 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.
-Preferred Practice: Each system considers the strengths and resources of the person in crisis, including the family and community
-Preferred Practice: Each program collaborates with others involved with the person in crisis whenever appropriate and possible.
-Comprehensive Array
Each CMHC shall design an emergency service system that is comprehensive in order to meet regional, client, and family needs in emergency situations.
-Preferred Practice: Each system will be flexible to account for regional differences.
-Preferred Practice: Each system will have a method to determine needs for crisis interventions that may include mobile crisis, a crisis stabilization unit, and crisis intervention.
-Preferred Practice: Crisis 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.
-Accessibility
The CMHC is responsible for providing behavioral health crisis responses to all citizens who seek services when experiencing a behavioral health or intellectual and other developmental disabilities crisis, regardless of age, diagnosis, priority population group or agency of origin.
-Preferred Practice: Each region is served by a hotline that operates 24/7/365.
-Preferred Practice: Each CMHC has at least one designated place where an evaluation can be completed, including law enforcement initiated cases.
-Preferred Practice: Each CMHC values crisis services as a critical element to an essential community safety net to prevent suicide and other unnecessary loss of human potential.
-Preferred Practice: Transportation resources are available within the region to permit rapid access to services.
-Timeliness
Quick response times are a critical feature of an effective behavioral health emergency system.
-Preferred Practice: A reasonable response time for a face-to-face interaction with a clinician is 30 minutes for a walk-in crisis assessment.
-Preferred Practice: On a crisis call, the individual or family member will be able to speak to a clinician within 15 minutes.
-Inclusion
Every person has the right to receive a timely, effective crisis response from their CMHC.
-Preferred Practice: Each CMHC 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.
-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.
-Preferred Practice: Each region has a secure, safe environment that is non-stigmatizing to conduct crisis evaluations and interventions.
-Preferred Practice: When possible, each region makes use of natural community supports, crisis prevention plans, support groups, and peer–run centers.
-Accountability
The emergency service system is accountable to individuals, their caregivers, families, communities and funding sources.
-Preferred Practice: The emergency services system will reduce the use of higher levels of care. The CMHC will be able to demonstrate a relationship between crisis intervention activities and the reduction of hospital admission/utilization rates.
-Preferred Practice: The CMHC 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.
-Preferred Practice: The CMHC will maintain reasonable cost planning for financial accountability and financial sustainability.
-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.
-Preferred Practice: Clients and family members are included in the annual process for designing and improving the crisis services system.
-Preferred Practice: Memoranda of Understanding or other formal mechanisms exist with key stakeholders in the community to outline roles and responsibilities.
-Data Informed
Decision making at the individual and systems level is guided by data.

-Preferred Practice: So that information is available for decision making, all CMHCs will report crisis services data faithfully and consistently using the DBHDID data system.
-Preferred Practice: Data will be used to drive quality improvement activities.
-Evidenced Based Practice
Emergency Services responses need to be delivered in a holistic manner using evidenced based and best practices.
-Preferred Practice: Trauma informed care is a guiding practice in all crisis services.
-Preferred Practice: Standardized tools (such as the Mental Health Triage Tool, CTRS, TAS, LOCUS, CASII, and ASAM) are used for determining the level of care needed.
-Preferred Practice: All services need to be co-occurring capable as measured by the DDCAT or DDMHT.
-Cultural Competence
Crisis services shall be provided by staff who are culturally and linguistically competent.
-Preferred Practice: All regions shall have culturally competent staff with access to language and culturally appropriate resources to meet clients' needs.
-Community Awareness
The procedure for accessing emergency behavioral health services should be common knowledge in the community.
-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.
-Preferred Practice: Law enforcement, first responders and other community partners should receive training on how to access crisis services.
Sources of Funding
CMHC behavioral health crisis services 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 $10.7 M for SFY 2018 to the CMHCs for crisis services and for services for diverting individuals from the justice system and psychiatric hospitalization.

Federal and Local Funds
In addition to state general funds, statewide the CMHCs allocated $441,384 of their SFY 2018 mental health block grant funds for crisis services, to serve adults with SMI and children with SED in crisis. This equaled 7.8% of the CMHCs' total MHBG allocation and 6.3% 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 purposes 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 experiencing a crisis, depending on one's individualized plan of care:
--Assessment and Screening
--Psychiatric Evaluation
--Medication Management and 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

DBHDID's CMHC contract requires crisis programs to ensure individuals in crisis have access to a team of professionals. This multidisciplinary team shall include a prescriber (Psychiatrist/Advanced Practice Registered Nurse) and other staff trained in crisis response such as a 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 may use DBHDID funding until the crisis is resolved (up to 72 hours anticipated) or the individual is referred to another level of care, however, once the crisis is stabilized the CMHC is expected to seek reimbursement from all third party payor sources, leaving DBDHID as the payor of last resort. The CMHC shall not require co-payments from individuals served for emergency behavioral health services funded by DBHDID.

DBHDID's contract states that the CMHCs shall develop a service plan with each client that receives crisis services. 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 the CMHC will provide and a plan of follow-up care (or documentation of referral to another level of care). Prior to discharge from the crisis service, the individual shall have developed a safety plan with the individual's continuing care provider, if appropriate and applicable. This brief plan shall include a description of the concrete steps the individual or the individual's family/significant others should take should the person become a danger to himself or others.

SFY 2018 Kentucky Community Mental Health Center Adult and Children's Crisis Services Array
The following is a list of crisis services and service components provided by Kentucky's community mental health centers and the number of agencies that provide the service to individuals in their catchment areas:
Adult Peer Support – Crisis Services 12
Commitment Hearing Attendance 3
Criminal Justice Drop-Off Sites 4
Crisis Case Management 11
Detoxification 5
Emergency Apartments 1
Emergency Psychiatric Evaluation and Medication Management 14
Emergency Respite 4
Family Peer Support – Crisis Services 9
Intensive In-Home Services 10
Intensive Outpatient Crisis Counseling 9
Mobile Crisis 14
Partial Hospitalization 4
Residential Crisis Stabilization 12
Safety Planning for Suicide Risk 14
Telehealth 12
Transportation Services 11
Virtual Crisis Support – Chat 3
Virtual Crisis Support – Email 4
Virtual Crisis Support – Text 3
Walk-in Crisis Intervention after Business Hours 12
Walk-in Crisis Intervention during Business Hours 14
Warm Line 6
Youth Peer Support – Crisis Services 10
23-Hour Observation 2
23-Hour Beds 4
24/7 Crisis Hotline 14

Diversion from the Justice System
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:
-Provide involuntary hospitalization evaluations;
-Provide 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;
-Collaborate with local crisis intervention teams to provide trainings and participate on local CIT advisory teams;
-Provide training and consultation to local jails; and
-Provide training and consultation to local juvenile detention centers.
The statewide data for SFY 2016 reveals that CMHC staff are providing more than 10,000 involuntary hospitalization evaluations for adults and almost 500 involuntary hospitalization evaluations for children. Fifty-four (54) percent of the individuals evaluated required emergency transportation requiring reimbursement. Law enforcement, child welfare, non-emergency medical transportation services, ambulances, taxi companies, and CMHCs provide reimbursed and unreimbursed crisis transportation services.
There are 85 jails and many juvenile detention facilities and programs in Kentucky. In SFY 2016, CMHCs provided 21,047 consultation calls to these facilities, 43 formally scheduled training events to over 500 jail and juvenile detention center staff.
Outcomes

DBHDID conducts an annual program performance and compliance review of the CMHC's program. Monitoring will consist of an off-site review of appropriate data and documentation and may include an on-site review of operations and documentation. DBHDID provides a summary report to CMHCs within 60 days of the review and submission of a corrective action plan may be required.

The Department re-introduced performance-based contracts for SFY 2015 and included eleven (11) performance indicators into the CMHC contract. Each year since then, there have been performance indicators regarding increasing access to crisis services, reducing psychiatric hospital admissions for adults who received services in a CMHC adult crisis stabilization unit, and increasing engagement in follow-up care for children and youth who received services in a CMHC children's crisis stabilization unit.

The incentive for achieving the targets is two one percent (2%) of the CMHC's total state general fund crisis allocation.

The CMHCs may monitor their progress toward their targets by reviewing monthly reports for each indicator. These reports are available online and refresh monthly so that all regional and department staff are able to stay abreast of performance.

The following are the three crisis performance indicators:

CRISIS1. Measure Name: Psychiatric Hospital Admissions for Adults Who Received Services in a CMHC Adult Crisis Stabilization Unit

Measure #1 applies to CMHCs that operate an Adult Crisis Stabilization Unit (01, 03, 04, 05, 10, 11, 12, 13, 14); for these CMHCs, this measure carries 1% financial risk.

The DBHDID shall assess the psychiatric hospital admission rate for clients receiving services in a CMHC Crisis Stabilization Unit (CSU) in accordance with 908 KAR 2:090. The expected standard of performance is that the percentage of psychiatric hospital admission rate will be no more than 5% during the monitoring period. This measure applies to CMHC CSUs that have operated for the entire monitoring period.

CRISIS2. Measure Name: Continuing Care Engagement Following Crisis Stabilization - Children/Youth

Measure #2 applies to CMHCs that operate a Children's Crisis Stabilization Unit (04, 05, 06, 08, 10, 11, 12, 13); for these CMHCs, this measure carries 1% financial risk.

DBHDID must ensure that child/youth clients receive ongoing engagement of services following an episode of care in CMHC operated residential crisis stabilization units. Toward this intent, the DBHDID shall assess the rate of follow-up for the region's clients who experienced an episode of residential crisis stabilization. The expected standard of performance is that children/youth clients must receive a service within thirty (30) calendar days after an episode of care at a CMHC-operated children's residential crisis stabilization unit. The measure includes only episodes that occur between the first day of the monitoring period and thirty (30) or more calendar days before the end of the monitoring period. The rate of follow-up must be at or above the median rate that is determined over the last five (5) completed years for each CMHC.

CRISIS3. Measure Name: Non-Residential Crisis Service Utilization by Adults and Children

Measure #3 applies to CMHCs that operate only a CSU Adult Unit or only a CSU Children's Unit yet not both (01, 03, 06, 08, 14); for these CMHCs, this measure carries a 1% risk.
Measure #3 applies to CMHCs that operate neither a CSU Adult Unit nor a CSU Children's Unit (02, 07, 15); for these CMHCs, this measure carries 2% financial risk.

For CMHCs not providing crisis stabilization unit services, DBHDID shall assess the utilization of three specific non-residential crisis services for adults (Clients/1,000 Census – Adult) and for children (Clients/1,000 Census – Children). The expected standard of performance is to deliver the three designated services at a rate that is, at minimum, 75% of the Region's average rate over the last three completed monitoring periods.

Summary

As Kentucky's Emergency Response and Crisis Prevention System enters its fourth decade, there are many exciting initiatives to rally around – an expanding behavioral health network of crisis services providers; continuous quality assurance of services, reporting and outcomes; 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.

Please indicate areas of technical assistance needed to this section.

Footnotes:

17. Recovery - Required

Narrative Question

The implementation of recovery supports and services are 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. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.
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:

- Clubhouses
- Drop-in centers
- Recovery community centers
- Peer specialist
- Peer recovery coaching
- Peer wellness coaching
- Peer health navigators
- Family navigators/parent support partners/providers
- Peer-delivered motivational interviewing
- Peer-run respite services
- Peer-run crisis diversion services
- Telephone recovery checkups
- Warm lines
- Self-directed care
- Supportive housing models
- Evidenced-based supported employment
- Wellness Recovery Action Planning (WRAP)
- Whole Health Action Management (WHAM)
- Shared decision making
- Person-centered planning
- Self-care and wellness approaches
- Peer-run Seeking Safety groups/Wellness-based community campaign
- Room and board when receiving treatment

SAMHSA strongly encourages states to take proactive steps to implement recovery support services. 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.
Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

   a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? Yes No

   b) Required peer accreditation or certification? Yes No

   c) Block grant funding of recovery support services. Yes No

   d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?

      Yes, through the Behavioral Health Planning and Advisory Council in particular, but also through Youth Council, Statewide Interagency Council, contracts with advocacy organizations and other venues.

2. Does the state measure the impact of your consumer and recovery community outreach activity? Yes No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

   Currently, Kentucky's Division of Behavioral Health (DBH) offers, though contracts with fourteen (14) CMHC regions and a variety of other community partners, the following recovery support services to individuals with SMI: targeted case management (TCM), peer support, Individual Placement and Support (IPS) supported employment, supportive housing based on Permanent Supportive Housing Toolkit through SAMHSA, assertive community treatment with peer specialists embedded, self-help facilitation, residential supports for individuals living in the community with greater supervision needs, comprehensive community support services, clubhouse model therapeutic rehabilitation programming, warm lines, services through consumer run services programs (COSP) as defined in SAMHSA toolkit, Wellness Recovery Action Planning (WRAP) and other wellness activities, person centered recovery planning which includes a shared decision making component, and a full array of crisis services including mobile crisis. DBH encourages all of these services on the continuum to include the involvement of individuals with lived experience. While peer support and COSP services are entirely provided by individuals with lived experience, peer support specialists can be embedded in each service along the continuum. In addition, Kentucky's four (4) state psychiatric hospitals also provide a "recovery mall" to assist adults with SMI who want to work on meaningful recovery activities prior to hospital discharge. One (1) of the state psychiatric hospitals has a contract that provides peer support specialists to assist with recovery mall work, group and individual peer support to individuals who are hospitalized as well as working with families during visitation times. Self-help groups offered throughout the state include Double Trouble in Recovery (DTR) and recovery support groups for individuals with mental illness facilitated by people with lived experience, often peer support specialists.

   Currently, Kentucky's DBH offers, through contracts with fourteen (14) CMHC regions and a variety of other community partners, the following recovery support services for children with SED: targeted case management (TCM), peer support, Individual Placement and Support (IPS) supported employment, supported housing, comprehensive community support services, drop in centers employing youth peer support specialists, coordinated specialty care services, service planning, Wellness Recovery Action Planning (WRAP), and a full array of crisis services including mobile crisis. Again, DBH encourages involvement of youth and family members with lived experience along the service continuum, and encourages all services to have the goal of enhancing resiliency and promoting recovery.

   Kentucky is now able to provide three (3) types of peer support as a Medicaid billable service: adult peer support, youth peer support and family 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.
   The manner in which individuals with lived experience receive certification training to become billable peer support specialists has changed into the following model in Kentucky:
   -A curriculum rubric has been developed by the DBHDID, outlining the required 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 certification training for peer support;
   -Individuals with lived experience must complete training requirements and pass an examination at 70% or above to receive certification; and
   -Agencies are required to submit names and numbers of peer support specialists who successfully complete training requirements.

In addition, CMHC contracts include a requirement to hire at least 2.0 FTE peer support specialist to work with adults with SMI who are at risk of institutionalization, as well as a requirement to hire at least .50 FTE peer support specialist to work on assertive community treatment (ACT) teams.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

Currently, Kentucky's Division of Behavioral Health (DBH) offers, through its provider base, the following recovery support services to persons with substance use disorders: targeted case management (TCM), peer support, self-help facilitation, supported employment, transitional housing, recovery housing, and medication assisted treatment (MAT). Kentucky's recovery support services aim to enhance effects and improve outcomes of existing treatment services in effort to make long-term recovery sustainable. Utilizing DBH approved curriculum, providers are required to ensure that those providing TCM and peer support services are appropriately trained. Self-help groups offered throughout the state include: Alcoholics Anonymous, Narcotics Anonymous, Al-Anon, Double Trouble in Recovery (DTR), as well as the Comprehensive Opioid Response paired with 12 Steps (COR-12) self-help component. Using a modified Individual Placement and Support (IPS) supported employment model, DBH providers now offer supported employment services to those with a substance use disorder. Transitional housing is available in certain regions focused on providing stable living environments for those currently in on-going treatment. Recovery housing is established through the Commonwealth's Group Home Loan Program. Due to being a recognized evidence based practice, Kentucky utilizes the Oxford House model for recovery homes and contracts directly with the organization to provide outreach to our state. Using regulatory compliance measures, the State Opioid Treatment Authority (SOTA) monitors provision of MAT at state approved sites offering primarily methadone. Additionally, Kentucky partners with People Advocating for Recovery (PAR) as a training and technical assistance center to assist individuals and organizations with recovery efforts. PAR provides services to individuals in all states of recovery, their family and friends, along with staff, programs, public, quasi-public, and private organizations and other entities that influence the recovery services within Kentucky.

5. Does the state have any activities that it would like to highlight?

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. The Department continues to provide funds for a variety of statewide and local support initiatives for individuals in recovery and family members. These initiatives have traditionally been focused on goals related to self-advocacy, discrimination and stigma reduction, wellness and recovery programs, peer support, education and training, and other support. During SFY 2010, Division staff used recommendations from individuals in recovery and family members to rewrite contracts to be awarded to statewide groups. Four (4) contracts were awarded during SFY 2011, as prescribed by the Request for Proposal (RFP) process monitored by the Finance Cabinet, the Recovery Oriented Training and Technical Assistance for adults with mental health issues contract, the Recovery Oriented Family Support Services for family members of adults with mental health issues, the Recovery Oriented Training and Technical Assistance for individuals with substance use disorders, and the Family Guided, Youth Driven Training and Technical Assistance contract for children and families. A liaison from DBH was designated as a program monitor for 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 2018 includes the following requirements:

-Provide a series of recovery oriented education and supports for family members across the state;
-Participate actively in Individual Placement and Support (IPS) Supported Employment implementation and training activities;
-Assist DBHDID with the distribution of a survey regarding recovery oriented system of care;
-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 education and support groups;
-Provide at least one (1) In Our Own Voice training annually;
-Provide at least twenty (20) In Our Own Voice presentations across the state annually;
-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;
-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 quarterly 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 quarterly conference call. 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 IPS 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 recovery listserv that is staffed by NAMI Kentucky.

NAMI Kentucky also collaborates with DBH on training efforts regarding IPS for young people and education regarding the First Episode of Psychosis.

The Recovery Oriented Training and Technical Assistance for adults with mental health issues 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.

KYSTARS is located within Participation Station, one of the first peer run centers in Kentucky. During SFY 2012, after the SAMHSA Consumer Operated Services Program (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. KYSTARS continues to provide educational classes and technical assistance in implementation and developing policies and procedures, form development, grant writing and fundraising, program evaluation, and other issues, to the COSPs across the state. Kentucky currently has COSPs in seven (7) of the fourteen (14) CMHC regions.

KYSTARS provides an annual fidelity review and technical assistance regarding outcome measures to all of the COSPs. Results of these reviews assist in shaping the educational opportunities made available at the annual KYSTARS statewide conference. An entire tract at this conference is dedicated to individuals working in COSPs across the state.

KYSTARS has provided an annual statewide conference since SFY 2011. During SFY 2017, KYSTARS hosted the 4th Annual Peer Excellence Awards, in a ceremony that occurs the night before the actual conference. This award ceremony recognizes an outstanding individual in recovery from each CMHC region across the state. It also recognizes supporters of peers and individuals with lived experience who have made significant contributions in the field of recovery. For the last two (2) years KYSTARS has also recognized a youth peer specialist and a family peer specialist who have been nominated for their stellar performance in supporting recovery and resiliency.

The NAMI LEX contract for SFY 2018 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;
-Establish recovery support groups for individuals with lived experience across the state;
-Assess statewide needs regarding mental health recovery;
-Provide a statewide recovery oriented conference annually along with a peer recognition ceremony;
-Provide FACIT reviews to all DBH funded COSPs annually;
-Provide technical assistance to all DBH funded COSPs based on results of reviews;
-Provide assistance with the POP outcome measure for all COSPs;
-Provide Mental Health First Aid (MHFA) training across the state, including coordination of MHFA trainings occurring statewide and including having some in-state trainers for MHFA; and
-Assist DBH in distributing survey regarding recovery oriented system of care.

The Family Guided, Youth Driven Training and Technical Assistance contract was awarded to the Kentucky Partnership for Families and Children (KPFC). KPFC is a statewide family-run advocacy and support organization for children and youth at risk of developing or with an already identified behavioral health need, and their families and is Kentucky's Federation of Families for Children's Mental Health chapter. DBHDID contracts with KPFC for a variety of services and supports aimed at creating a family- and youth- driven System of Care that supports youth and family involvement and leadership at all levels of the System of Care.

KPFC achieves these goals by providing training and technical assistance in:
-DBHDID-approved curricula for Family and Youth Peer Support Specialists;
-Coaching for supervisors of Family and Youth Peer Support Specialists;
-Special education law;
-Engaging families and youth;
-Youth Mental Health First Aid;

-Family Leadership; and
-Integrating KY Strengthening Families protective factors into system change efforts.

KPFC also supports DBHDID in the implementation of several SAMHSA grants to participate on councils and attend state and national training (stipends, travel, child care, etc.). KPFC employs state-level staff for Kentucky's SAMHSA Healthy Transitions grant, including the Project Director and two Youth Coordinators. This staff is responsible for improving access to treatment services and recovery and community supports for youth and young adults who have or are at risk of developing serious behavioral health conditions.

KFPC provides leadership in statewide advocacy activities regarding children and youth at risk of developing or with an already identified behavioral health need, and their families. To this end, KFPC participates in activities with other organizations or coalitions to support improved services, reduce stigma, and increase empowerment and resiliency for children and youth at-risk of developing or with already identified behavioral health concerns and their families.

Finally, KFPC conducts a strengths-based family and youth involvement status assessment in CMHC programming in three (3) Regional CMHCs per year. The review focuses on the extent to which family and youth are meaningfully involved at all levels of the child-serving system and in decisions about the services and supports that they receive. The KPFC include non-staff family members and youth in the review process.

For SFY 2017/2018, DBH is also collaborating with Bridgehaven, a behavioral health services organization, to assist with supporting the infrastructure for peer support specialists who are working in the behavioral health workplace. This work includes:

-Maintaining a Center for Peer Excellence, including an experienced board or advisory committee to guide activities;
-Bringing Wellness Recovery Action Plan (WRAP) to Kentucky by hosting national trainers and then by assisting with Kentucky growing their own WRAP workforce;
-Making available trainings for supervisors of peer specialists in the behavioral health field;
-Coordination of a peer support specialist database regarding peers who are working;
-Providing conference calls, newsletters, webinars, for peer specialists who are working and others, regarding issues related to recovery; and
-Provide at least one (1) leadership academy training, which targets individuals who have lived experience and want to learn leadership skills to contribute in their communities.

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

Footnotes:

18. Community Living and the Implementation of Olmstead - Requested

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 M/SUD 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 setting appropriate to the individual 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 for 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 settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based 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.

Please respond to the following items

1. Does the state's Olmstead plan include :

   housing services provided. ( ) Yes ( ) No

   home and community based services. ( ) Yes ( ) No

   peer support services. ( ) Yes ( ) No

   employment services. ( ) Yes ( ) No

2. Does the state have a plan to transition individuals from hospital to community settings? ( ) Yes ( ) No

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?

   Kentucky has an Olmstead Compliance Plan in response to the landmark civil rights case of Olmstead v. L.C. 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. Kentucky's current Olmstead Plan created in 2015, consists of nine (9) goals:
   -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.
   -Education/Outreach to prevent facility placement, with input from his/her family and legal guardian, as required.
   -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.
   -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.
   -Increase available, accessible, quality, and affordable community housing.
   -Ensure a safe and appropriate transition from an institution to a community setting.
   -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.
   -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.
   -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 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 that meet Olmstead criteria. 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 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 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 the Olmstead Housing Initiative (OHI). These funds are to serve the Olmstead population and can be used in a variety of ways including for rent, security deposits, furniture, utility deposits, etc. This provides the flexible funding needed to make a transition successful. During SFY 2017, $500,000 additional dollars were added to fund OHI for a designated total of $886,000 per year. In addition, the Louisville Metro Housing Authority, in collaboration with DBH, provides fifty (50) Housing Choice vouchers for individuals who meet Olmstead criteria in Jefferson County.

Does the state have any activities related to this section that you would like to highlight?

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 one hundred, thirty-three (133) individuals with SMI who expressed a desire to move out of personal care homes and into housing in the community. The original 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: Vital Early Responsive Treatment System (DIVERTS) services across the state to individuals with SMI who were institutionalized or at risk of institutionalization and 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 Adult Mental Health and Recovery Services Branch was restructured to support the work necessary to make the settlement agreement a priority.

October 1, 2015, this agreement was amended and signed by the Cabinet of Health and Family Services and Kentucky Protection and Advocacy. This agreement is now known as the Amended Settlement Agreement (ASA). This agreement extended terms to move at least six hundred, seventy-five (675) individuals with SMI out of personal care homes into community based housing of their choice before October of 2018. At this point, all but five (5) of the original expressers have been transitioned from personal care homes. In June of 2016, a state administrative regulation was filed regarding the transition of individuals with serious mental illness into communities of their choice. http://www.lrc.ky.gov/kar/908/002/065.htm

The desired outcomes of the ASA 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 Amended Settlement Agreement are met or exceeded; with progress and quality measured by defined formal reports and established processes.

Due to these efforts, several collaborative efforts have resulted in positive changes in the service system for adults with SMI. 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 individuals on their caseload with SMI. Work with the Kentucky Housing Corporation (KHC) has been monumental to the success of transitioning individuals. Work involving the state Long-Term Care Ombudsman and the Office of the Inspector General has also been pivotal. In addition, a movement to implement person centered planning across the service system was strengthened by the efforts to meet the terms of this agreement.

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 of recovery as early as possible and with individualized, quality supports and services.

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

Footnotes:

19. Children and Adolescents Behavioral Health Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. 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 emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community[66]. Most mental 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[67]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death[68].

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[69]. 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 point person 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 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

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 SUD and co-occurring M/SUD 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, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs[70].

According to data from the 2015 Report to Congress[71] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. 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 (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

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[66]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[67]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.

[68]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.

[69]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[70]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

[71] http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf

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Please respond to the following items:

1. Does the state utilize a system of care approach to support:

   a) The recovery and resilience of children and youth with SED? ( ) Yes ( ) No

   b) The recovery and resilience of children and youth with SUD? ( ) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address behavioral health needs:

   a) Child welfare? ( ) Yes ( ) No

   b) Juvenile justice? ( ) Yes ( ) No

   c) Education? ( ) Yes ( ) No

3. Does the state monitor its progress and effectiveness, around:

   a) Service utilization? ( ) Yes ( ) No

   b) Costs? ( ) Yes ( ) No

   c) Outcomes for children and youth services? ( ) Yes ( ) No

4. Does the state provide training in evidence-based:

   a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? ( ) Yes ( ) No

   b) Mental health treatment and recovery services for children/adolescents and their families? ( ) Yes ( ) No

5. Does the state have plans for transitioning children and youth receiving services:

   a) to the adult behavioral health system? ( ) Yes ( ) No

   b) for youth in foster care? ( ) Yes ( ) No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

   See Criterion 3 in the Environmental Factors #10

7. Does the state have any activities related to this section that you would like to highlight?

   n/a

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

   N/A

Footnotes:

Environmental Factors and Plan

20. Suicide Prevention - Required MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges behavioral health agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide through the use of MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the behavioral health agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years? Yes No

2. Describe activities intended to reduce incidents of suicide in your state.

The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (KDBHDID) employs one FTE as the State Suicide Prevention Coordinator, housed in the Behavioral Health Prevention and Promotion Branch, within the Division of Behavioral Health. Additionally, the KDBHDID works through its Community Mental Health Centers (CMHC)/Regional Prevention Centers to deliver clinical care and community prevention efforts across the fourteen (14) CMHC regions in the state. The KDBHDID provides focused and intentional training and technical assistance to staff of these centers in order to ensure the broadest reach of suicidal care to the residents of Kentucky.

During SFY 2016/2017, the regional prevention centers conducted readiness assessments for communities within their catchment area to determine their readiness to implement suicide prevention programming. Statewide readiness was identified as a level three (3) as classified by the Tri-Ethnic Readiness Assessment. Individual regions scored higher and lower, and each regional implementation plan focused on the readiness level identified to ensure that activities meet the communities at their level of implementation readiness.

Garrett Lee Smith Memorial Act Suicide Prevention Funding

Kentucky is currently implementing its third SAMHSA-funded Suicide Prevention Grant and is finishing number three (3) of five (5) years of this effort. 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 settings for Suicide Safer Communities.

Within the grant project, efforts are focused on peer-led programming, implementation of evidence based curriculum in schools; training gatekeepers, training clinical providers and utilizing those with lived experience in the planning and implementation of efforts.

Evidence-based programming/trainings supported by these grant funds include, Sources of Strength, Question, Persuade and Refer (QPR), Applied Suicide Intervention Skills Training (ASIST), Assessing and Managing Suicide Risk (AMSR), and Collaborative Assessment and Management of Suicidality (CAMS), providing a full-spectrum of programming to address suicidal behavior across the continuum of care.

Zero Suicide Initiative

In June 2017, KDBHDID sponsored a two (2) day Zero Suicide Academy with fourteen (14) participant teams attending. The attendees included a ten (10) member team from Western State Psychiatric Hospital as well as the Louisville Veterans Administration Hospital. KDBHDID leaders as well as program implementation staff were on hand and trained in the effort. The state’s academy was followed by a one (1) day academy in Louisville for agencies and organizations in the state’s largest city to learn more about how they can implement Zero Suicide in their effort. Kentucky currently has three pilot sites fully implementing the Zero Suicide framework and many others that are looking at the various policies and procedures in order to do so. Additionally, the Garrett Lee Smith Memorial grant provides funding for a training and technical assistance coach to walk with organizations as they implement the framework in their organization.

Coalitions, Collaborations and Partnerships

KDBHDID works collaboratively and in partnership with many different agencies and organizations in regards to suicide prevention activities, some of which include: Kentucky Department for Public Health; Kentucky Department of Education; Kentucky Department for Community Based Services; Kentucky Department for Veterans Affairs; Kentucky Partnership for Families and Children; Louisville Health Advisory Board; Kentucky Suicide Prevention Workgroup; Suicide Prevention Consortium of Kentucky; Owensboro Suicide Prevention Group; REACH of Louisville; Kentucky Safety and Prevention Alignment Network; Kentucky Prevention Network; Kentucky Injury Prevention and Research Center; Kentucky YMCA; Kentucky Boys and Girls Clubs; University of

Louisville; Eastern Kentucky University; University of Kentucky; Kentucky Faith Based Coalition; and others. The goal of these collaborative efforts is to empower professionals across the state to embed suicide prevention activities into their deliverables as appropriate to their mission and vision.

Improved Surveillance

A key focus has also been on increasing surveillance measures to develop a better understanding of the environmental risk factors that are woven into the thread of Kentucky's culture, offering prevention opportunities. These increased surveillance activities include focus groups and key informant interviews with nurses from inpatient psychiatric facilities as well as family resource center directors from within the state school system. Final efforts are underway to gain access to a rapid response data system to identify potential suicide deaths sooner rather than later to increase opportunity to secure information and better understand the issue. In addition, the state has requested assistance through an Epidemiologic Assistance (EPI-Aid) visit from the Centers for Disease Control (CDC) to investigate high adult suicide rates in Western Kentucky and high youth suicidal behavior in Northern Kentucky. Details of that process are being developed.

We also work with the Kentucky Violent Death Reporting System; Child Death Review; Kentucky Incentives for Prevention (KIP), Kentucky's statewide youth risk behavior survey; the CDC Youth Risk Behavior Survey; Vital Statistics, and Treatment Episode Data Set, Medicaid, and other data sources to accurately assess and identify the need for suicide prevention efforts in the state.

Social Marketing Campaign

Twelve (12) of Kentucky's fourteen (14) regional prevention centers are participating in a comprehensive social marketing campaign to include Facebook, Instagram and other social media as well as digital and print files for community level use. The campaign will focus on the Hope, Help and Strength topics to augment the implementation of the Sources of Strength peer led wellness campaign in one hundred (100) of Kentucky's schools over the next school year. The program uses the influence of a diverse group of trained peer leaders, under the guidance of trained adult advisors, to spread messages of Hope, Help and Strength throughout their school or organization. Messages promote help seeking, school attachment, and connectedness to trusted adults using the safe messaging guidelines provided by the program. The program is being implemented in middle and high schools in the state, as well as in connection with some post-secondary institutions.

Training and Technical Assistance to Schools

In addition to supporting implementation of the Sources of Strength program, the Kentucky Division of Behavioral Health through the regional prevention centers is providing one-on-one technical assistance to schools as they meet state laws around suicide prevention education for certified staff and suicide prevention information for middle and high school students. State laws require that all certified staff receive two hours of suicide prevention education each school year and that all middle and high school students receive suicide prevention information by September 1 of each school year.

School Curricula Implementation

In addition to the implementation of Sources of Strength in Kentucky's school, KDBHDID provides support for the implementation of evidence-based curriculums, such as Lifelines, Signs of Suicide and More than Sad within Kentucky's schools. These curricula help meet the state mandate that requires all middle and high school students receive some type of suicide prevention information by Sept. 1 of each school year.

National Suicide Prevention Lifeline

Five (5) of Kentucky's community mental health centers are currently Lifeline certified and five (5) others have initiated efforts to become Lifeline certified. The addition of these certified lines will allow Kentucky to meet SAMHSA's requirement of at least 70% of calls originating in the state being answered in the state as well. Work continues with the remaining four (4) centers to encourage them to pursue certification as well.

Military-connected

KDBHDID partners in a number of ways to ensure that military connected residents, including those on active duty and Veterans receive the care they need to manage suicidal behavior. These partnerships include: work with the VA on their annual summit, as well as serving on their Zero Suicide implementation committee; working with the National Guard to implement programming that is designed to increase awareness of military culture and the specific issues that arise as a result of it; and community level mobilization to address military connected family members accessing services off base or from those not specifically trained in military culture. Clinical care providers as well as community level prevention providers have been trained in military culture and are aware of the importance of delivering services to this population in a manner that recognizes this culture.

3. Have you incorporated any strategies supportive of Zero Suicide? (•) Yes ( ) No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? (•) Yes ( ) No

5. Have you begun any targeted or statewide initiatives since the FFY 2016-FFY 2017 plan was submitted? (•) Yes ( ) No

If so, please describe the population targeted.

i. Individuals who have been connected to the community mental health system
ii. Adult males
iii. Military-connected individuals
iv. Substance using individuals

Does the state have any activities related to this section that you would like to highlight?

i. All fourteen (14) community mental health centers have begun implementation of the Zero Suicide Framework at some level within their system. While some of the centers are much further along in the process than others, the progression of implementation is moving faster in each new center that begins the process. There is an opportunity for a transfer of knowledge from centers who have moved further along the implementation scale and this assists those coming on board.
ii. Collaborative work is occurring between Kentucky Opioid Response Effort (KORE) (21st Century Cures Act) and the suicide prevention staff in order to address the increased risk of suicide that accompanies substance use and opioid use in particular. The peer led evidence based program, Sources of Strength is being implemented among schools in the identified hot spot regions of the state. The program is evidenced-based for suicidal behavior as well as substance use, violence and bullying, providing schools and opportunity to address four (4) problem behaviors in one implementation process. Additionally, transition of care processes are being implemented into emergency departments' (ED) processes for those who present with an overdose. These individuals are being connected to care directly from the emergency room and one of the screenings that will occur will consider their suicidal risk to identify appropriate placement.

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

Additional technical assistance/training related to the connection of substance use and suicidal behavior and appropriate ways to treat these co-occurring issues to ensure that the individual remains as safe as possible until the crisis subsides.

Footnotes:

Environmental Factors and Plan

21. Support of State Partners - Required MHBG

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 M/SUD 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 factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, 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 homeland security/emergency management agency 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 respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? ( ) Yes ( ) No

2. Has your state identified the need to develop new partnerships that you did not have in place? ( ) Yes ( ) No

   If yes, with whom?

   Several previous partnerships/ agreements have been expanded, including: Vital Statistics, Dept of Corrections, UK-KIPRIC (KY Injury Prevention & Research Center)

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilites Education Act.

   See Criterion 3 in Environmental Factor #10

   Does the state have any activities related to this section that you would like to highlight?

   n/a

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

   n/a

Footnotes:

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application - Required MHBG

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 services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, 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 misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.[72]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with behavioral health problems. 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.

[72] http://beta.samhsa.gov/grants/block-grants/resources

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc...)

   a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

   Department program staff conducts monitoring and technical assistance site visits of the DBHDID funded substance use disorder treatment and prevention programs statewide. The site visit format for the treatment programs 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 Planning Council also provides guidance in this area. The Council's membership is truly integrated and provides rich information about prevention, treatment and recovery supports needed for individuals in recovery, their parents and family members.
   The Department has been sponsoring an annual alcohol and other drug prevention and treatment conference called the Kentucky School of Alcohol and Other Drug Studies for forty-four years. This conference is planned by and attended by many individuals in recovery and their family members. It is attended by individuals who work in the fields of 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 are held in the evenings and provide a particularly rich opportunity for discussion. This year's conference is being held August 23-27, and there are more than 800 individuals pre-registered for the conference. SAMHSA staff often attend the conference and present workshop and plenary presentations.
   Department staff also solicits input from the regional substance use treatment directors and the Regional Prevention Center (RPC) Directors at quarterly peer group meetings. The Directors and Department collaboratively creates the agenda.

   b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into i — Yes / No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linquistic, rural, suburban, urban, older adults, families of young children)? — Yes / No

3. Please indicate 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.

   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.
Council members also chair and serve as members to the following committees: Membership, Finance and Data, Bylaws, and Policy and Advocacy.
The Council recognized a need to assist members with advocacy efforts so the Policy and Advocacy Committee was established in 2013. The Committee submitted its inaugural set of Legislative Priorities to the Council for approval, in June 2014. These Legislative Priorities provide a common set of legislative goals for the Council and have been revised and used by members every year since that time. The Committee also educates members on advocacy best practice a couple times per year. The following are the Council's Legislative Priorities for the 2017 legislative term:
1. Increase access to effective mental health substance use, prevention, treatment and recovery services.
o Continue to build a stronger provider network (first responders, courts, juvenile justice, peer support, hospitals, treatment and recovery facilities and behavioral health prescribers and providers).
o Continue to sustain a 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)
o Maintain funding of Medicaid expansion and health insurance coverage for Kentuckians.
o Enhance and increase early childhood intervention services and training to meet the social, emotional, and behavioral health needs of children by increasing awareness, screenings and building family support systems.
o Ensure managed care organizations approves targeted behavioral health and physical health 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.
o Ensure adequate and stable funding to meet community needs and training of families to make them whole and healthy.
o Ensure all prescribers and providers are trained in best practice models across all systems.
3. Provide housing for transition age youth and adult individuals living with mental health and/or substance abuse disorders.
o Continue to ensure necessary supports and services to help individuals live successfully in the community (case management, housing, peer support, assertive community treatment, and Individual Placement and Support (IPS) supported employment).
o Continue to ensure supports and services for transition age youth to smoothly transition into adult services (case management, coordinated specialty care, housing, peer support, IPS Supported Employment)
o Educate individuals on their legal rights regarding housing options and employment.
o Ensure individualized access to Individual Placement and Supports (IPS) Supported Employment in every Kentucky County.

Each of the Block Grant supported statewide behavioral health advocacy organizations are connected with thousands of members and contacts. They are a valuable resource for sharing information, including Council-related information, across the state via email and newsletter.
Diversity
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. The Council's membership application includes the following diversity statement:
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. At your option, you may state how you would contribute to the diversity of the Council.
For the Membership Committee's review of applications for 2017, 93% of applicants chose to answer this question. Committee members report that this is extremely valuable as they consider membership. The diversity responses are usually the most influential to Committee members because members learn where an applicant can fill a gap and provide a voice on the Council.
The following are types of diversity reported by applicants reviewed by the Council in 2017:
• "Single mother who has lived below the poverty level."
• "Caregiver of a terminally ill parent."
• "As a youth, I provide a diverse perspective from a younger generation."

• “Single parent with a son with disabilities.”
• “Recovering heroin addict who has lost everything and rebuilt my life.”
• “I am a woman and disabled.”
• “I am a mother who has dealt with addiction for a long time.”

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 or is under represented. The Council experiences difficulty recruiting members from the far western portion of the state, with barriers including distance and a different time zone. The Council shares its brochure at annual conferences to increase awareness of the Council and to recruit applicants from the West.

The Membership Committee’s Member Orientation includes cultural awareness as a topic. The Member Orientation is led by members and presented annually.

Does the state have any activities related to this section that you would like to highlight?

During a discussion of the Council’s need to increase member racial and ethnic diversity, members brainstormed organizations to target for outreach. Member volunteers reached out to those organizations to share the Council’s brochure and provide information about the Council. The Council expressed an interest to continue this brainstorming and outreach initiative. (For more information, see November 17, 2016 meeting summary at the Council’s archive of meeting summaries).

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

N/A

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[73]

[73]There 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.

Footnotes:

Kentucky Behavioral Health Planning & Advisory Council

August 17, 2017

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 and Advisory Council to confirm that Council members have reviewed Kentucky's drafted FFY 2018-19 SAPT and CMHS Block Grant Behavioral Health Assessment and Plan. Time was allocated at today's Council meeting to discuss the state plan and the tables required for this submission for the September 1st due date. The Department for Behavioral Health, Developmental and Intellectual Disabilities welcomes recommendations and comments prior to and after submission of the Plan.

Our Council has met quarterly over the past year. The committees have met to carry out their work and members have been diligent as we continue to build a solid Council that guides the development of Kentucky's behavioral healthcare.

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,

Gayla Lockhart

Gayla Lockhart
Chair, Kentucky Behavioral Health Planning and Advisory Council

Cc: Michele Blevins, Assistant Director, Division of Behavioral Health

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2017 End Year: 2019

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Susan Abbott	State Employees	Protection and Advocacy	5 Mill Creek Park Frankfort KY, 40601 PH: 502-564-2967	susan.abbott@ky.gov
Kalon Bagby	State Employees	Child Welfare	Department for Community Based Services - State Child Welfare and Social Services Agency Frankfort KY, 40601 PH: 502-564-2136	Kalon.Bagby@ky.gov
Mike Barry	Others (Not State employees or providers)		People Advocating Recovery Louisville KY, 40206 PH: 502-552-8573	mike@peopleadvocatingrecovery.org
Kyle Burchett	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		904 E. Midland Trail Grayson KY, 41143 PH: 606-255-0733	pknbag@gmail.com
Rebbeca Burton	Parents of children with SED		115 Sawgrass Lane, Apt. 20 Grayson KY, 41143 PH: 606-225-4123	phpwithspecialneedschilden@gmail.com
Becky Clark	Family Members of Individuals in Recovery (to include family members of adults with SMI)		32 E. Willow Dell Drive Ewing KY, 41039 PH: 606-267-4101	simplifylife321@gmail.com
Deborah Coleman	State Employees	Department of Corrections	Department of Corrections - State Criminal Justice Agency LaGrange KY, 40031 PH: 502-222-7808	deborah.coleman@ky.gov
Melony Cunningham	Others (Not State employees or providers)		NAMI Kentucky Somerset KY, 42501 PH: 606-677-4066	namikyed@gmail.com
Shelley Elswick	Family Members of Individuals in Recovery (to include family members of adults with SMI)		1096 Chetford Drive Lexington KY, 40509 PH: 859-619-4397	shelley.elswick@gmail.com
Kelly Gunning	Others (Not State employees or providers)		869 Sparta Court Lexington KY, 40504 PH: 859-309-2856	Kelly@namilex.org
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	haneyl@fuse.net
			Department for	

Bill Heffron	State Employees	Department for Juvenile Justice	Juvenile Justice Frankfort KY, 40601 PH: 502-573-2738	BillM.Heffron@ky.gov
Ann Hollen	State Employees	Department for Medicaid Services	Department for Medicaid Services - State Medicaid Agency Frankfort KY, 40601 PH: 502-564-1647	Ann.Hollen@ky.gov
Joy Hoskins	State Employees	Department for Public Health	Department for Public Health - State Health Agency Frankfort KY, 40601 PH: 502-564-3970	Joy.Hoskins@ky.gov
Amy Jeffers	Providers		Regional Prevention Center Ashland KY, 41105-0790 PH: 606-329-8588	amy.jeffers@pathways-ky.org
Michael Karman	Parents of children with SED		2217 Wendell Avenue Louisville KY, 40205 PH: 502-807-4204	karmanism70@gmail.com
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: 606-585-3639	brandon@kypartnership.org
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	lak77goherd@yahoo.com
Maggie Krueger	Parents of children with SED		265 Tamarack Road Columbia KY, 42728 PH: 270-384-1134	maggiekrueger@windstream.net
Gayla Lockhart	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		401 Pebbles Avenue Franklin KY, 42134 PH: 270-586-3367	gaylalockhart@att.net
Linda Lucas	Parents of children with SED		PO Box 255 Rush KY, 41168 PH: 606-939-8487	lindalucas6@gmail.com
Steven Lyons	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		96-9th Street Shelbyville KY, 40065 PH: 502-321-1951	lyonssadsack@aol.com
Franci Middleton	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		570 Glancy Fork Road Denton KY, 41132 PH: 606-475-9851	francicampbell@yahoo.com
Ron O'Hair	State Employees	Office of Vocational Rehabilitation	Office of Vocational Rehabilitation - State Vocational Rehabilitation Agency Morehead KY, 40351 PH: 606-783-8615	RonnieL.O'Hair@ky.gov
			Kentucky	

Carmilla Ratliff	Others (Not State employees or providers)		Partnership for Families and Children Frankfort KY, 40601 PH: 502-875-1320	Carmilla@kypartnership.org
Jeanette Rheeder	State Employees	KY Housing Corporation	KY Housing Corporation - State Housing Agency Frankfort KY, 40601 PH: 502-564-7630	jrheeder@kyhousing.org
Peggy Roark	Family Members of Individuals in Recovery (to include family members of adults with SMI)		100 Leesway Court Nicholasville KY, 40356 PH: 859-396-1561	peggyroark8@gmail.com
Sherry Sexton	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		452 Wellington Gardens Drive Lexington KY, 40503 PH: 606-336-4106	Sherry.l.sexton606@gmail.com
Steve Shannon	Providers		Kentucky Assocation of Regional Programs Lexington KY, 40503 PH: 859-272-6700	SShannon.KARP@iglou.com
Koleen Slusher	State Employees	Department for Behavioral Health	Department for Behavioral Health, Developmental and Intellectual Disabilities Frankfort KY, 40601 PH: 502-564-4456	Koleen.Slusher@ky.gov
Matthew 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
Betty Stephens	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		4935 KY 755 Sandy Hook KY, 41171 PH: 606-738-4421	stephensbetty40@gmail.com
Kathryn Tillett	State Employees		300 Sower Blvd Frankfort KY, 40601 PH: 502-564-4970	Kathryn.Tillett@ky.gov
Tonia Wells	State Employees	Department for Aging and Independent Living	Department for Aging and Independent Living - State Agency on Aging Frankfort KY, 40601 PH: 502-330-6861	toniaa.wells@ky.gov

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2017 End Year: 2019

Type of Membership	Number	Percentage
Total Membership	38	
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)	6	
Parents of children with SED*	4	
Vacancies (Individuals and Family Members)	2	
Others (Not State employees or providers)	4	
Total Individuals in Recovery, Family Members & Others	23	60.53%
State Employees	11	
Providers	2	
Federally Recognized Tribe Representatives	0	
Vacancies	2	
Total State Employees & Providers	15	39.47%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	1	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	1	
Persons in recovery from or providing treatment for or advocating for substance abuse services	26	

* 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?

Initiatives to Increase Feedback

Two years ago the Kentucky Behavioral Health Planning and Advisory Council began initiatives to facilitate improved system of care planning. The following is an update on the status of those initiatives:

• Year-round review of the plans/reports. The Council is now dedicating a portion of each quarterly meeting to reviewing Environmental Factors selected by the Council. The narrative for the Environmental Factor is provided in meeting packets and included with the meeting notice so that participants can review the narrative and draft their verbal and/or written feedback prior to the meeting. Guided questions are included with the narrative. Two examples of guided questions are attached at the end of this document.

• Focus on a targeted area of the system of care. Council members have responded positively to this review process because they are able to focus their discussion on a particular aspect of Kentucky's behavioral health system of care. Staff record members' comments during discussions and include them in

the minutes. The following is a sample of comments provided at the March 16, 2017 quarterly Council meeting when the Recovery Environmental Factor was reviewed:
o “The state would benefit from peer-based crisis services.”
o “The state needs to develop peer run diversion services.”
o “The drop-in element is important and more centers should be developed across the state.”
o “Drop-in centers become not just a hub for peer services but for recovery services.”
o “Recovery services are enhanced when the team includes a Supported Housing Specialist and a Supported Employment Specialist.”
o “The state would benefit from peer-run respite services.”
• Increased member choice in the focus of the Council’s review. Staff provide members with a list of the Environmental Factors and a vote is taken to select Factors to discuss during upcoming quarterly meetings. At the last vote, members selected the Recovery, Health Disparities, Suicide Prevention, and Prevention for Serious Mental Illness as their areas of focus.

In addition to the quarterly reviews of Environmental Factors, the Kentucky Behavioral Health Planning and Advisory Council's Finance and Data Committee holds an annual meeting in April. Members are provided with copies of the MHBG and SABG proposed allocations for the upcoming fiscal year and the approved allocations for the current fiscal year. These documents contain the 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 review the documents with committee members and encourage feedback on the allocations.

Following that discussion, members are provided with an overview of projects to potentially fund if reserve block grant funds are available. During the past two years, members voted to support the following initiatives:
• Transitional Housing, especially for women with children;
• Reintegration services and housing;
• Programs to train and educate the community (e.g., SUD training for all police);
• Oxford House Case Manager and Supported Employment Training for Trainers;
• Military Training Modules;
• Forensic ACT Team
• Emergency Preparedness
• Crisis Stabilization Services
• Reintegration Services for SMI
• Supported Housing Initiative at Wellspring in Louisville

The minutes from the April 2016 and 2017 Finance and Data Committee meetings are included at the end of this document.
DBHDID reviews the Block Grant Plan and Assessment during its August meetings and the Behavioral Health Reports during its November meetings. Department staff draft the state plan. Council members and the public are encouraged to provide recommendations and feedback. The draft of the plans and reports are sent via email to individuals on the Council listserv and the draft documents are placed as a “Hot Topic” on the home page of the Department’s website. The Council website also contains a document that details opportunities to provide written and/or verbal feedback. An archive of draft, submitted and approved plans and reports going back to 2012 is maintained on the Council’s webpage. Council members, the public and BHDID staff are invited to the quarterly meeting of the Council as one opportunity to provide verbal and/or written feedback. As is customary with all Council meetings, members (individuals in recovery, family members, parents and young adult in recovery) are offered lodging, travel reimbursement and a stipend to support their attendance. Staff provide a PowerPoint presentation of the drafted application/report. Time is given on the agenda for attendees to provide feedback and recommendations. Council members may provide verbal or written feedback. Staff note and compile written feedback. The Council creates a letter confirming the Council’s participation and opportunity to review and provide feedback on the Plan. At the Council meeting, staff encourage members and the public to continue to submit feedback/comments and provide information about how to submit comments via email, US Mail, fax or by telephone to the lead Block Grant staff (Michele Blevins). Comments and recommendations are reviewed and incorporated into the final document as applicable.
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 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.

Footnotes:

Environmental Factors and Plan

23. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, 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.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? (•) Yes ( ) No

b) Posting of the plan on the web for public comment? (•) Yes ( ) No

c) Other (e.g. public service announcements, print media) (•) Yes ( ) No

If yes, provide URL:

http://dbhdid.ky.gov/kdbhdid/ (Hot Topics)
Planning Council Web site and past submissions of Block Grant applications and Implementation Reports:
http://dbhdid.ky.gov/dbh/kbhpac.aspx

Footnotes:

The state received comments on the plan, both verbally at the 8-17-17 BHPAC meeting, and through other correspondence. These comments were incorporated into the application prior to submission.

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 involved in the development and review of the state plan and report? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).*

Attachments

Kentucky Behavioral Health Planning and Advisory Council Finance Committee Meeting Summary
April 19, 2017 10:00am to 2:00pm Transportation Bldg. Frankfort, Kentucky

Members Present: Gayla Lockhart, Steve Lyons, LeeAnn Kelly, Becky Burton, Brandon Kelly, Kyle Burchett, Linda Lucas, Franci Middleton
Staff Present: Michele Blevins, Missy Runyon, Christie Penn

Topic	Discussion	Next Steps
Call to Order & Introductions	Gayla Lockhart, Council Chair, called the meeting to order at 10:00 AM. Committee members and staff introduced themselves. *(Peggy Roark, Chair was not able to attend the meeting today.)*	
Overview of CMHS and SAPT Block Grants	Michele Blevins provided an explanation of the funding for Mental Health and Substance Abuse Prevention and Treatment Block Grants at the federal level. She shared information about the recent discussion at the federal level to also "block grant" federal Medicaid funds. Brief history of the move to block grant the MH/SAPT funds during the Reagan Administration. (*PowerPoint*)	
Review of Contracting Process	Michele Blevins provided an informational overview of Kentucky's 2018 budget for the CMHCs and how the Plan and Budget process works. (*PowerPoint)* She explained how the block grant funds are part of the larger budget for MH/SAPT including state general funds, agency funds and other federal funds. Members reviewed the information and Michele answered questions.	
Block Grant Drafted Budgets for 2018 (*Beige Sheets*)	Committee members reviewed the SFY 2018 MHBG & SABG allocations as drafted by DBHDID. Michele shared the allocation formulas used to distribute funding to the 14 CMHCs and provided an overview of the funding priorities (PowerPoint). Michele also shared information about the SFY 2018 Plan and Budget Process used with the CMHCs and the data entered by the CMHCs and used by the Department. Members reviewed the information and Michele answered questions. Committee members were encouraged to make comment of the plan and to make other suggestions for how to allocate the block grant funds.	These may be revised over the next few months and Michele will share revised copies with Council members
Data Review	Michele shared a variety of data reports generated from the data that the CMHCs enter monthly to show who they are serving in what programs: Mental Health (SMI,SED), Substance Abuse, Co-Occurring, Crisis programs, etc. Also shared Medicaid members by county, by MCO enrollment.	Links for CMHC data reports in PowerPoint. Send out link to Medicaid report & data about Opioid deaths by county when available.
Block Grant Funding Requests	**MHBG:** Funding Ideas for which the Department seeks BHPAC Feedback: Flexible Community Care and Support Funds Services for Service Members, Veterans, and Family Members Diversion from Criminal Justice/Juvenile Justice Jail Triage Services **SAPT:** Funding Ideas for which the Department seeks BHPAC Feedback: Adolescent Treatment Funds	

	Emergency Preparedness- $3,000 per Center =$42,000 Oxford House - Support Case Manager(s) $50,000 Oxford House –Supported Employment -Additional Funds to Support Statewide Trainer-Training $50,000 Committee Members believe all of the requests and shared their priorities. Ideas from the Committee: Transitional Housing, especially for women with children; reintegration services and housing; and programs to train and educate the community (e.g., SUD training for all police)	Oxford House presentation is planned for the May 18th Full Council Meeting
Adjournment	LeeAnn Kelly made a motion to adjourn the meeting, Becky Burton seconded and **Motion passed.** The meeting adjourned at 2:17 PM.	Next Meeting April 2018, Location TBD

Kentucky Behavioral Health Planning and Advisory Council
Finance Committee Meeting Summary
April 21, 2016 10:00am to 2:00pm
CHFS/DBHDID 4th Floor Conference Room Frankfort, Kentucky

Members Present: Betty Jo Moss, Mary Singleton, Gayla Lockhart, Steve Lyons, Ann Hollen, Yayo Radder, Jeanette Rheeder, Sherry Sexton
Staff Present: Michele Blevins, Missy Runyon, Christie Penn, Maggie Schroeder

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 2017 Budget for the CMHCs.	
Review of Kentucky's 2017-2018 Biennium Budget	Michele Blevins provided an informational overview of the Kentucky's 2017-18 Biennium Budget and copies of the proposed SFY 2017 SA & MH Block Grant Allocations. She also shared information about the various sources of funding that the Department uses, including competitive federal grants, agency funds, etc. Members reviewed the information and Michele answered questions. While the SGF budget is not yet passed, there are anticipated cuts of 9% ($16.5M) in SFY 2017 and 2018.	These may be revised over the next few months and Michele will share revised copies with Council members
Block Grant Drafted Budgets for 2017	Committee members reviewed the SFY 2017 MHBG & SABG allocations. Members reviewed the information and Michele answered questions.	
Discussion/ Recommendations	Michele shared the allocation formulas used to distribute funding to the 14 CMHCs and provided an overview of the funding priorities (PowerPoint). Michele also shared information about the SFY 2017 Plan and Budget Process used with the CMHCs and the data entered by the CMHCs and used by the Department.	
Block Grant Funding Requests	**MHBG:** Funding Ideas for which the Department seeks BHPAC Feedback: Additional Crisis Stabilization Services – all or multiple regions Emergency Preparedness - $3,000 per Center =$42,000 Forensic ACT Team - Region 6 (Seven Counties Services -SCS) -$200k Adult Peer Support Training and Coaching - $100-200k Reintegration Services for SMI - $100k Wellspring- additional funding to support Housing Initiative for SMI **SAPT:** Funding Ideas for which the Department seeks BHPAC Feedback: Emergency Preparedness- $3,000 per Center =$42,000 Military Training Modules - $25,000 + $5,000 ongoing annually Oxford House - Support Case Manager(s) $50,000	

	Oxford House –Supported Employment -Additional Funds to Support Statewide Trainer-Training $50,000 Committee Members believe all of the requests are valid and rank ordered their priorities.	
BHPAC Expenditures	Council Chair requested review of the Council operation expenses which were provided as a handout to all members.	
Adjournment	Mary Singleton made a motion to adjourn the meeting, Gayla Lockhart seconded and **Motion passed.** The meeting adjourned at 2:17 PM.	Next Meeting April 20, 2017 10:00 AM - 2:00 PM Location TBD

Guided Questions for Recovery Narrative

SAMHSA guidance – The implementation of recovery-based approaches is imperative for providing comprehensive, quality behavioral health care. SAMHSA promotes the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals with mental disorders and/or substance use disorders.

SAMHSA developed the integrated, working definition of recovery from mental disorders and/or substance use disorders as: a process of change through which an individual improves their health and wellness, lives a self- directed life and strives to reach their full potential.

SAMHSA encourages states to consider ways to incorporate recovery support services, including peer delivered services, into their continuum of care.

All handwritten comments are appreciated and will be collected any time prior to March 16, 2017.

Guided Questions

1. What subpopulations/geographical areas served by the public behavioral health system need to have more peer delivered services? (e.g. veterans; youth; individuals experiencing trauma; eastern; western)

2. Please 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).

3. Please list any efforts in Kentucky you are aware of that promote the overall wellness of individuals being served by the public behavioral health system. (e.g. smoking cessation efforts; diabetes prevention programs; obesity awareness programs).

Guided Questions for Health Disparities Narrative

Definitions of Health Disparity

- The HHS Action Plan to Reduce Racial and Ethnic Disparities defines **health disparities** as differences in health outcomes that are closely linked with social, economic, and environmental disadvantage.

Source: U.S. Department of Health and Human Services*. HHS Action Plan to Reduce Racial and Ethnic Disparities: A Nation Free of Disparities in Health and Health Care.* Washington, D.C.: U.S. Department of Health and Human Services, [April 2011].

- Healthy People 2020 defines a ***health disparity*** as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."

Source: U.S. Department of Health and Human Services. *The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020. P*hase I report: Recommendations for the framework and format of Healthy People 2020 [Internet]. Section IV: Advisory Committee findings and recommendations [cited 2010 January 6].

All handwritten comments are appreciated and will be collected on August 18th.

Guided Questions

1. What do you think are subpopulations/groups in Kentucky who are vulnerable to behavioral health disparities?
2. What initiatives do you recommend to address behavioral health disparities in Kentucky?
3. What technical assistance do you think the state of Kentucky should request from SAMHSA related to behavioral health disparities?

Please share any other comments related to Kentucky's behavioral health system of care or health disparities.

EXECUTIVE SUMMARY
Unified Community Mental Health and Substance Abuse Prevention and Treatment Block Grant Application for FFY 2018-2019 Funds

Please note that no Executive Summary is required/able to be loaded into the electronic web application but is provided by KDBHDID for informational purposes.

This document contains Kentucky's plan for State Fiscal Years 2018-19 to strengthen the publicly-funded behavioral health systems of care for adults and youth across the Commonwealth. It is submitted by the Kentucky Department for Behavioral Health, Intellectual and Developmental Disabilities (DBHDID), the state's designated authority for both mental health and substance abuse prevention and treatment (in compliance with Public Law 102-321) and applies to funds that will become available in Federal Fiscal Years 2018 and 2019. The anticipated funding for the **Community Mental Health Services (CMHS) Block Grant is $5,104,370**, a proposed decrease of $1,855,839 from the current year. This decrease is a result the President's/SAMHSA's proposed budget and not an official award amount, at this point. The anticipated funding for the **Substance Abuse Prevention and Treatment Block Grant is $20,339,514.** The state is also awarded a small, non-competitive grant for data infrastructure to support the extensive and required data reporting for the two Block Grant awards.

Historically, the federal Center for Mental Health Services (CMHS) and the Centers for Substance Abuse Prevention and Treatment (CSAP/CSAT), within the Substance Abuse and Mental Health Services Administration (SAMHSA) have had markedly different planning and application processes, as well as different reporting requirements and timeframes. In recent years, SAMHSA has encouraged states to submit a "unified" application with a significantly changed format. While the funds will continue to be awarded separately, states are strongly encouraged to participate in joint planning in an effort to transform their behavioral health system into one that is fully integrated.

In addition to the new planning and reporting processes, Block Grants are transitioning to funding cycles more aligned to the state fiscal years used in the majority of states and this application allows the Commonwealth to submit a bi-annual plan, along with an annual abbreviated "funding" application. A detailed timetable for this is included at the end of this summary.

Since the passage of the Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 and subsequent implementation regulations, SAMHSA states that Block Grant funds should be directed toward three purposes: (1) To fund services for those without insurance either short or long-term; (2) To fund priority services not covered by another payor and that are successful in improving outcomes and/or supporting recovery; and (3) To collect data to determine effectiveness of services and to plan for implementation of new services. States are instructed to include in their plan the efforts made toward the utilization of block grants for these purposes.

Block Grant funds will only be used to carry out the activities identified in Kentucky's approved plan; to evaluate programs under the plan; and to plan, administer and educate stakeholders regarding services and supports under the plan. The majority (approximately 85%) of the block grant funds are allocated to Kentucky's fourteen Regional Behavioral Health Boards (the *Community Mental Health Centers*) that provide a full array of mental health and substance abuse prevention and treatment services. Federal limitations on administrative costs and maintenance of effort requirements will be met. A certain percentage of the state's mental

health funding must be set aside for children's services and ten percent of the total mental health block grant funding for first episode psychosis programming. Also, twenty percent of substance abuse funding must be set aside for prevention activities and another portion for treatment services to pregnant/postpartum women and women with dependent children. Kentucky generally exceeds the minimum requirements.

The plans required by the block grant must address all activities and funding that build systems of care for individuals with behavioral health care needs, not just those supported by Block Grant funds. Therefore, this application for federal funds helps drive the development of stronger services and supports utilizing all funding sources, including Medicaid, other federal grants, locally obtained funds, and State General Fund appropriations for mental health and substance use prevention and treatment, from the Kentucky General Assembly.

The planning process required by the federal agency also provides an opportunity to present the plan for formal review by a panel of stakeholders, the Kentucky Behavioral Health Planning & Advisory Council. Parents, family members, and individuals in recovery are well represented on the Council, and we believe that the state's plan is stronger because of their involvement, ideas, and comments. In addition to the Council meetings, a drafted application will be posted on the DBHDID website and comments are received through Friday August 25, 2017.

The application is comprised of four sections, including:

(I) State Information;
(II) Planning Steps 1 and 2 and Quality and Data Collection Readiness;
(III) Nine Planning Tables; and
(IV) Twenty-three Environmental Factors (Narrative responses to questions).

Within the plan, states are required to address five (5) federally mandated Criterions for Adults with Serious Mental Illness (SMI) and Children with Severe Emotional Disabilities (SED). Requested Criterion for Substance Use Disorders has been added in this year's application. States are required to develop *Performance Indicators* with *Goals* and *Strategies* to address a number of federally prescribed priority areas/populations. States also are required to provide detailed planned and expended financial tables for mental health, substance use primary prevention, and substance use treatment.
As a result of the required planning process for this funding application, the table below represents *Performance Indicators* chosen for Kentucky for each of the prescribed priority areas/populations, including:

- Adults with Serious Mental Illness (SMI)
- Children/Youth with Severe Emotional Disabilities (SED)
- Early Serious Mental Illness (ESMI)
- Primary Prevention
- Persons who have substance use disorders and are:
  - Pregnant
  - Parents with dependent children
  - Intravenous drug users
  - Diagnosed with tuberculosis.

STATE PERFORMANCE INDICATORS	
1	Increase the Number of Adults with SMI who receive Adult Peer Support Services
2	Ensure appropriate programming for individuals during the onset of SMI (*Early Interventions for First Episode Psychosis)*
3	Increase the Number of Children/Youth with SED who receive Youth Peer Support Services
4	Reduce the Incidence of Underage Drinking
5	Increase the Number of Individuals who are Pregnant/Have Dependent Children who receive Case Management for Substance Use Disorders, including Adolescents (under age 18)
6	Reduce the outbreak of Hepatitis by increasing the availability and awareness of syringe exchange programs statewide.
7	Ensure Individuals Receiving Substance Use Services are appropriately screened for tuberculosis.

Detail about measurement and strategies to achieve the goals above are provided in Section III of the FFY 2018-2019 application.

A Note about the Application and Reporting Due Dates and Fiscal Years

The FFY 2018-19 block grant unified application must be submitted by September 1, 2017 for the two year period of October 1 2017-September 30, 2019. States, also, are required to submit an abbreviated funding application based on their plan in the interim year (prior to September 1, 2018). The table below shows the timelines with which states must comply.

Application for FFY	Two Year Plan Due	Abbreviated Funding Application	Plan is for the Period of	Implementation Reports Due	Reporting Period
2018	9/1/2017		10/1/17-9/30/18	12/1/18	7/1/17-6/30/18
2019		9/1/2018	10/1/18-9/30/19	12/1/19	7/1/18-6/30/19

Note: Reporting timeframes for SYNAR (sale of tobacco products to minors) will remain on the same schedule and are annually due by December 31.

I. State Information

Chief Executive Officer's Funding Agreements, Assurances Non-Construction Programs and Certifications (Form 3)
Fiscal Year 2018/19

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32
Section 1935	Core Data Set	42 USC § 300x-35
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

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

State: Kentucky

Name of Chief Executive Officer (CEO) or Designee: Vickie Yates Brown Glisson

Signature of CEO or Designee[1]: Vickie Yates Brown Glisson

Title: Secretary

Date Signed: 8/28/17 (mm/dd/yyyy)

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

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 sub agreements.

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.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

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.

COMMONWEALTH OF KENTUCKY
OFFICE OF THE GOVERNOR

MATTHEW G. BEVIN
GOVERNOR

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

August 16, 2017

Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
5600 Fisher Lane, Rm 17E20
Rockville, MD 20857

To Whom It May Concern:

As the Governor of the Commonwealth of Kentucky, for the duration of my tenure, I delegate authority to the current Cabinet Secretary, or anyone officially acting in this role in the instance of a vacancy, for all transactions required to administer the Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SABG).

Please contact Michele Blevins, Assistant Director within the Division of Behavioral Health, if you have any questions. You may reach Ms. Blevins electronically at Michele.Blevins@ky.gov or by phone at (502) 782-6150.

Sincerely,

Matthew G. Bevin
Governor

I. State Information

Chief Executive Officer's Funding Agreements, Assurances Non-Construction Programs and Certifications (Form 03)
Fiscal Year 2018/19

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

Title XIX, Part B, Subpart I of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

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

State: Kentucky

Name of Chief Executive Officer (CEO) or Designee: Vickie Yates Brown Glisson

Signature of CEO or Designee[1]: Vickie Yates Brown Glisson

Title: Secretary

Date Signed: 8/28/17
mm/dd/yyyy

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

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to

all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the 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.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

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.

COMMONWEALTH OF KENTUCKY
OFFICE OF THE GOVERNOR

MATTHEW G. BEVIN
GOVERNOR

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

August 25, 2017

Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
5600 Fisher Lane, Rm 17E20
Rockville, MD 20857

To Whom It May Concern:

As the Governor of the Commonwealth of Kentucky, for the duration of my tenure, I delegate authority to the current Cabinet Secretary, or anyone officially acting in this role in the instance of a vacancy, for all transactions required to administer the Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Block Grant (MHBG).

Please contact Michele Blevins, Assistant Director within the Division of Behavioral Health, if you have any questions. You may reach Ms. Blevins electronically at Michele.Blevins@ky.gov or by phone at (502) 782-6150.

Sincerely,

Matthew G. Bevin
Governor