Kentucky

UNIFORM APPLICATION
FY 2022/2023 Combined MHBG ApplicationBehavioral Health Assessment and Plan

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

OMB - Approved 03/02/2022 - Expires 03/31/2025
(generated on 07/26/2023 4.42.44 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 2022

End Year 2023

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 Brittney

Last Name Allen

Agency Name Cabinet for Health and Family Services

Mailing Address 275 East Main Street 4W-G

City Frankfort

Zip Code 40621

Telephone (502) 782-6740

Fax (502) 564-4826

Email Address Brittney.Allen@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. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ○ No

First Name	
Last Name	
Agency Name	
Mailing Address	
City	
Zip Code	
Telephone	
Fax	
Email Address	

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

From	
To	

V. Date Submitted

Submission Date	8/31/2021 2:52:58 PM
Revision Date	12/28/2022 11:39:40 AM

VI. Contact Person Responsible for Application Submission

First Name	Melissa
Last Name	Runyon
Telephone	5027826238
Fax	
Email Address	Melissa.Runyon@ky.gov

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

State Information

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

Fiscal Year 2022

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		
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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 19 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, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean 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 Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

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

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

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

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

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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 other Certifications summarized above.

State: _____

Name of Chief Executive Officer (CEO) or Designee: Eric Friedlander

Signature of CEO or Designee[1]: _____

Title: Cabinet Secretary

Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

COMMONWEALTH OF KENTUCKY
OFFICE OF THE GOVERNOR

Andy Beshear
GOVERNOR

Capitol Building, Suite 100
700 Capital Avenue
Frankfort, Kentucky 40601
(502) 564-2611
Fax: (502) 564-2517

January 30, 2020

Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
5600 Fisher Lane, Rm 17E20
Rockville, Maryland 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,

Andy Beshear
Governor

AN EQUAL OPPORTUNITY EMPLOYER M/F/D

Kentucky Behavioral Health Planning & Advisory Council

275 East Main Street, 4W-G, Frankfort, KY 40601

August 19, 2021

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

To Whom it May Concern,

I am writing on behalf of Kentucky's Behavioral Planning and Advisory Council to confirm that Council members met today and reviewed the application for funding for Kentucky's mental health and substance abuse prevention and treatment block grant funding for FFY 2022-2023. Time was allotted at today's meeting to discuss the application and it is also posted for review on the KY Department for Behavioral Health, Developmental and Intellectual Disabilities web site at https://dbhdid.ky.gov/dbh/kbhpac-bg.aspx. Department staff welcomes comments and recommendations prior to and after submission of the 2022-2023 application on September 1, 2021.

Thank you for the continued support of community-based services for adults and youth with behavioral health disorders. Our Council is honored to serve as advisors for planning in Kentucky.

Sincerely,

Robin Osborne

Robin Osborne
Chair, Kentucky Behavioral Health Planning and Advisory Council

Cc: Melissa Runyon, Block Grant State Planner

State Information

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

Fiscal Year 2022

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Section 1943	Additional Requirements	**42 USC § 300x-53**
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As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
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.
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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.).
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17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
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19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
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2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

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

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Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

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

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

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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 other Certifications summarized above.

State: Kentucky

Name of Chief Executive Officer (CEO) or Designee: Eric Friedlander

Signature of CEO or Designee[1]: DocuSigned by: Eric Friedlander 0AEA1D6C15D6431...

Title: Cabinet Secretary

Date Signed: 8/28/2021

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

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

Eric Friedlander

Title

Cabinet Secretary

Organization

Kentucky Cabinet for Health and Family Services

Signature: DocuSigned by: Eric Friedlander 0AEA1D6C15D6431... Date: 8/28/2021

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Footnotes:

N/A for the State of Kentucky

State Information

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

Fiscal Year 2022

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 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 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**
Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
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

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 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
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17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
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19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

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c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
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The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

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

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
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The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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: Eric Friedlander

Signature of CEO or Designee[1]: _____

Title: Cabinet Secretary

Date Signed: _____

mm/dd/yyyy

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

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

COMMONWEALTH OF KENTUCKY
OFFICE OF THE GOVERNOR

Andy Beshear
GOVERNOR

Capitol Building, Suite 100
700 Capital Avenue
Frankfort, Kentucky 40601
(502) 564-2611
Fax: (502) 564-2517

January 30, 2020

Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
5600 Fisher Lane, Rm 17E20
Rockville, Maryland 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,

Andy Beshear
Governor

State Information

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

Fiscal Year 2022

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 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 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**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

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

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

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The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

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The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

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

Name of Chief Executive Officer (CEO) or Designee: Eric Friedlander

Signature of CEO or Designee[1]: DocuSigned by: Eric Friedlander 0AEA1D6C15D6431...

Title: Cabinet Secretary

Date Signed: 8/28/2021

mm/dd/yyyy

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

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

ARPA Funding Proposal for MHBG

As Submitted to SAMHSA July 2, 2021

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

ARPA Funding Proposal for SABG

As Submitted to SAMHSA on July 2, 2021

Substance Use Treatment and Prevention ARPA Funded Project/Activity/Initiative	Set Aside /Required Initiative	Total for Grant Period
Total		$16,496,159
SUD Primary Prevention **$3,299,232.00**	Yes 20%	$3,500,000.
Crisis Continuum - 988	Suggested	$1,750,000.
SUD Treatment (Includes gender specific services and Tx for Individuals that use drugs IV)	Required	$4396,159.
SUD Recovery Services	Suggested	$2,000,000.
Workforce Development 50/50	Suggested	$500,000.
CCBHC Readiness 50/50	Suggested	$4,000,000.
Disaster Preparedness, Response, Resilience (SUD)		$350,000.

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

Eric Friedlander

Title

Cabinet Secretary

Organization

Kentucky Cabinet for Health and Family Services

Signature:

Date:

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

N/A for the State of Kentucky

Planning Steps

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

Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems of care, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system of care 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 SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems of care address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

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.

The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) has a mission to provide leadership, in partnership with others, to prevent disability, build resilience in individuals and their communities, and facilitate recovery for people whose lives have been affected by mental illness, intellectual disability or other developmental disability, or substance abuse. The DBHDID vision for 2021 and beyond is to:

- Expand the recovery-oriented system of care to address the opioid crisis and other substance use disorders;
- Support and promote the behavioral health and wellness of children and families involved with or at risk of involvement with the child welfare system;
- Mitigate adverse behavioral health outcomes exacerbated by the pandemic and racial inequity while preserving and enhancing the behavioral health safety network;
- Advance efficient and effective operations of state inpatient and residential facilities; and
- Assure a safe and adequate system of care for people with intellectual and other developmental disabilities.

Kentucky's DBHDID Department goals include:

- Developing an infrastructure that ensures the use of research-based knowledge, both internally and externally, to enhance the continuum of care,
- Empowering Kentuckians, regardless of disability or age, to lead lives of dignity and hope in accordance with their individual choices,
- Ensuring responsible fiscal and programmatic oversight and accountability,
- Promoting quality outcomes through best practices and data driven decisions,
- Promoting resiliency, recovery and inclusion in community living,
- Providing education and resources to all stakeholders to create and sustain an infrastructure base for evidence-based practices.

Kentucky's 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, adults and youth with substance use disorders, and individuals with co-occurring mental health and substance use disorders. DBHDID is developing a statewide network of early intervention services and supports to address transition age youth and young people experiencing multiple behavioral health issues, including first episode psychosis. With guidance from SAMHSA's *Strategic Plan: FY2019 - FY2023*, the DBHDID strives to further promote access to a full continuum of care for mental health and substance use disorders, and to provide necessary resources and data to assist community providers in local-level decision-making, including policies, program development and the provision of evidence-based practices. Kentucky

is working to enhance the behavioral health crisis intervention programming across the state. DBHDID promotes the reality that access to a full continuum of care for mental health and substance use disorders advances the recognition that mental health and freedom from addiction is essential to overall health.

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 designated as the primary state agency for developing and administering programs for the prevention, detection and treatment of behavioral health disorders (adults and children); including developing and administering treatment, rehabilitation, and recovery services for individuals with behavioral health disorders and developmental and intellectual disabilities. The Department receives state general funds allocated for the prevention and treatment of behavioral health (mental health and substance use) disorders in a biennial budget and is charged with administering the funds 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 (including the Office of the Ombudsman and the Office of Public Affairs);

Office of Health Data & Analytics (including KY Health Information Exchange, KY Health Benefit Exchange and Telehealth Services);

Office of the Inspector General (Certificates of Need, Licensing and Regulation Authority);

Office for Children with Special Health Care Needs

Department for Public Health (Local and State Public Health Programs and Health Equity Branch);

Department for Medicaid Services (Medicaid Authority, including Managed Care);

Department for Aging and Independent Living (Aging, Guardianship, Long-term Care Services, and Dementia Services);

Department for Community-Based Services (Adult and Child Protection, Child Welfare);

Department for Income Support (Disability Determinations, Child Support Enforcement); and

Department for Family Resource Centers and Volunteer Services.

https://chfs.ky.gov/Pages/index.aspx

Within DBHDID, there are four Divisions, including: Administration and Financial Management; Developmental and Intellectual Disabilities; Program Integrity; 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.

The Division of Behavioral Health Director's Office includes a broad dashboard of subject matter expertise. The Division Director, two (2) Assistant Directors, several division-wide Program Administrators, including Deaf and Hard of Hearing Services, Early Interventions for First Episode

Psychosis programming, and Disaster Preparedness, as well as Administrative Specialists and Program Coordinators are seated in the office. Additional areas of focus represented within the Director's Office include staff supporting the Kentucky Opioid Response Effort (KORE), which includes a Re-Entry Coordinator for inmates with serious mental illness (SMI) or co-occurring SMI and substance use disorder (SUD), who are serving out or paroled from two (2) of the state's correctional facilities and returning to the community upon the completion of their sentence. Rounding out the Director's office is the Behavioral Health Services Information System (BHSIS) Coordinator, who manages the Department's client, service and facility-based data sets, as well as the data-tracking tool for the Settlement Agreement for adults with SMI.

DBHDID's Division of Behavioral Health is comprised of the Director's Office and four Branches, including:

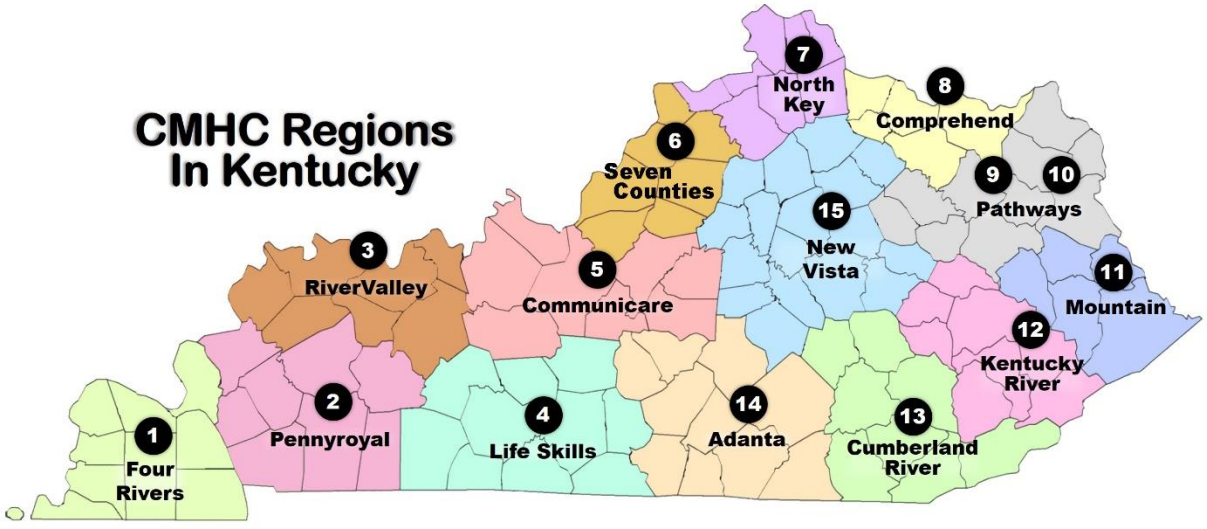
Behavioral Health Prevention and Promotion Branch – Oversees and supports programs across the state in the use of evidence-based prevention strategies to decrease risk factors and increase protective factors and resilience, with the goal of reducing rates of substance use and suicide among residents of Kentucky. Prevention and Promotion Branch efforts focus on reducing or delaying the initiation of substances, mental health issues, and their related consequences.

Adult Substance Abuse Treatment and Recovery Services Branch – Oversees and supports the administration of the community-based, outpatient and residential services for individuals with substance use disorders across the state. This Branch manages several statewide specialty programs for key SUD populations, (e.g. pregnant women; women with dependent children; Medications for Opioid Use Disorder; Veterans, Service Members and their families), coordinates efforts to build a recovery-oriented system of care across the lifespan, and provides guidance and technical assistance on the implementation of evidence-based practices for this population.

Children's Behavioral Health and Recovery Services Branch - Oversees the services and supports for children and youth across the state who have or are at-risk of developing behavioral health concerns (including both mental health and substance use) and their families. This Branch works with community providers across the state to provide oversight and technical assistance regarding the delivery of a continuum of behavioral health care that includes promotion, prevention, early intervention, treatment, and recovery service and supports. This Branch manages several statewide and regional initiatives including adolescent substance use prevention and treatment, high-fidelity wraparound, youth and family peer support, early childhood mental health, and others.

Adult Mental Health Services and Recovery Branch - Oversees the planning and implementation of mental health services for adults with serious mental illness across the state. This Branch provides training and technical assistance to providers regarding the delivery of an array of evidence-based practices that focus on the promotion, treatment, and recovery services and supports for adults with serious mental illness. Specific evidence-based practices include Assertive Community Treatment, Peer Support, Supported Employment (utilizing the Individual Placement and Support (IPS) model), and Permanent Supportive Housing. This Branch also provides a criminal justice interface for adults with serious mental illness who are involved with the justice system in Kentucky, including overseeing Crisis Intervention Team (CIT) training for law enforcement officers across the state, and collaborating with the Department of Corrections (DOC) to fund a position at the Kentucky State Reformatory to work with adults with SMI who are serving out or being paroled.

Kentucky is divided into fourteen (14) 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. All agencies are licensed by the Cabinet for Health and Family Services as a "Community Mental Health Center." In July 2019, two (2) of the region's Community Mental Health Centers merged to become one of the largest behavioral healthcare organizations in Southern Kentucky. LifeSkills, Inc. (Region 4) and the Pennyroyal Center (Region 2) became a merged entity with a total over 875 employees and 26 service locations. The combined entity continues to operate under the LifeSkills and Pennyroyal Center names in their respective regions.



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 1 - 15.

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 be provided off-site in homes, school and in other 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 the main focus is aimed at Primary Prevention for substance abuse, they also support some selective and indicated prevention strategies (using funds other than those set aside for Primary Prevention) when those activities directly support the Primary Prevention goals for each region identified through a comprehensive needs assessment. With its available resources of state general funds, block grant/other federal funds, and awarded agency funds, DBHDID contracts with the fourteen (14) 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 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.

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

Fourteen (14) community mental health centers;

Two (2) state-owned psychiatric hospitals;

Two (2) state-contracted psychiatric hospitals;

Four (4) intermediate care facilities for individuals with intellectual disability; and

Two (2) 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. According to 2019 population estimates from the Kentucky State Data Center, located at the University of Louisville, the population of Kentucky is 84% White alone, 8.2% Black or African American alone, 1.6% Asian alone, .07% Native Hawaiian or Other Pacific Islander alone, 3.9% Hispanic alone, and 2% Other or Mixed Race. The median income in Kentucky is $52,295/year.

CHFS and DBHDID are committed to addressing health disparities, particularly mitigating adverse behavioral health outcomes exacerbated by the pandemic, racial, and other inequity. 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 of the State Interagency Council. 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 of 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.

During SFY 2020, a Commissioner-level Executive Advisor was hired to work on racial equity within the DBHDID. A Department-wide Racial Equity Action Plan was developed that focused on applying the principles of intersectionality and targeted universalism. It is anticipated that as data is disaggregated by race and actionable steps are taken within the Department, efforts will produce benefits beyond a spectrum inclusive of race and ethnicity, but will include equitable outcomes for Kentuckians who represent the full spectrum of gender identity and sexual orientation. CHFS has held monthly panels to address racial equity since the summer of 2020. The Executive Advisor developed and presented a mandatory training for all supervisors and a mandatory training for all staff. In addition, a collaboration with Spaulding University in Louisville resulted in training for up to 200 CMHC/state facility staff in Racial Trauma Therapy, with online modules and follow up coaching that allows certification in the Racial Trauma Therapy approach.

Additionally, the DBHDID data groups, consisting of DBHDID staff, CMHC staff, and data contractor staff worked to add relevant data points to the DBHDID client data set and to enhance existing client set data points. As a result, beginning on July 1, 2021, all CMHCs will collect "gender identity" and "sexual orientation" data for all new clients. In addition, the "gender" category in the client data set for the CMHCs has been updated to be inclusive.

DBHDID 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. Three (3) of the four (4) are Institutes for Mental Disease (IMD) designated facilities.

State Hospital/Location Operation	**ADC* SFY 2017**	**ADC* SFY 2018**	**ADC* SFY 2019**	**ADC* SFY 2020**
Western State Hospital/ Hopkinsville State Operated	113	115	114	107
Central State Hospital/ Louisville State Operated	57	58	54	51
Eastern State Hospital/Lexington Contracted	130	127	102	104
Appalachian Regional Hospital (ARH) Psychiatric Center/Hazard Contracted	56	54	102	55
TOTAL	**356**	**354**	**372**	**317**

*ADC = Average Daily Census

Data Source: DBHDID Client Event Data/Report ID: FIS_ADC_YR

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, KCPC facilitates outpatient competency evaluations through contracts for professional services with CMHCs. The facility's average daily census in SFY 2020 was 60 people.

Kentucky does not operate any state funded inpatient facilities for children/youth under eighteen (18) years of age. There are currently 607 available child psychiatric beds located in thirteen (13) hospitals that are geographically located in eight (8) of the fourteen (14) regions. *The 2019 Hospital Report cited below is the most recent data available.* 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, Kentucky's child welfare agency.

Psychiatric Inpatient Utilization - Statewide - Children and Adolescents 0-17 Years of Age								
Calendar 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 %
2016	13	712	609	10,609	123,612	338	11.90	47.44%
2017	14	699	596	11,473	131,449	360	11.15	51.52%
2018	13	700	596	11,098	124,190	340	11.52	48.61%
2019	13	710	607	12,381	133,844	367	11.04	51.65%

Data Source: Kentucky Office of Health Data & Analytics: 2019HospitalReport.pdf (ky.gov)

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 provider 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 44th to 47th among several sources, in recent years.

Mental Health Spending By State Across the US - Drug Rehab Options (rehabs.com)

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 1960s, 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 (14) Community Mental Health Centers (CMHCs) who provide a full continuum of behavioral health services to nearly five (5%) percent of the state's population of nearly 4.5 million people. However, 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. During SFY 2020 and SFY 2021, the COVID 19 pandemic forced behavioral health providers to rethink their methods of delivering service. All fourteen (14) CMHCs delivered services through telehealth during the pandemic, and several CMHCs developed creative ways to continue to safely provide in-person services as necessary and preferred. The effects of the pandemic are still being analyzed for behavioral health care in Kentucky. 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 (3) managed care organizations (MCOs) to provide services to approximately 540,000 Medicaid enrollees in seven (7) of the Commonwealth's eight (8) 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 had contracts with five (5) managed care entities for physical and behavioral health services for Medicaid enrolled citizens statewide. A new procurement process was initiated in SFY 2020 and new MCO contracts for six (6) managed care entities have been awarded. This process is still being finalized, but as of July 1, 2021, the contracted entities include Wellcare, Humana, Aetna, Anthem, United Healthcare, and Molina.

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. Over 450,000 Kentuckians enrolled in health coverage under Medicaid expansion and an additional 105,877 enrolled in coverage through a Qualified Health Plan.

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 Licensed Alcohol and Drug Counselors. Several new licensure categories have been created including, Behavioral Health Services Organizations (BHSOs) and Multi-Specialty Groups (MSGs). A few services are limited in 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 affected by this epidemic and efforts are currently underway to address the increase in opioid overdose deaths, substance exposed infants, children placed in out-of-home care due to the death, incarceration or drug use by parents. Kentucky's efforts to address the opioid epidemic includes strategies to stymie the increase of overdose deaths, create an effective pathway for individuals to engage in accessible treatment once an overdose has occurred and engage in robust universal, selective and indicated prevention efforts. The Kentucky Opioid Response Effort (KORE) focuses its efforts across the continuum of need, including prevention, treatment and recovery support services.

Kentucky DBHDID has worked for several years to create a recovery-oriented system of care for individuals experiencing mental illness, substance use disorders, or co-occurring mental health and substance use disorders. DBHDID has partnerships with many organizations comprised of individuals with a wide variety of lived experience, including adults, young adults, transition age youth, and family members. During the last few years, DBH has hired full time employees based on their specific lived experience to assist with the development of more systematic methods of garnering input from others with lived experience across the state. DBHDID is committed to having services available across the state that are evidence-based and specifically designed with input from those who benefit from the use of the services. For individuals with substance use disorders, DBH contracts with People Advocating Recovery (PAR) and Young People in Recovery (YPR), as well as other organizations dedicated to supporting recovery experiences for these individuals. DBHDID's vision for 2021 includes a goal to more fully expand the recovery-oriented system of care to address the opioid crisis and other substance use disorders.

Kentucky has worked for many years to create a responsive crisis system of care for individuals with behavioral health challenges in need of care 24/7. DBHDID provides crisis services through contracts with the fourteen (14) CMHCs, and utilizes a blended funding stream to support these services. The different regions provide crisis services in a variety of ways. Some regions have crisis stabilization units for overnight care, some have mobile crisis units that travel for outreach, and others have robust walk-in services as needed. With the pandemic, statewide behavioral health crisis services have become more relevant. Work will continue in this area.

DBHDID collects data from Community Mental Health Centers and other funded providers on a monthly basis. This data supports DBHDID's efforts to monitor client-level demographic and diagnostic statistics, service utilization, and provider staffing used to provide direct care behavioral health services (including services for mental health, substance use, and developmental & intellectual disabilities). This data is evaluated monthly and each data file is required to meet a set of accuracy, completeness and timeliness standards. DBHDID uses this data as its 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. Kentucky has successfully reported CLD using the original MH-CLD methodology since the inception year. Similarly, Kentucky has successfully reported URS data since the inception year of 2002.

Daily, DBHDID collects data from its state operated and state contracted facilities that for behavioral health include two (2) state-operated psychiatric hospitals and two (2) state-contracted psychiatric hospitals. One (1) of the state-contracted psychiatric hospitals is located within a medical facility. Three (3) of the state psychiatric hospitals maintain data using the same electronic health record; the unit within a medical facility manages data with a similar EHR. The data collected from these systems by the DBHDID includes client level admission and discharge information and includes demographics, diagnostic, and living arrangement (housing) status at admission and discharge. This data is evaluated monthly according to facility utilization expectations and requirements. The DBHDID uses this data for internal operations and facilities management responsibilities. This data is also the source for DBHDID's reporting on the 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.

Prevention process measures are recorded through Kentucky's web-based Prevention Data System (PDS). The PDS is patterned after CSAP's Minimum Data Set to collect information related to the type of primary prevention services used to reduce and prevent substance abuse among the residents of the Commonwealth. Information is collected on:

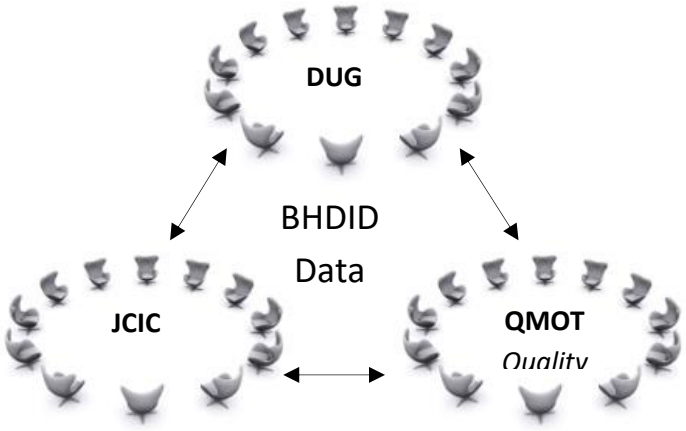
- Strategies and prevention services implemented, such as attempts to involve schools, businesses, government agencies and individuals,
- Using the processes of information dissemination, education, alternative activities, community based processes, environmental, and problem identification, and referral strategies
- Demographic composition of population served, including number served, age, gender, race, ethnicity, and whether part of high-risk population.
- Intervention strategies or types for the population served.

The Prevention Data System is maintained by Prevention and Health Promotion Branch staff. Reports are developed in conjunction with Regional Prevention Center (RPC) Directors and other special projects of the Branch. Reports are reviewed monthly by Prevention and Health Promotion Branch staff collaboratively with the RPC staff.

The reports give RPC Directors the ability to evaluate activities and effectiveness at the county level, and information is used to plan for future activities; as well, for state staff to track progress towards attaining Work Plan objectives. The Regional Prevention Centers are required by contract to enter data on their substance abuse prevention efforts on a monthly basis. The PDS data is used in the compiling of Kentucky's annual SAPT Block Grant Report.

The Kentucky Incentives for Prevention (KIP) survey is the primary data source used to set block grant priorities and track outcomes for Substance Use Prevention. The KIP survey is implemented biannually in 155 of 172 of Kentucky's school districts, and provides data on substance use, risk and protective factors, behavioral health and school safety on the county or school district level for grades 6,8,10, and 12. The KIP survey is modeled after the National Monitoring the Future Survey. During the last survey period (2018), 127,572 students participated in the KIP Survey, 31,197 of which were 10th graders. Prior to the COVID 19 pandemic the KIP Survey was implemented in even numbered years. However, since the survey could not be administered in 2020 we have now changed to odd numbered years. The next survey is planned for October 2021. In addition to the KIP Survey, Kentucky utilizes usage rates through the National Survey on Drug Use and Health (NSDUH), which is implemented annually among randomly selected youth aged twelve (12) and older, and the Youth Risk Behavioral Survey System. The NSDUH data allows for tracking general usage rates among youth ages 12-17 on an annual basis. NSDUH also provides much needed adult data which is used to set priorities for the over seventeen (17) population. YRBSS is implemented every two (2) years in odd numbered years and provides state level consumption data. With this broad approach to data collection, plus additional local surveys and data, Kentucky's substance use preventionists complete thorough needs assessments to guide their community-level efforts.

Kentucky hosts three (3) data-related standing teams that involve state and community partners. Each team plays a key role in defining data elements, defining processes to ensure accurate, complete and timely data collection and defining indicators and measures of quality. Contributions from all three (3) teams lead to successful implementation of data collection, issue resolution, and measure development.



The Data Users Group (DUG) is comprised of DBHDID staff and contracted data managers. This 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 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.

The Joint Committee for Information Continuity (JCIC) is comprised of department staff and IT representatives from the fourteen CMHCs and other contracted providers. This 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 of the information system to manage a public behavioral health system.

The Quality Management & Outcomes Team (QMOT) is comprised of the quality assurance officers from the fourteen (14) CMHCs. This team provides 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.

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 M/SUD system of care 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 M/SUD system of care.
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, SUD prevention, and SUD treatment goals at the state level.

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Footnotes:

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 M/SUD system as well as the state sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system. Especially for those required populations described in the 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.

A data-driven process must support the state's priorities and goals. 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, 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 disorder prevention, 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.

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 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.

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 has compared it with data available nationally. The DBHID and stakeholders have participated in a number of activities regarding needs and comprehensive data to drive planning efforts, including:

- Analyzing data reports for performance indicators and deliverable in provider contracts;
- Communicating data trends to providers in a variety of forums;
- System of care development for children and youth and child welfare reform;
- Readiness assessments and other assessments completed for a variety of competitive grant applications;
- A 2019 Analysis of Gaps for Assertive Community Treatment;
- An analysis of Oxford House data regarding accessibility completed in SFY 2021;
- Various training surveys regarding technical assistance needs;
- A statewide Certified Community Behavioral Health Centers (CCBHC) needs assessment completed in May of 2021;
- Technical assistance from multiple consultants;
- Strategic planning process for the Statewide Interagency Council (SIAC) created November 2020;
- Priorities and supporting research from federal experts and funders, including SAMHSA.

At present, a number of priorities have been identified but there are also a number of overarching influences to be considered as planning occurs, including:

- The impacts of the pandemic on behavioral health in Kentucky and changes in provision of behavioral health care across the state;
- The increasingly large network of Medicaid enrolled behavioral health providers that are continually implementing an array of behavioral health services;
- Managed Behavioral Health Care, including the Department for Medicaid Services contracts with six (6) Managed Care Organizations (MCOs), and the adjustment for providers and DBHDID to the unique processes required by each MCO for prior authorizations, billing, monitoring, data, etc.;
- Substantial federal funding for the Kentucky Opioid Response Effort (KORE) including the State Opioid Response Grant (SOR-II), which resulted in reorganization efforts within DBHDID;
- The continued implementation of full performance based contracting by DBHDID;
- The challenges navigating the full implementation of Medicaid Expansion in Kentucky paired with large reductions in state general funds for behavioral health since Medicaid Expansion as a result of anticipated savings with more services being Medicaid billable and more individuals being eligible for Medicaid;
- The continued promulgation of new/amended regulations, in collaboration with various state agencies, as well as continued new legislative actions, sometimes unfunded mandates;
- The Second Amended Settlement Agreement between the Cabinet for Health and Family Services and Kentucky Protection and Advocacy (signed October 2019), requiring the transition of adults with SMI from Personal Care Homes into community settings of their choice;
- The rebalancing of DBHDID facility funds into community funds for Direct Intervention: Vital Early Response Treatment System (DIVERTS), which has been vital in enhancing the continuum of care for adults with SMI;
- Continuous workforce issues with recruitment and retention, which has always been a challenge for rural Kentucky, but which has increased statewide since the pandemic;
- The underfunded state pension system and the increased retirement contributions required by the majority of the CMHCs;
- Returning Service Members, Veterans and their Families (SMVF) with behavioral health needs; and
- The recent welcomed addition of Comprehensive Addiction and Recovery Act (CARA) and American Rescue Plan Act (ARPA) funding from SAMHSA for the next several years.

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 2021:

- Housing and re-entry services for individuals with SMI exiting prison;
- Individuals on probation or parole with Intellectual/Developmental Disorders and/or SMI;
- Oxford Houses for individuals with a criminal justice background;
- Wi-Fi services;

- Greater warm line capacity;
- Connection to care coordinators who help individuals access Medicaid;
- More Certified Community Behavioral Health Centers (CCBHCs);
- Adaptable workplaces;
- Housing and housing support; and
- Specialized services for LGBTQ, older adults and communities of color.

Other BHPAC feedback regarding funding issues and challenges needing addressed included:

- Increase of Kentuckians charged with felony drug possession and how felony leads to ineligibility for many services and supports;
- Many clients in Kentucky lack tablets or other technology in order to adequately connect with treatment providers virtually; and
- For long-range sustainability, consumer operated services programs and similar programs must be operated in cooperation with CMHCs or other behavioral health organizations.

The following DBHDID priorities have been identified by DBHDID leadership for 2021 and beyond:

- Expand the recovery-oriented system of care to address the opioid crisis and other substance use disorders;
- Support and promote the behavioral health and wellness of children and families involved with or at risk of involvement with the child welfare system;
- Assure a safe and adequate system of care for people with intellectual and developmental disabilities;
- Advance efficient and effective operations of state inpatient and residential facilities; and
- Mitigate adverse behavioral health outcomes exacerbated by the pandemic and racial equality while preserving and enhancing the behavioral health safety network.

Kentucky Priority Populations

As required in the above instructions, 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 of the various populations is located in other areas of the plan as required by the block grant application instructions, particularly in the *Environmental Factors and Plan* where the federal criterion are addressed in Factor numbers 8, 9 and 10, including several of the Leading Health Indicators from the Healthy People 2030 Initiative.

Adults with SMI

Prevalence Data for this population:
Using 2010 census data and the state's agreed upon prevalence rate estimate of 2.6 percent, Regional Boards are aware of the number of adults with SMI in potential need of services. The Boards also rely heavily on indicators and recommendations from the local communities, consumer and family advocacy groups and the Behavioral Health Planning and Advisory Council (BHPAC).

Kentucky's statutory definition of Serious Mental Illness (SMI) is more aligned with the federal Serious and Persistent Mental Illness (SPMI) definition. The following denotes the adult

population in Kentucky and the estimated number of adults with a serious mental illness (SMI) and thus percentage served.

Adult Census (2010) – 3,315,996
Estimated Number of Adults with SMI (2.6% of Kentucky's adult population) – 86,216
Kentucky SMI Adults Served in SFY 2020 – 43,410 or 50% (of the 2.6% SMI population)

Unmet Needs and Critical Service Gaps:
In October 2018, the Cabinet for Health and Family Services renewed a Settlement Agreement with Kentucky Protection and Advocacy, agreeing to transition 1,275 adults with SMI living in personal care homes. During two previous agreements, 926 individuals transitioned, leaving 350 adults with SMI to move from personal care homes into community-based living by October 2021. One of the critical gaps is the limited availability of community residential support services and supportive housing to assist individuals with complex and intensive service needs. There also is a continuing lack of safe, affordable housing in the community for adults with SMI, especially in rural areas.

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, but 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 2018 KY MIS Client/Event data, approximately 50% of adults with SMI in Kentucky received serves from the Regional Boards, and about 7.5% of them received targeted case management services. SFY

2020 data show similar percentages of adults with SMI served and only 6.9% receiving targeted case management services. While the number of adults with SMI served by the Regional Boards seems to rise (or stay the same), the number of those individuals receiving targeted case management services has decreased. 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 has been working to enhance the community-based behavioral health system in Kentucky for adults with SMI. Several community evidence-based services are now available, including assertive community treatment (ACT), individual placement and support (IPS) supported employment, and peer support. ACT fidelity reviews from SFY 2018 show that all CMHCs meet “fair implementation” of the model, with two CMHCs meeting “good implementation”. IPS Supported Employment fidelity reviews show that five regions meet exemplary fidelity, five meet good fidelity, and four meet fair fidelity. Each of these services are available to adults with SMI in most CMHC service regions, however, they are not available in every county in Kentucky. 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. An additional $400,000 has been allocated during each subsequent fiscal year.

KYSTARS use the findings from COSP fidelity reviews to design beneficial workshops offered at their annual conference for peers and providers. An entire conference track is 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. KYSTARS will continue to provide other training and technical assistance on an annual basis to peer support specialists, supervisors of peer support specialists, and other providers regarding recovery and recovery principles.

DBH continues participating in quarterly meetings with each of six (6) Managed Care Organizations (MCOs), which began 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 for adults with SMI in Kentucky. While DBHDID continues to work collaboratively with MCOs and Medicaid on many issues, including reimbursement rates, other efforts for sustainability continue. Such efforts include training for agencies who hire Peer Support Specialists, specifically in how to recruit, retain and supervise these individuals. Historically, most agencies have not hired peers but many had a few peer volunteers. Thus, 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. An implementation team oversees and guides all aspects of the delivery of IPS Supported Employment. The team is comprised of DBH staff, Office of Vocational Rehabilitation staff, and trainers/coaches and fidelity reviewers (contracted through two universities).

DBH also has been working to implement *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
- Interim Settlement Agreement (signed August 2013)
- Amended Settlement Agreement (signed October 2015)
- Second Amended Settlement Agreement (signed October 2018)

Early Serious Mental Illness

Prevalence Data:

The following table shows prevalence data and some targeted demographics for young people aged 16 – 25 in Kentucky.

2019 Census Estimates (Kentucky State Data Center)	**KY 2019**
Total population in Kentucky	4,467,673
Total # between 15-25 years old*	583,798
% of population between 15-25 years old*	13%
By % Race/Ethnicity/Language (15-25 year olds)	
Black	59,990
Asian	10,340
White (non-Hispanic)	464,786
Hispanic	29,485
Other	19,197
By Gender (2019 census estimate % of total number of 15-25 year olds)	
Female	49%
Male	51%
By Socioeconomic characteristics	
% of persons 18 – 24 years of age in workforce	67%
% of persons 18 – 24 years of age in poverty	24%
16-25 year olds served within the CMHC SFY 2020	
Total: all clients served at CMHCs	167,458
Total:16-25 year olds served in Mental Health Programs	30,733
Penetration rate - total #16-25 year olds served (%)	18.3%
Total 16-25 served in Substance Use Disorder Programs	12,860

Penetration rate – total #16-25 year olds served with SUD (%)	7.7%
Total clients served at CMHCs with either SMI or SED	67,504
Total 16 -25 served with either SED/SMI	13,303
Penetration rate SED/SMI (%)	19.7%

**2019 Population Estimates used due to 2020 Census Numbers for Kentucky not being available in detailed format at time of report. 15-25 age group captured due to population and demographic prepopulated age clusters used for those data reports. 18 -24 age group used for socioeconomic characteristics due to those being prepopulated age clusters used for those data reports.*

In addition to the above prevalence rates for individuals who are transition age youth, with or at risk of developing early serious mental illness, utilizing the .03 % national incidence rate for First Episode Psychosis, and utilizing the formula made available by OnTrack NY, approximately 1,340 Kentuckians per year are at risk of developing First Episode Psychosis.

Unmet Needs and Critical Gaps:
The demographic and prevalence data above indicates several areas of unmet needs and critical gaps in services for transition age youth with or at risk of developing early serious mental illness. While research shows that at least 20% of individuals will experience a behavioral health issue in their lifetime and these behavioral health issues most often surface by the time a person is 24 years old, the CMHCs are serving 18.3% of the total population of 16-25 year olds. In addition, while research shows that between 5-10% of a population will experience a serious behavioral health issue, Kentucky's CMHCs are serving 19.7% of the 16-25 year olds who may have SED/SMI.

During SFY 2021, DBH surveyed all individuals in Kentucky who had been trained in the Structured Interview for Psychosis Risk Syndromes (SIPS) assessment tool for young people who are at risk or experiencing first episode psychosis, regarding training and implementation of the utilizing of the SIPS tool in practice. Overwhelming, respondents indicated they would benefit from a SIPS Refresher course as well as continued consultation from both national experts as well as local SIPS coaches.

Addressing the Need:
Kentucky was recently awarded a second Healthy Transitions Grant through SAMHSA in order to continue identifying these critical gaps for the population of focus. The grant assists in continuing the work to better identify and treat youth and young adults with early serious mental illness. In addition, Kentucky was awarded a Community Programs for Outreach and Intervention with Youth and Young Adults at Clinical High Risk for Psychosis (CHR-P) grant in September of 2018. The Healthy Transitions Grant along with the CHR-P grant and the 10% set aside for first episode psychosis has allowed programming to be better coordinated and additional services to be developed across the continuum. In addition, DBHDID hired a program administrator for first episode psychosis programming in SFY 2021, to enhance DBH efforts for this population. Specific supports in addressing first episode psychosis programming, including early serious mental illness, includes the following:

1) 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. In addition, each CMHC is required to assign one (1) key contact for adolescent substance use disorder (SUD) services. These requirements

encourage collaboration, at the local level, between systems of care for this vulnerable population.

2) DBH has one (1) program administrator under the Division of Behavioral Health Director's office, who coordinates first episode psychosis programming across the state, with the assistance of two (2) additional program administrators, one (1) from the Children's Behavioral Health and Recovery Services Branch, and one (1) program from the Adult Mental Health and Recovery Services Branch. In addition, DBH is working to include program administrators from the Adult Substance Abuse Treatment and Recovery Services Branch, the Behavioral Health Prevention and Promotion Branch, and the Kentucky's Opioid Response Effort (KORE) on statewide implementation efforts.
3) Key contacts from across the state are targeted for training opportunities, and available technical assistance through the Early Assessment and Support Alliance (EASA), including trainings on the Structured Clinical Interview for DSM-5 (SCID-5), Structured Interview for Psychosis Risk Syndromes (SIPS), differential diagnoses, and Cognitive Behavioral Therapy for Psychosis (CBTp). For SFY 2022, two (2) additional SIPS training, including SIPS refreshers, will be offered for individuals across the state, serving this population. In addition, SFY 22 contracts with CMHCs with iHOPE teams will require identification of at least one (1) SIPS lead and at least one (1) CBTp lead for the agency. Statewide consultation and coaching will target those leads.
4) A statewide education and technical assistance meeting, coordinated by DBH with the assistance of EASA, is held two (2) times per year and provides an opportunity to educate the workforce on issues related to early psychosis and assist with coordinating evidence-based practices for this population. Key contacts from all CMHCs are required to attend this meeting.
5) EASA also provides monthly consultation calls and various educational opportunities as needed based on information discussed in monthly calls, to Kentucky's eight (8) programs for first episode psychosis called iHOPE (Helping Others Pursue Excellence). A statewide education and technical assistance meeting, coordinated by DBH with the assistance of EASA, is held two (2) times per year, targeting the current iHOPE programs.
6) Kentucky continues to make other training opportunities widely 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), as well as training in numerous screening and assessment tools.
7) DBH also has one (1) program administrator that focuses on transition age youth programming, who coordinates statewide programming through the Healthy Transitions grant, which is called TAYLRD (Transition Age Youth Launching Realized Dreams) in Kentucky, as well as the CHR-P (Clinical High Risk Program) grant. Much of this programming blends with first episode programming and DBH works to encourage local sites to collaborate on efforts for transition age youth. DBH strives to have early identification of behavioral health issues for transition age youth, appropriate assessment, and rapid access to appropriate services that benefit each individual, no matter where they live in Kentucky, or which service system they happen to come in contact with.

Data Sources

Kentucky State Data Center (KSDC) University of Louisville. 2019 Population Estimates.

KIDS COUNT Report through KSDC
Population and Housing Estimates | Kentucky State Data Center (louisville.edu)

DBHDID Client Data Set through Institute for Pharmaceutical Outcomes and Policy (IPOP)

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

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 2019 – 25,883 or 51% (of the 5% SED population)
Kentucky SED Children Served SFY 2020 – 24,094 or 47% (of the 5% SED population)

Regional Boards	Child Census 2010	Estimated Prevalence (5% of the Child Census)	Kentucky Children with SED Served in SFY 2019	Penetration Rate of Children with SED Served in SFY 2019	Kentucky Children with SED Served in SFY 2020	Penetration Rate of Children with SED Served in SFY 2020
Four Rivers	44,367	2,218	1,836	83%	1,548	70%
Pennyroyal	51,686	2,584	987	38%	1,010	39%
RiverValley	51,495	2,575	1,181	46%	911	35%
LifeSkills	66,964	3,348	1,056	32%	880	26%
Communicare	68,477	3,424	2,561	75%	2,246	66%
Seven Counties Services	228,248	11,412	5,370	47%	4,754	42%
NorthKey	112,412	5,621	2,255	40%	2,661	47%
Comprehend	13,721	686	610	89%	582	85%
Pathways	48,935	2,447	2,053	84%	2,041	83%
Mountain	34,337	1,717	2,494	145%	2,396	140%
Kentucky River	25,212	1,261	784	62%	688	55%
Cumberland River	55,508	2,775	2,252	81%	2,152	78%

Adanta	47,054	2,353	954	41%	890	38%
New Vista	174,955	8,748	1,490	17%	1,335	15%
TOTAL	**1,023,371**	**51,169**	**25,883**	**51%**	**24,094**	**47%**

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 2020KY MIS Client/Event data, approximately 47% of children with SED were served by Regional Boards and approximately 11% 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. Numbers for SFY 2020 include three (3) months overlap with the onset COVID-19 pandemic during which there was a decrease in services as agencies and service recipients transitioned to telehealth and other non-traditional means of service delivery.

Addressing the Need:
DBHDID staff met with CMHC CEOs regularly throughout the fiscal year, with increased contact during the pandemic, in an effort to identify barriers to service provision and find solutions. Additionally, Children's Branch staff met monthly with CMHC children's directors and quarterly with other key CMHC staff including TCM supervisors to provide technical assistance and support in transitioning to virtual and telehealth platforms. DBHDID met regularly with Department for Medicaid (DMS) staff to discuss identified problems and potential solutions. During SFY 2020, a Request for Proposals for new Medicaid managed care organizations (MCOs) was issued. Contracts will be awarded in SFY 2021. DBHDID staff intends to reconvene quarterly meetings with the selected MCOs with the intent increased communication and data review among DBHDID, DMS, and the MCOs and collaboratively guide continuous quality improvement efforts.

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 2020, 30,248 individuals diagnosed with co-occurring mental health and substance use disorders were served by the Regional Boards. The number of individuals with co-occurring disorders receiving treatment has increased over the last few years, due in part to the 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 co-occurring serious mental illness and substance use disorder. Reviews show that few ACT staff has 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. Due to staff turnover in these programs, DBHDID is considering offering these trainings again.

Children and youth with 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 created 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 serve 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 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;
- 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, mental health, 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 Global Appraisal of Individual Needs (GAIN) tool, Screening, Brief Intervention and Referral to Treatment (SBIRT), 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. In addition, DBH has been involved in the implementation of several Motivational Interviewing initiatives, in adult, children and traditional substance abuse realms.

Data Sources Used:

- Kentucky MIS Client/Event Data Set
- DBHDID SFY 2022 Plan and Budget Documents
- Institute of Pharmaceutical Outcomes and Policy (IPOP) Data
- DBHDID/CMHC SFY 2022 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 most recent U.S. Department of Veterans Affairs (VA) 2017, Fiscal Year reports 295,390 military Veterans reside in Kentucky, of which 24,415 are female and 270,975 are male. According to the report, the total number of women Veterans in Kentucky, increased by 331. This is a good sign that women Veterans are seeking services and identifying themselves as a Veteran. Unfortunately, some women Veterans are not aggressive in seeking services, as some do not consider themselves a “Veteran”. With the current awareness campaigns and events encouraging individuals with prior military service to register with the Veterans Administration, there is hope that male and female Veterans will begin to receive the care they so richly deserve.

There are approximately 44,749 current military personnel, predominately Army (including the Reserve and National Guard), with two (2) large army military instillations located within our borders - Ft. Campbell and Ft. Knox. Kentucky currently ranks tenth highest among the fifty (50) states with 32,247 active duty military personnel stationed in the Commonwealth, and seventeenth in the number of total military personnel (including civilian workers, reservists, and National Guard). Kentucky continues to have the fourth highest number of active duty Army personnel following Texas, Georgia and North Carolina. There are an additional 420 members of the U.S. Coast Guard Sector Ohio Valley, under the U.S. Department of Homeland Security, assigned to Louisville and Paducah.

The Kentucky National Guard is comprised of nearly 8,000 Soldiers and Airmen in the Army National Guard and the Air National Guard. The Kentucky National Guard has mobilized and deployed more than 18,000 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.

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 (19) 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, sometimes as 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 4.468 million residents have served in the military
- Kentucky currently has a Veteran population of 295,390
- Kentucky ranks 8th nationally in defense spending by state GDP and 14th in direct defense spending
- In the Commonwealth, there are:
    - 24,415 Female Veterans
    - 270,975 Male Veterans
    - 31,911 Active Duty Military Personnel
    - ~8,000 Soldiers & Airmen in the Army National Guard & the Air National Guard
    - 44,749 Total Military Personnel
    - 54,754 Total DOD Personnel (Military and Civilian)
    - 420 U.S. Coast Guard personnel under U.S. Dept. of Homeland Security (Coast Guard Sector Ohio Valley)

Veteran and Active Duty Personnel Served by CMHC's										
Fiscal Year 2020 - (July 1, 2019 - June 30, 2020)										
CMHC	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
01 - Four Rivers Behavioral Health	248	233	188	283	311	335	338	307	321	269
02 - Pennyroyal Regional Center	326	412	525	519	526	378	419	253	350	336
03 - River Valley Behavioral Health	86	104	82	69	58	51	51	45	56	84
04 - Lifeskills	280	103	188	212	125	159	170	115	61	59
05 - Communicare	155	159	144	323	353	272	283	257	305	291
06 - Seven Counties Services	356	387	311	337	354	363	396	389	384	352
07 - NorthKey	210	179	158	194	225	194	116	136	134	139
08 - Comprehend, Inc.	106	133	166	125	108	116	95	78	64	56
10 - Pathways, Inc.	330	355	331	313	297	320	287	261	250	188
11 - Mountain Comprehensive Care	155	135	170	145	162	219	244	256	260	302
12 - Kentucky River Community Care	72	181	212	218	202	152	70	97	45	45
13 - Cumberland River	175	179	19	15	37	117	160	191	157	114
14 - Adanta	252	206	173	186	213	254	203	297	192	169
15 – New Vista	456	398	380	330	338	208	180	160	165	137
Total Unduplicated Count	3,189	3,148	3,032	3,250	3,288	3,098	2,133	2,893	2,737	2,541

Active Duty Personnel Served by CMHC's										
Fiscal Year 2020 - (July 1, 2019 - June 30, 2020)										
CMHC	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
01 - Four Rivers Behavioral Health	58	51	37	39	33	53	42	45	51	47
02 - Pennyroyal Regional Center	104	100	105	116	132	81	131	65	63	64
03 - River Valley Behavioral Health	47	54	30	35	32	29	25	27	13	16
04 - Lifeskills	255	42	78	88	49	42	34	37	15	20
05 - Communicare	14	18	15	85	97	80	76	69	95	96
06 - Seven Counties Services	75	79	66	84	82	83	113	111	91	70
07 - NorthKey	56	53	44	41	47	48	44	43	29	33
08 - Comprehend, Inc.	47	52	47	39	46	42	44	26	13	17
10 - Pathways, Inc.	49	63	54	48	62	49	61	51	38	39
11 - Mountain Comprehensive Care	93	72	96	55	60	78	101	90	85	100
12 - Kentucky River Community Care	32	105	121	114	110	71	35	34	17	15
13 - Cumberland River	1	4	6	6	11	40	54	83	58	46
14 - Adanta	51	37	30	39	48	58	58	81	59	52
15 – New Vista	85	79	83	81	77	52	61	48	53	42
Total Unduplicated Count	964	808	811	870	886	806	760	705	680	657

Veteran Served by CMHC's										
Fiscal Year 2020 - (July 1, 2019 - June 30, 2020)										
CMHC	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
01 - Four Rivers Behavioral Health	192	183	151	247	278	286	296	262	270	222
02 - Pennyroyal Regional Center	223	316	421	407	395	298	288	188	287	272
03 - River Valley Behavioral Health	39	50	52	34	26	22	26	18	43	68
04 - Lifeskills	186	61	112	130	77	117	136	78	46	39
05 - Communicare	141	142	129	238	256	192	207	188	210	195
06 - Seven Counties Services	287	319	250	259	282	280	283	278	293	282
07 - NorthKey	160	130	117	158	182	149	72	93	105	106
08 - Comprehend, Inc.	59	82	119	86	67	77	51	52	51	39
10 - Pathways, Inc.	283	292	279	265	236	271	226	210	212	149
11 - Mountain Comprehensive Care	63	64	74	91	102	141	143	166	175	202
12 - Kentucky River Community Care	40	76	91	105	92	81	35	63	28	30
13 - Cumberland River	174	175	13	9	26	78	106	108	99	68
14 - Adanta	204	172	143	149	168	197	145	216	133	117
15 – New Vista	373	328	301	262	265	156	119	112	112	95
Total Unduplicated Count	2,416	2,383	2,244	2,431	2,441	2,318	2,133	2,032	2,064	1,884

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 suicide 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 (1) 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, ease soldier apprehension, and increase access to treatment. The Kentucky Division of Behavioral Health and the Kentucky National Guard have teamed up to present a comprehensive four (4) day training in military culture and issues unique to Service Members, Veterans and their Families. This training immerses Behavioral Health Providers and Professionals 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 nine (9) 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. Four hundred and ninety-six (496) 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.

Uniting Forces

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 care that is more adequate 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, and participate in a two (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

Service Members, Veterans and their Families - Peer Support Specialist (SMVF-PSS)

Program Description:

Four (4) Community Mental Health Centers (CMHCs) have been selected to hire and train Peer Support Specialist (PSS) with lived experience with a substance use disorder, military experience, and status as a Veteran as part of a pilot program. These peers will be hired to provide PSS services to Service Members, Veterans and their Families (SMVF) with opioid and stimulant use disorder in the CMHC Crisis Stabilization Units (CSUs). These PSS will provide additional support in community outreach, SMVF population identification, and assist in safely transitioning the consumer to care in outpatient or inpatient follow up programs. This professional will work closely in collaboration with the CMHC Military Behavioral Health Coordinators, the Regional Prevention Centers, Crisis Services, and all Outpatient programs. The SMVF-PSS will help facilitate

continuity of care by being a bridge to aftercare services and by monthly monitoring of consumers within the program post discharge.

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:

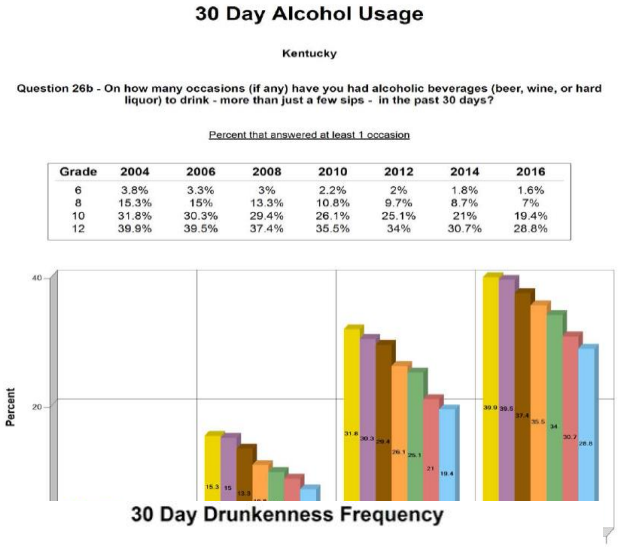
- U.S. Department of Veterans Affairs, Veteran Data
  https://www.va.gov/vetdata/Veteran_Population.asp
  https://www.va.gov/vetdata/stateSummaries.asp
- The Kentucky Commission on Military Affairs
  https://kcma.ky.gov/Documents/Final%20Report.pdf
- Military Active-Duty Personnel, Civilians by State 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/
- Defense Manpower Data Center https://www.dmdc.osd.mil/appj/dwp/dwp_reports.jsp

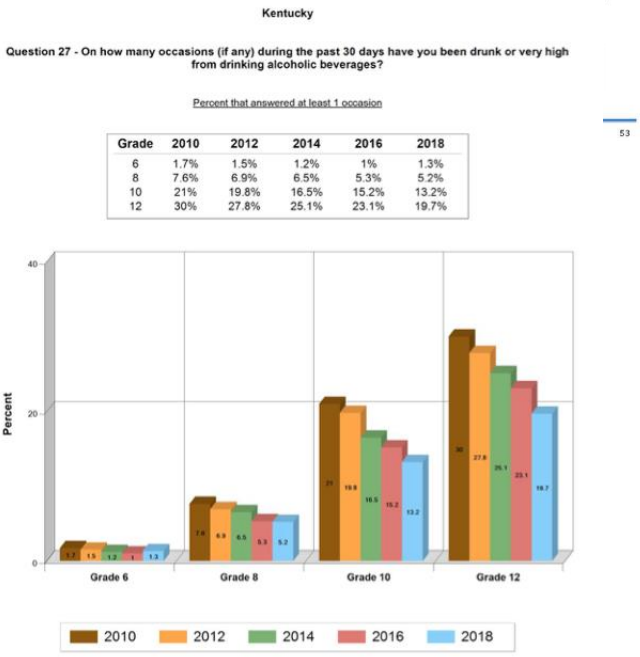
Substance Abuse Prevention

Prevalence Data for Kentucky's Selected Substances:

SUBSTANCE 1: ALCOHOL

Despite the significant improvement made by the Kentucky prevention system has made in reducing underage drinking over time, (see graph right), alcohol use by adolescents remains problematic in the Commonwealth and is expected to increase. Unfortunately, the administration of Kentucky's youth survey, Kentucky Incentives for Prevention (KIP) was delayed during 2020 because of COVID-19 and school closings. As a result, updated data is unavailable. Kentucky is including the 2018 KIP data as a baseline for this application.

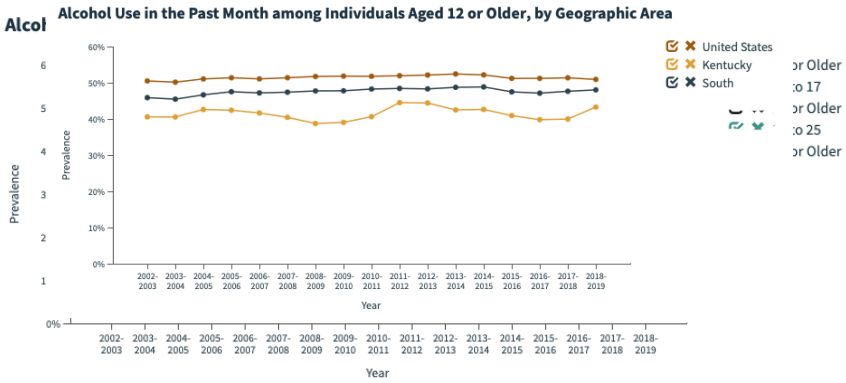




The 2018 Kentucky Incentives for Prevention (KIP) survey data reveals that 16.8% of 10th graders drank alcohol in the past 30 days, and of that number 13.2% also report they have been drunk on at least one occasion in the past 30 days. This means that an alarming 68% of 10th graders who reported drinking in the past 30 days also have been intoxicated on at least one occasion within that same time frame. Youth are not just drinking to drink but drinking to get drunk. Furthermore, 8.6% 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 nine 10th graders surveyed, or 2,682 students in Kentucky 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 8.6% in 2018) the number of Kentucky youth who engage in past 30-day drinking and binge drinking is still unacceptably high.

Research shows that increased sales of alcohol correlates with increased youth access to alcohol. Increased youth access to alcohol is correlated with increased 30-day use and binge drinking. According to revenue data from April 2020, wine consumption taxes increased 32 percent and taxes from distilled spirits rose by almost 20%, when compared to data collected for the same month in 2019. Similarly, this data could point to increased adult use as well. Kentucky had already started to see a slight increase in alcohol use in all age groups except those 12-17, according to the 2019 National Survey on Drug Use and Health (NSDUH) data. In the latest iteration of the survey results, Kentucky's alcohol use is below the national average in every age category except youth, ages 12-17. More than 43% of Kentucky adults reported past 30-day use of alcohol, compared to a national rate of 50.8%. That rate climbs to nearly 46% for those ages 18-25, compared to nearly 54.3% nationwide. About 46% percent of adults over the age of 26 reported using alcohol in the past 30 days, compared to about 55% nationwide.



As was the case for alcohol use, binge drinking in Kentucky is lower than the national rate in every category except those 12-17 years of age. Across all populations, 20.5% of Kentuckians over the age of 12 reporting binge drinking in the past month, according to the 2019 NSDUH. Comparatively, the rate was 4 nationally. Kentucky youth binged at a rate of 5.2%, compared to 4.9% nationally. And among those over the age of 26, 22% of Kentuckians reported binge drinking in the past 30-days, compared to 24.5% nationwide. The binge drinking question changed in 2015, therefore trend data before 2014 are not included for this question.

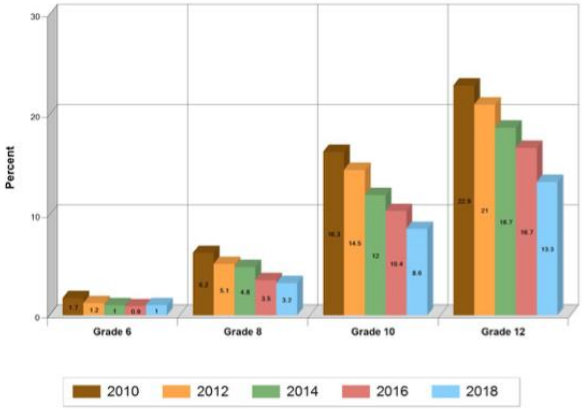
Binge Drinking: Five Drinks or More

Kentucky

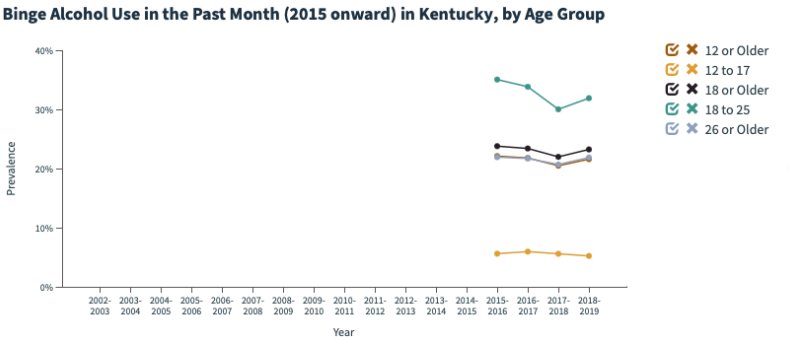
Question 28 - Think back over the last two weeks. How many times (if any) have you had five or more alcoholic drinks in a row?

Percent that answered at least 1 time

Grade	2010	2012	2014	2016	2018
6	1.7%	1.2%	1%	0.9%	1%
8	6.2%	5.1%	4.8%	3.5%	3.2%
10	16.3%	14.5%	12%	10.4%	8.6%
12	22.9%	21%	18.7%	16.7%	13.3%



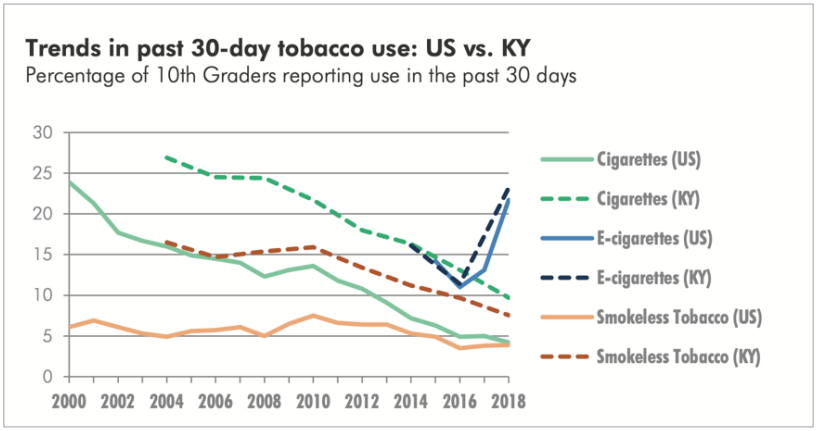
The cost of excessive alcohol use has been well documented. A 2010 study found that binge drinking is responsible for 77% of the total excessive drinking costs in all states and responsible for some of the serious health problems including alcohol poisoning, fetal alcohol spectrum disorder, sexually transmitted diseases, 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. In Kentucky, at that time, the cost per person was $736 with a total societal cost of more than $3.1, roughly equal to the Block Grant allocation for prevention services.



Because of the significant cost and impact of alcohol use among Kentucky residents, initiatives implemented under Block Grant funding will focus on reducing early initiation of alcohol use and decreasing youth and adult binge drinking.

SUBSTANCE 2: NICOTINE PRODUCTS

The Kentucky Prevention System has made significant progress in reducing underage tobacco use. According to the 2018 Kentucky Incentives for Prevention Survey, past 30-day use of combustible cigarettes by all grades surveyed (6,8.10,12) have fallen to record lows. Use among 10th graders for example has decreased by 55% from 21.7% 1n 2004 to 9.7% in 2018.

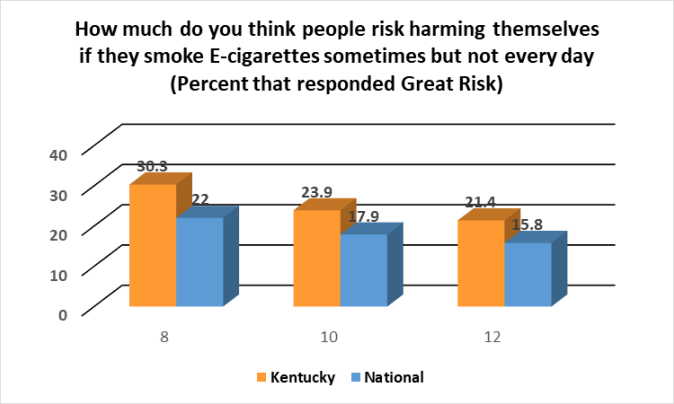


However, these gains have been reversed by a corresponding increase in the use of e-cigarettes. (See graph below.) In fact, use of e-cigarettes in Kentucky across all grades is roughly equivalent to combustible cigarette rates 15 years ago. Kentucky's 2018 KIP Survey findings mirror nationwide results. E-cigarettes have now surpassed alcohol as the most widely used substance among young people in Kentucky. Following a decrease in use from 2014 to 2016, reported rates of electronic cigarette use by Kentucky 10th graders shot up 11.4 percentage points to 23.2% in 2018. Statewide, the percentage of 10th graders responding that they had used an e-cigarette on at least one day in the past 30 days jumped from 11.4% in 2016 to 23.2% in 2018. Eleven out of 14 regions report usage rates above the statewide average. At 29.2%, the Lifeskills region is at the high end, followed closely by several regions in the 26-28% range. In the Mountain region, reported e-cigarette usage jumped 18.3 percentage points from 9.3% in 2016 to 27.6% in 2018. 2018 figures in the Centerstone are the lowest at 14.7%.

It is hypothesized that the popularity of JUUL, a new e-cigarette that uses nicotine salts rather than a traditional liquid nicotine solution, is a contributing factor to this increase. The nicotine salt

allows for a more pleasing “throat hit” and allows nicotine to enter the blood stream faster than other brands of e-cigarettes which provide the user with a dopamine rush similar to combustible cigarettes. JUUL was virtually unknown in Kentucky in 2016. Since that time, however it has become the e-cigarette brand of choice in the United States, capturing 70% of the e-cigarette market share. Our survey data also reveals that students who do not smoke combustible cigarettes are now at risk for nicotine addiction through the use of e-cigarettes. In 2014, 18.2% of students who used a JUUL in the last 30 days had never smoked a cigarette in their lives. In 2018, that number rose to 40%. In real numbers, using the 2018 survey results, this means that an additional 8,162 youth in Kentucky who had never smoked a cigarette have now entered the nicotine gateway.

The manufacturer of JUUL states on its website that one JUUL pod has the nicotine content of roughly one pack of cigarettes. Subsequent lab analysis by non-industry researchers, however, reveal that the nicotine level in JUUL is closer to two packs of cigarettes. Moreover, because the concentration of nicotine in e-cigarettes is significantly higher than combustible cigarettes the trajectory from experimentation to addiction happens at much faster rates.



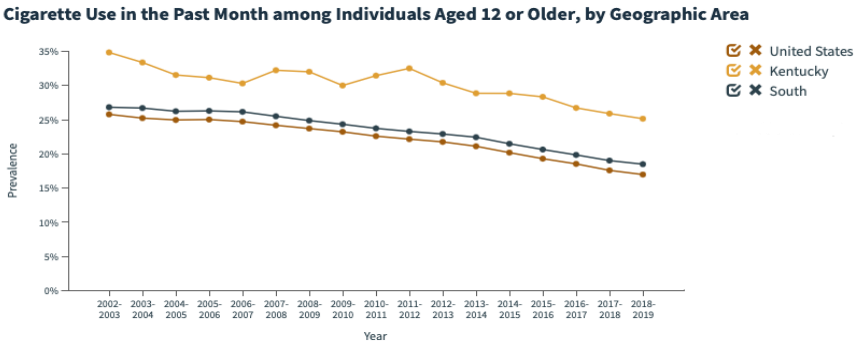
National focus group data has shown that many youth do not equate JUUL with other types of e-cigarettes and refer to their JUUL use as “JUUling” rather than vaping. It was for this reason that JUUL was specifically added to the menu of e-cigarettes in the 2018 administration of the KIP survey. This misconception, coupled with the fact that 70% of youth were not even aware that JUUL contains nicotine, are cause for great alarm. Compared to national data, Kentucky youth have a higher perception of risk of e-cigarettes than their national counterparts; however, their usage rates are only slightly below the national average. To assess youth perception of risk associated with e-cigarette use, the question, “How much do you think people risk harming themselves if they vape/use e-cigarettes some days but not every day?” was added to the 2018 KIP Survey instrument. KIP response rates indicate that students perceive little risk of harm with e-cigarette use. Across all grades, levels of perceived risk for vaping are the lowest of all substances addressed on the KIP Survey.

Additionally, focus group data collected by Kentucky’s Tobacco Prevention Enhancement Site (recently renamed Nicotine Prevention Enhancement Site) reveals that peer pressure, virtually non-existent when it comes combustible cigarettes, is a significant factor in youth use of E-cigarettes. In four focus groups conducted in different areas of the state, youth routinely said that they rarely, if ever, felt pressured to smoke “regular” (combustible) cigarettes because they smelled bad and were unhealthy. But e-cigarettes were cool, easy to inhale because of the flavors and were thought to be much safer than regular cigarettes.

The KIP survey does not ask youth how youth obtain their e-cigarettes. The YRBS however, does track retail access. In 2017 YRBS, 12.3% - a decrease of 12% from 2017 - of Kentucky youth who had used electronic cigarettes in the last 30 days prior to the survey reported that they bought them in a store such as a convenience store, supermarket, discount store, gas station, or vape

store. Focus group data shows that underage youth obtain e-cigarettes from peers who sell them at school.

In relation to adult use, while there has been a significant decrease in the use of cigarettes in Kentucky, 25% of Kentucky residents still report they've used in the past 30-day tobacco use, and 32% report they use some type of nicotine product in the last 30 days (NSDUH). Dip, snuff, chew, and snus are all tobacco products that are utilized within Kentucky. The rate of tobacco use in Kentucky is significantly higher than across the U.S. or even in comparison to the South region within which Kentucky sits. Residents of the Commonwealth also report less perceived risk from consuming one or more packs of cigarette than across the U.S. or in the southern region of the nation

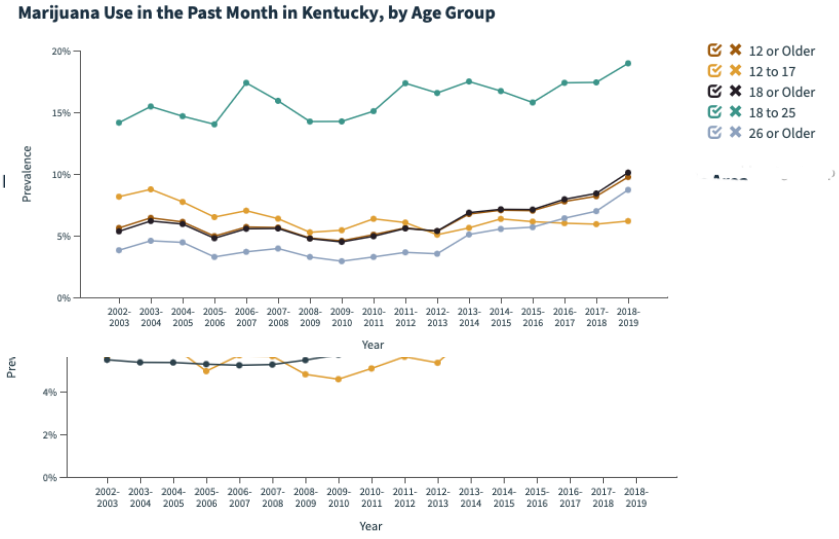


SUBSTANCE 3: ILLICIT DRUGS

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

While Kentucky currently does not have legal medical or recreational marijuana sales, the use of marijuana among residents is climbing exponentially. Since the 2015-2016 NSDUH report, Kentucky's past use marijuana use among those over the age of 12 has climbed 38%, from 7.02% to 9.75%. The majority of those increases are among Kentucky residents over the age of 26. Past 30-day use rate among that age group has climbed 38% since 2015,



from 6.8% to 9.39%. Among the 18-25 age group, the rate has climbed 11% and among the 12-17 age group, 4%. Residents aged 18-25 use marijuana at significantly greater rates than other age groups, with nearly 23% reporting past 30-day use in 2018-2019. Over the past two iterations

of the survey, Kentucky's rate has climbed twice as fast as the rest of the nation (19% KY vs. 9% U.S.).

Overall, nearly 10% of Kentuckians report 30-day use of marijuana. A little over 2% of Kentucky's residents reported first use of marijuana in the last year, with increases noted in all age groups, but significantly within those who are 12 to 17 and 18-25. Marijuana use also has been attributed to a 40% to 60% increase in suicidal ideation, planning and attempts among those aged 18-34 over the past decade with the greatest increases noted among women and those with major depressive episodes (NSDUH).

Marijuana remains the most widely used illicit substance by young people in Kentucky (KIP, 2018) despite the fact that 30-day use of marijuana by 10th grades in Kentucky (6.18%, NSDUH) is slightly lower than the national rate (6.56%) for this age group. Use among middle and high school students has been on the decline between 2010 and 2018 but ticked up slightly in 2019 (NSDUH). Marijuana use among 10th graders has fluctuated on a national level over recent years. Marijuana use among US 10th graders steadily dropped between 2013 and 2016 but increased sharply between 2016 and 2019. Kentucky has not mirrored these trends, with usage rates among Kentucky 10th graders falling steadily from 2010 through 2018.

Regionally, 10th graders in Four Rivers (at 14.5%) reported the highest rates of 10th grade marijuana use in 2018. Regions with the lowest rate of marijuana use in 2018 were Kentucky River and Comprehend.

Past year marijuana use rates, as measured on the (KIP survey), steadily increase from 6th through 12th grades, with 1.3% of 6th graders reporting use within the last year compared to 25.9% 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, 4.9% report they first smoked marijuana by the age of 12. Eighth graders were even higher at 5.1%, followed by 12th graders at 3.7% and 6th graders at 1.4%. Interestingly, age of first use has declined for 10th and 12th graders but increased among 6th and 8th graders between 2016 and 2018.

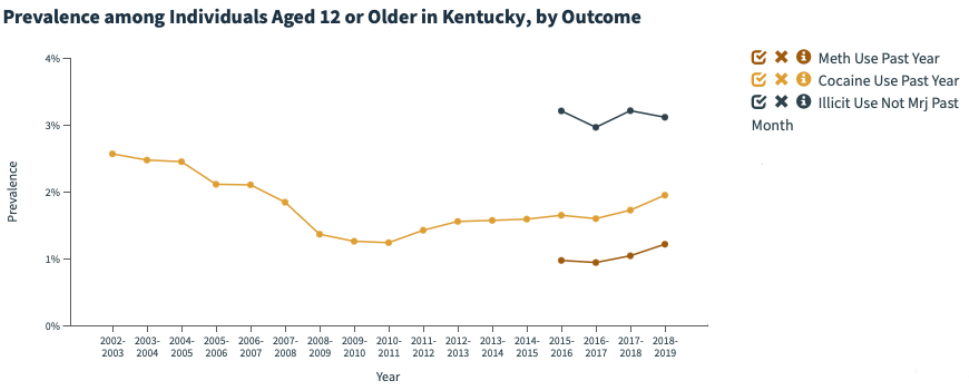
While the percentage of students reporting that access to marijuana has been decreasing since 2004, 56.8% of 12th graders and nearly 43% of 10th graders reported that it would be "sort of easy" or "very easy" for them to access the illicit substance. Personal disapproval of marijuana use decreases significantly from the 6th grader, where 96.4% of students said it was "wrong" or "very wrong" for someone to smoke marijuana to 12th graders where only 55.1%% answered in the same manner. Generally, personal disapproval of marijuana use is decreasing in Kentucky. Personal disapproval ratings have decreased between 2010 and 2018 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 more than 16% 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, a more than double decrease in disapproval ratings. 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 about marijuana use. Between 2012 and 2016, peer disapproval for 6th graders was 96%. It fell to 95% in 2018. By the time those students got to 12th grade, the percentage who reported that their friends would say it was "wrong" or "very wrong" for them to smoke marijuana fell to 49.1%, a 48.3% decrease in disapproval rate from 6th to the 12th

grade. This decrease reflects reports of increased use among 12th graders, compared to 6th graders.

This number coincides with perception of peer use of marijuana, which ranges from 37.8% for 10th graders to 47.1% 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 (3.4%, 18.7% respectively), the percentage of students perceiving that their friends are using has decreased among 10th and 12th graders over the last 10 years, it has remained virtually unchanged among 6th and 8th graders. Just as disapproval ratings for marijuana use have fallen over the past decade so too have risk perception. Only 37.6% 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 66%, compared to less than 31% for 12th 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 17.35 to 18.96. Data from the Treatment Episode Date Set (TEDS) shows that admissions for marijuana use decreased 12% between 2015 and 2017, the latest data available. 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.

STIMULANTS (Methamphetamines, Cocaine, Prescription Drugs)



Just as Kentucky thought it had a handle on the opioid crisis, a fourth wave in the nation's substance use disorder epidemic began – stimulant use. Use of prescription drugs - such as Adderall, Ritalin and Adipex - and illicit substances - including methamphetamine and cocaine – began increasing about 2015. Methamphetamine use increased 29% between 2015 and 2019 in Kentucky, compared to 25% across the U.S. Similarly, in that same time frame, cocaine use has increased in the state by 18%. Use of methamphetamine is below the national averages as is cocaine use. Among youth in Kentucky, cocaine, methamphetamine, and stimulant use is small, compared to use of alcohol, tobacco, and marijuana. According to the 2018 KIP survey, 30-day cocaine use among 10th graders is about 1%. Methamphetamine use among this same age group is about the same, while stimulant use climbs to about 1.5%.

Lethality, availability, and polysubstance use have all increased the consequences of using and misusing these substances (KYODCP). The switch to methamphetamine has been attributed by state substance use subject matter experts as a response to a reduction in access to pain medication. Often, meth is mixed with cocaine and/or fentanyl because it is inexpensive to produce, enhances the effects of meth, and results in a faster addiction to the substance. Both

synthetic and natural cocaine have been found in Kentucky, and as is the case with methamphetamines, it is often mixed with an opioid to increase its effects. This deadly mixture has increased overdose death numbers in the state.

Methamphetamines

According to the KIP, among youth, methamphetamine use has remained steady since 2008 with an average of approximately 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 95.8% among seniors to 98.1% among sixth graders. Perception of parental disapproval of meth use is even higher, ranging from 97.5% for 12th graders to 98.8% of 6th graders. In comparison, 4.1% of 12th graders said at least one of their four best friends had used the illicit substance in the past year; 1.1% of 6th graders did. The Adanta region in south central Kentucky has the highest rates of 10th grade methamphetamines use at 1% (compared with a statewide 10th-grade rate of .6%). The lowest rate was within the Communicare, North Key, and River Valley regions with .4% 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.

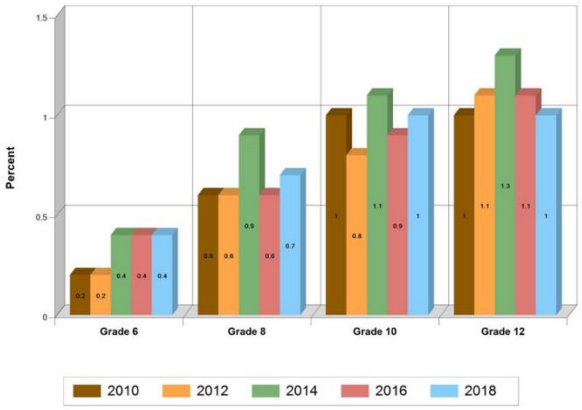
Past Year Methamphetamine Usage

Kentucky

Question 42a - On how many occasions (if any) in the past 12 months have you used methamphetamines ("meth," "crystal meth," "ice," "crank")?

Percent that answered at least 1 occasion

Grade	2010	2012	2014	2016	2018
6	0.2%	0.2%	0.4%	0.4%	0.4%
8	0.6%	0.6%	0.9%	0.6%	0.7%
10	1%	0.8%	1.1%	0.9%	1%
12	1%	1.1%	1.3%	1.1%	1%



years has been Similar to marijuana, cocaine use over the last 12 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 2.2% of 12th graders report past year cocaine use. NSDUH data shows that 4.61% of 18-25-year old's reported cocaine use in 2018, with a significant uptick in usage from 3.76% in 2010 but down from 5.09% in 2015. 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 94.1% for 12th graders to 98.1% to 6th graders. Percentage of parental disapproval to cocaine use ranged from 97.3% for 12th graders to 98.8% for 6th graders. Yet, nearly 7% of 12th graders said at least one of their four best friends had used cocaine in the last years. That percentage was 5.2% for 10th graders; 3.1% for 8th graders and 1.3% for 6th graders. Adanta and the Life Skills region in southern Kentucky had the highest rate of 10th graders reporting cocaine use (1.4%) in the past 30 days while Communicare, NorthKey, and River Valley had the lowest at 0.6%. The overall 10th grade rate was .8%. NSDUH data indicates that cocaine use has been slowly on the rise across all age groups since 2010, except for 12-17-year old's who have been decreasing. For those in the 18-25-year-olds range, the prevalence increased from 3.76% in 2010 to 4.61% in 2018.

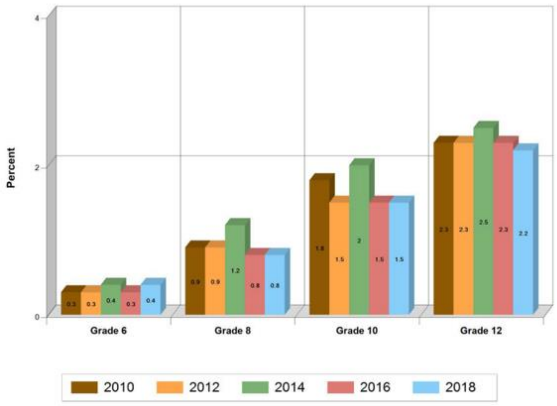
Past Year Cocaine Usage

Kentucky

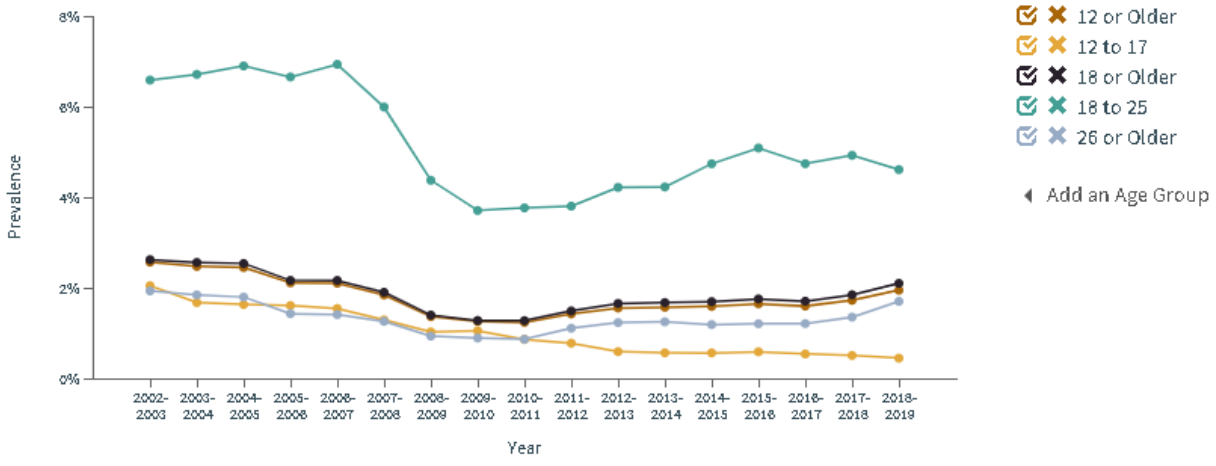
Question 37a - On how many occasions (if any) in the past 12 months have you used cocaine or crack?

Percent that answered at least 1 occasion

Grade	2010	2012	2014	2016	2018
6	0.3%	0.3%	0.4%	0.3%	0.4%
8	0.9%	0.9%	1.2%	0.8%	0.8%
10	1.8%	1.5%	2%	1.5%	1.5%
12	2.3%	2.3%	2.5%	2.3%	2.2%

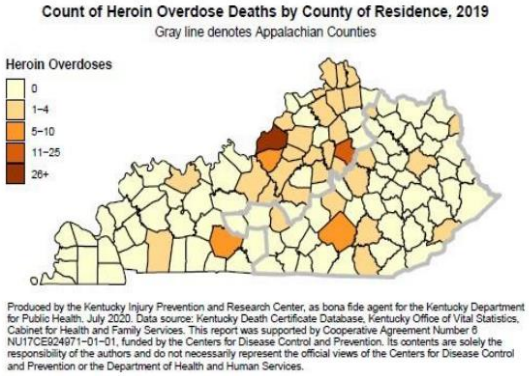


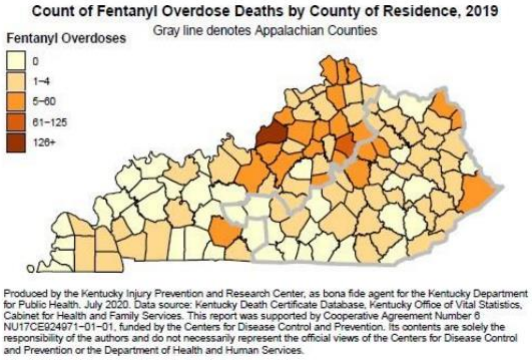
Cocaine Use in the Past Year in Kentucky, by Age Group



Opioids/Heroin/NMUPD

Substance abuse, particularly the use of prescription drugs along with heroin and illicit fentanyl, continues to be a disparaging public health concern for Kentucky. According to 2019 findings in the Overdose Fatality Report released by the Kentucky Office of Drug Control Policy, there were 1,316 overdose deaths in Kentucky in 2019, up 5% from 2018. After a 15% decline in overdose deaths in 2018, this uptick in deaths may be attributable to newly increased supply and availability. The largest number of overdose deaths in Kentucky were among those aged 35-44, followed by those aged 45-54. At least 67 youths under the age of 25 died by overdose in 2019, however. The top five counties for overdose deaths per capita were Estill (80.99), Grant (77.41), Boyd (64.56), Greenup (61.96), and Anderson (50.96).

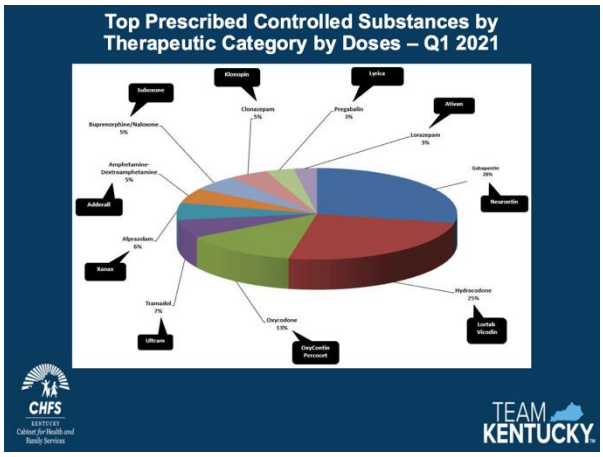


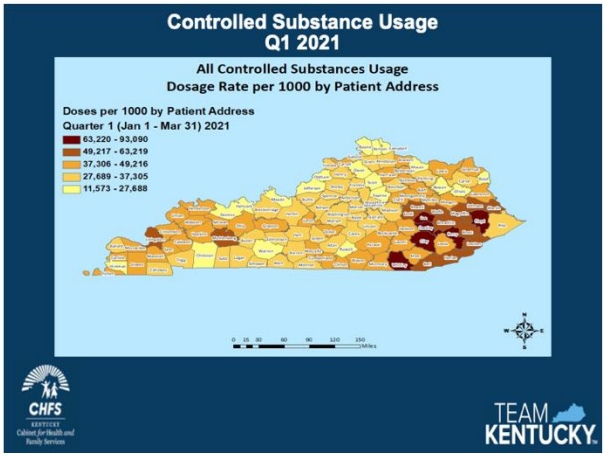


Recently, heroin was present in approximately 13% of OD deaths in which autopsy and toxicology reports are available. This is down from 2015 and 2018 data. The top five counties for heroin-related overdose deaths were Jefferson (61), Fayette (17), Bullitt (8), Pulaski (5), and Warren (5). Additionally, the report shows that fentanyl was involved in 58% percent of overdose deaths in 2019, up from 34% in 2015. Acetylfentanyl was involved in 32% of all overdose deaths for the year as well. Jefferson (204) and Fayette (20) also represented the top five counties for fentanyl-related deaths, along with Madison (15), Kenton (14), and Boone (12).

The prescription drug monitoring program in Kentucky is referred to as the Kentucky All Schedule Prescription Electronic Reporting (KASPER) system. According to the 2020 Combined Final Annual Report of the Kentucky Office of Drug Control Policy and the Kentucky Agency for Substance Abuse Policy, there were approximately 4,532,018 opioid prescriptions given in Kentucky according to KASPER data, which is approximately 1.01 prescriptions per person. The number of total opioid prescriptions have been slowly declining for years.

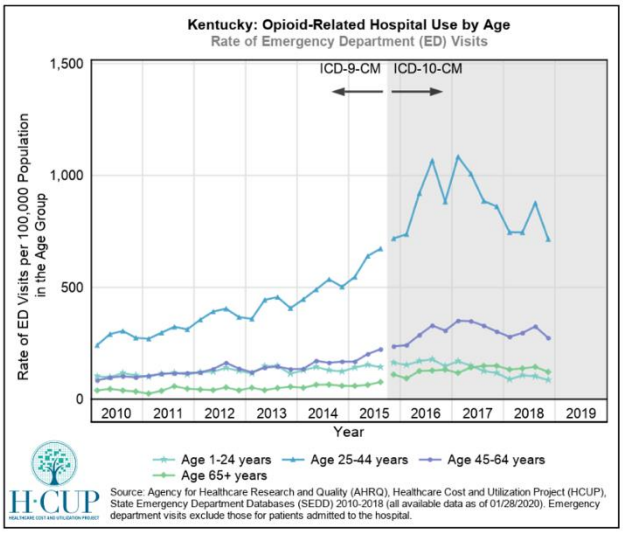
Overall, the greatest percentage of controlled substances prescribed in Kentucky is for Gabapentin, representing 28% of all controlled substances dispensed in the state for Quarter 1 of 2021. Gabapentin, or Neurontin, is followed by hydrocodone (Lortab, Vicodin) at 25% and Oxycodone (OxyContin and Percocet at 13%. Additional prescribed controlled substances include Tramadol (7%), Alprazolam, 6%), Amphetamine/Dextroamphetamine (5%), Buprenorphine/Naloxone (5%), Clonazepam, (5%), Pregabalin (3%) and Lorazepam (3%). - The highest number of doses of prescribed controlled substances were found in Louisville, Northern Kentucky, and Fayette County, all of which represent Kentucky populations centers and metropolitan areas. The highest dosage rates per 1,000 residents by patient address, however, were located in six counties in southeastern Kentucky each with between 63,220-93,090 does per 1,000 residents.





The highest opioid morphine equivalent doses per 1,000 residents by addresses (excluding Buprenorphine/Naloxone are found in Floyd, Knott, and Perry counties in southeastern Kentucky, Greenup County in the northeastern portion of the state, Grant County in northern Kentucky, Powell County in central Kentucky, and Livingston County in Western Kentucky. These counties all had a rate of 5 doses per 1,000 residents. Use of Benzodiazepines and Opioids are especially problematic in the state, with 11 of 120 counties reporting a rate of 17-23 per 1,000 residents of seven-day overlap by patient addresses. Ten of those counties were in southeastern Kentucky, with one in Western Kentucky.

The Kentucky opioid overdose emergency department visit rate was 395.9 visits/100,000 population in year 2017, compared to 249.1 for the U.S. Individuals aged 25-44 comprised the largest percentage of individuals treated for opioid overdoses in Kentucky emergency departments (EDs) followed by those aged 45-64 and those under the age of 25. TEDS data shows a steady downward trend, from a high of 25.6% in 2015 to 16.4% in 2019, highlighting the work that has been done across Kentucky to stop access and use to heroin. Admissions for other opioids showed a similar decrease, falling from 19.6% in 2015 to 3.5% in 2019. Males are more likely to be admitted for both heroin and other opioid use than females. Those aged 26-30 are most likely to be admitted for heroin use, while those 26-40 are



Age 65+ years
H·CUP
Source: Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and Utilization Project (HCUP), State Emergency Department Databases (SEDD) 2010-2018 (all available data as of 01/28/2020). Emergency department visits exclude those for patients admitted to the hospital.

most likely to be admitted for other opioid use. Whites are more likely than Black or African Americans to be admitted for either heroin or other opioid use, but heroin use among Blacks is at a disparate level compared to the state population (10.2% admitted, 8.75% percent of population). Those who are Hispanic, or Latino are at disparate risk related to heroin and other opioid use for hospital admissions, compared to the percent of the population.

Heroin use in youth has declined for most age groups from 2014 to 2018 according to KIP. The percentage of children who responded, “at least 1 occasion” to the question “on how many occasions (if any) in the past 12 months have you used heroin (“smack,” “junk,” or “China White”)” has improved or stayed consistent for most age groups between 2014 and 2018. Most recent numbers indicate that 6th graders had a .3% prevalence and 8th graders had a .5% prevalence, maintaining similar numbers to those reported in 2014 and 2016. 10th graders improved by having a decrease from .9% in 2014 to .6% in 2018 and 12th graders improved by decreasing from 1% in 2014 to .7% in 2018.

2018 KIP result also show that 1.9% 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 graders since 2012 when the question was added to the KIP survey. The results for 12th graders have also been steady since 2012, but in 2018, it dropped from 1.7% to 1.3%. However, this same question has shown significant increases for 6th and 8th graders in that time frame, rising from 2% to 2.6% for 8th graders (30% increase) and from 1.3% to 1.7% for 6th graders (31% increase).

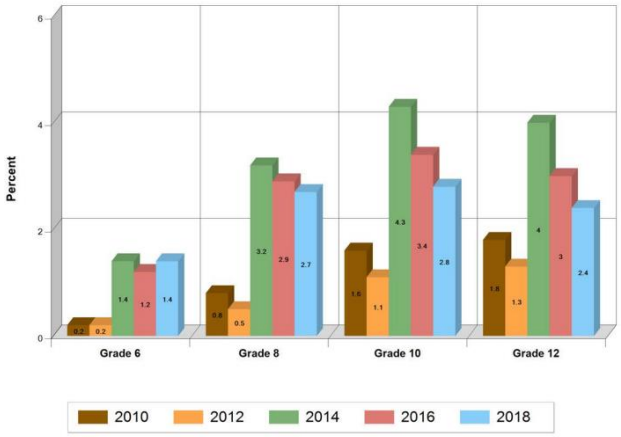
30 Day Painkiller Usage

Kentucky

Question 39b - On how many occasions (if any) in the past 30 days have you taken painkillers (OxyContin, Percocet, Vicodin, Codeine) without a doctor's prescription?

Percent that answered at least 1 occasion

Grade	2010	2012	2014	2016	2018
6	0.2%	0.2%	1.4%	1.2%	1.4%
8	0.8%	0.5%	3.2%	2.9%	2.7%
10	1.6%	1.1%	4.3%	3.4%	2.8%
12	1.8%	1.3%	4%	3%	2.4%



Past year prescription drug use, as reported on the KIP, has shown a decrease from 2010 to 2018 for all age groups. There was a decrease of 1.8% to 1.2% for 6th graders, 5.3% to 3.1% for 8th graders, 11.3% to 4.9% for 10th graders, and 13.1% to 4.9% for 12th graders. Thirty-day use of prescription drugs has similarly declined in that time frame as well, falling from 1% to 0.5% for 6th graders, 2.9% to 1.6% for 8th graders, 6.2% to 2.5% for 10th graders, and 7.2% to 2.3% for 12th 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 graphs below for specifics). This suggests that more attention should be given for prevention efforts that address the misuse of these painkillers specifically.

Personal disapproval of prescription drug use without a doctor’s prescription was high across the grades, with 96.5% of 6th graders and 91.9 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 96.7% 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% of 6th graders. Perception of peer disapproval was lower, however, with just 81% of 12th graders and 82.1% 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, 2012-2018, with a slight improvement in 2018 from 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 44% between 2012 and 2018 and the percentage of 12th graders answering the same way dropped 51%. Risk perception increased among younger students but decreased among older students in the 2012-2018 timeframe. Sixth graders reporting they felt that using a prescription drug without a doctor's orders was a "moderate" or "great risk" climbed 7.6%, with perception of risk peaking in 2016, while the percentage of 8th graders answering similarly increased remained about the same from 2012 to 2018. Conversely, the percentage of 10th and 12th graders who reported moderate or great risk fell 4% and 5.3% respectively.

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 declined to .7% in 2018. Among 10th graders, .6% reported heroin use in 2016 and 2018. Thirty-day heroin usage is even lower with .6% of 12th graders, .5% of 10th graders, and .3% of 8th and .2% of 6th graders reporting heroin use, representing just 451 students across the entire state of Kentucky. Risk perception regarding heroin use has remained relatively steady across the grade levels between 2014 and 2018, with between 74.2% (6th graders) and 82.6% (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. Additionally, addressing early alcohol use as a gateway to later increased substance use, substance use disorder, and related consequences to substance use is vital in developing healthy, thriving adults and communities in which they live.

E-CIGARETTE USE

As e-cigarette use continues to grow in Kentucky, it is imperative that prevention efforts target youth who do not perceive the use of e-cigarettes as harmful. Efforts will also focus on increasing the personal, peer and parental disapproval ratings related to e-cigarette use as well as decreasing access to e-cigarettes. Because Kentucky had made such inroads in the use of cigarettes, prevention providers had turned their attention to other substances, such as opioids, letting some of the attention and focus on e-cigarette use lapse.

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 because 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 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 to reduce use and consequences of use and reduce deaths.

Workforce Issues are also identified as a significant gap in Kentucky. Between 2016 and 2021, significant time and effort has been devoted to building the providers' (RPC) capacity regarding operationalizing the SPF in their communities. Additionally, funding through discretionary grants, specifically the State Opioid Response grant, have allowed for expansion of prevention providers both in the community and at the state level. As a result of these new staff – two positions at each of the 14 RPCs - the Branch pushed out extensive technical assistance and national subject matter experts along with the Prevention Technology Transfer Center were heavily utilized to increase the knowledge and skills related to the shared risk and protective factors that underlie substance use behaviors. Despite additional funds provided to contracted prevention providers, turnover has been significant. Over the last five years, all 14 have lost prevention staff, with turnover being close to 40%, and seven of the 14 have a new director.

Additional, salaries for prevention specialists are relatively lower and traditionally lower than similarly credentialed staff on the treatment side of the Community Mental Health Centers in which RPCs are co-located. The CMHCs are 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. Often many who complete licensure requirements are lured to the treatment side of the CMHC because of more money and promise of sustained employment.

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. Similarly, to address e-cigarette use by youth, each RPC will have an e-cigarette component within their annual work plan submitted to the branch. The workplan item will address either perceptions of approval, perception of risk, or reduction in access for youth.

Surveillance gaps are noted for the 18-25-year-old populations as well as for assessing illicit substance use, especially at the county level. 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 around the 18-25-year-old population. This needs assessment will serve as the basis for future planning efforts to address alcohol use or other identified needs with the targeted adult population. The SEOW will also help identify data indicators that can be utilized to assess the need around use of illicit substances by adults at the regional and county level, specifically related to stimulants (cocaine and methamphetamines, as well as prescription drugs) and marijuana use. Currently there is no data beyond state level data that identifies local need, except for youth data.

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 continue to 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 also refining its needs assessment process to include provision of data related to incidence and prevalence through a dashboard that will guide county-level assessments. The dashboard and data will be utilized to develop risk indexes for alcohol, tobacco, marijuana, opioids, stimulants, and mental health issues taking into consideration incidence, prevalence, morbidity, mortality, community contexts (poverty, lack of housing, discrimination) and health disparities. Once the index is established, RPC staff will share with community members to identify their agreement with the issues in the community and conduct key stakeholder and focus group qualitative data collection to further identify local contexts that contribute to substance use and mental health issues, creating a focused action plan for each Kentucky county. They will also assess the readiness and capacity of the community to implement the identified strategies and guide communities in selecting those that are aligned with the community's current readiness level. Additionally, an analysis of the activities delivered to each county will be conducted to determine if they have the strength and reach necessary to create change in that community (basically, is the dosage high enough to help change behavior?).

DBHDID Program Administrators meet in a yearly strategic planning session to review available information from the regions, updated trend data on substances, and changes in readiness levels

to develop an internal strategic plan that guides the work of the branch in supporting the delivery of training and technical assistance to communities based on local needs.

Additionally, Prevention program administrator will continue to provide monitoring and technical assistance to DBHDID-funded prevention programs by meeting one-on-one with providers at least monthly as well as holding virtual peer group meetings twice a month (one formal, one a peer sharing call). Based on these calls, and coupled with the needs assessment, a training and technical assistance plan is developed for each region. Needs noted across the regions are used to identify trainings and other skill-building opportunities for the RPCs.

The state is also in the process of developing an onboarding training plan for all new hires, as well as providing Prevention 201 type trainings for more advanced providers to ensure they retain and expand their prevention knowledge to keep up with changing trends, different substances used, and to connect with stakeholders based on identified shared risk and protective factors, especially factors revealed by new research. The onboarding system will allow learning opportunities to be layered over the new hires first year of employment, will facilitate the Certified Prevention Specialist certification process, and create a sense of purpose and mission among those entering the system, hopefully resulting in lower turnover and higher retention of prevention specialists. 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.

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 has been conducted bi-annually in the fall in even-numbered years (2014, 2016, 2018 etc.), however the 2020 administration was delayed as a result of school closings from COVID-19. The next administration will be in the fall of 2021. The survey includes 6th, 8th, 10th, and 12th graders attending school in Kentucky communities. In 2018 the total sample size for 6th, 8th, 10th, and 12th grades was more than 128,000 students. The sample includes schools from 113 out of 120 Kentucky counties, and 151 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.

- **Healthcare Costs and Utilization Project (HCUP) -** The Healthcare Cost and Utilization Project includes the largest collection of longitudinal hospital care data in the United States. Data collection began in 1988 and databases contain encounter-level information for all payers compiled in a uniform format with privacy protections in Place. The Nationwide Emergency Department Sample specifically is a database that yields national estimates of emergency department (ED) visits). Databases within the HCUP were developed through a Federal-State-Industry partnership and sponsored by the Agency for Healthcare Research and Quality (AHRQ).
- **Kentucky All Schedule Prescription Electronic Registry -** is a controlled substance prescription monitoring system designed to be a source of information to assist practitioners and pharmacists with providing medical and pharmaceutical patient care using controlled substance medications. KASPER also provides an investigative tool for law enforcement and regulatory agencies to assist with authorized reviews and investigations.
- **Kentucky Injury Prevention and Research Center (KIPRC) –** KIPRC was established in 1994 as a unique partnership between the Kentucky Department for Public Health and the University of Kentucky College of Public Health. This state–university partnership provides KIPRC access to expertise and support in injury and violence-related research, data, services, outreach, communications, interventions, evaluation techniques, and policy development, at both the state government and academic levels. KIPRC's uses injury prevention research to inform and implement targeted interventions that are evaluated and adopted into local and state injury prevention practice.
- **Kentucky Overdose Fatality Report 2018** – 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 and is updated annually 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-driven 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, selected and indicated methodologies. It is through the

PDS that the Branch is evaluates the work being done in each region and identifies 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. As a result a quality improvement process was implemented in 2020 and continues to evolve to ensure that the data entered into the Prevention Data System is accurate and complete.

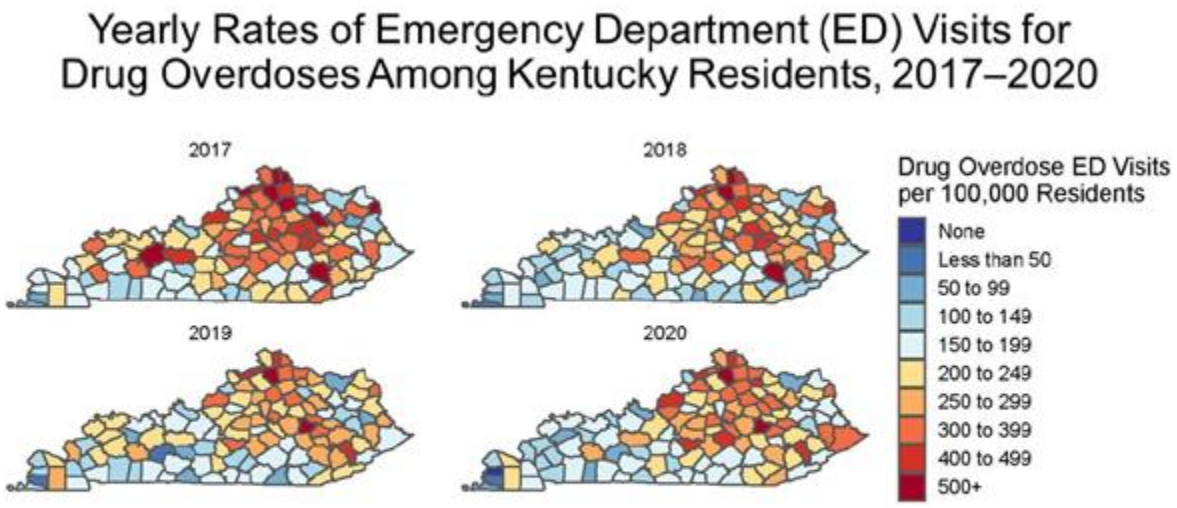
Substance Abuse Treatment

Individuals with Substance Use Disorders

Prevalence Data for this population:

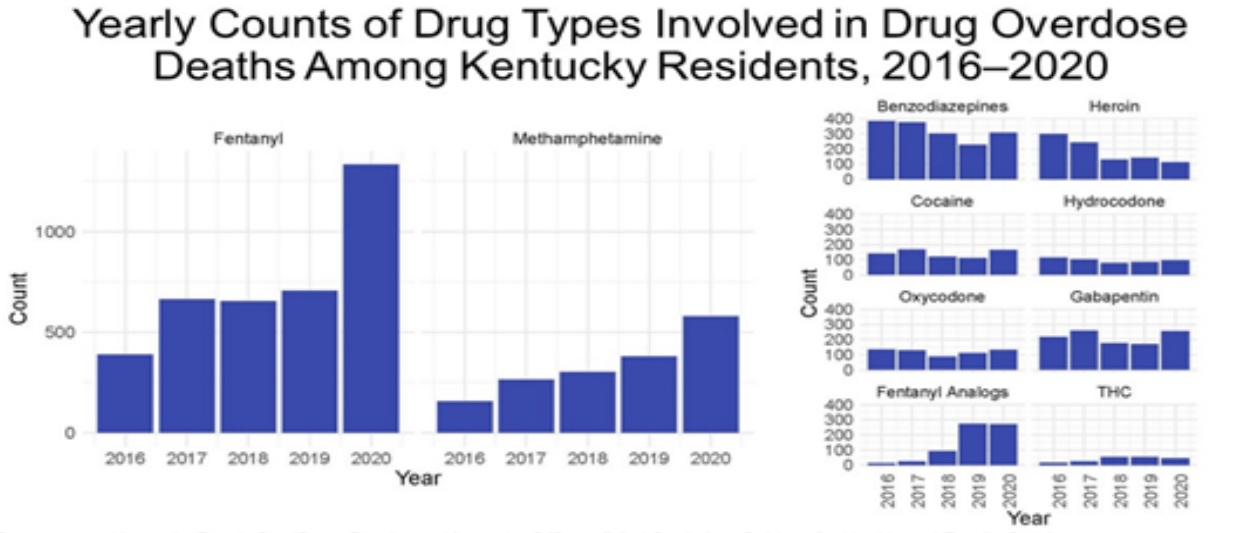
An estimated 10% of the population age 12 and older meet diagnostic criteria for SUD. Based on the 2010 census data, this equates to 363,204 of Kentucky's population over the age of 12 (3,632,035; U.S. Census Bureau, 2010). During SFY 2020 (July 1, 2019 - June 30, 2020), Kentucky's Community Mental Health Centers (CMHCs) provided substance use specific treatment for 21,858 unique individuals; 366 of whom were under age 18. These numbers are slightly lower than the year prior but are anticipated to increase in the current and subsequent years. The total number of unique individuals served across the CMHCs in state fiscal year 2020 was 153,355 and 30,248 were identified as having co-occurring mental health and substance use disorders.

Nationally, the CDC estimates that drug overdose deaths increased by 30% from October 2019 to October 2020. In contrast, drug overdose deaths in Kentucky increased by more than 53% according to the CDC. In 2018, Kentucky experienced the first drop in overdose deaths in nearly a decade. However, the rate of fatal overdoses began to rise slowly in October 2019. In 2020, overdose rates began to rapidly increase beginning in mid-March reaching their peak in April and May (KIPRC, 2020). Fatal and non-fatal overdoses remain significantly elevated above pre-pandemic levels as of June 2021. In addition, daily opioid-overdose-related emergency medical services (EMS) runs in Kentucky increased during the COVID-19 state of emergency. Specifically, the number of opioid overdose runs by EMS that included transportation to an emergency department (ED) increased by 17% whereas those in which transport to an ED was refused increased by more than 70% (Slavova, Rock, Bush, Quesinberry, & Walsh, 2020). In addition, there was a 50% increase in EMS runs for suspected opioid overdoses, with deaths at the scene (Slavova et al., 2020).



Data source: Kentucky Outpatient Services Database, Office of Health Data and Analytics, Cabinet for Health and Family Services.
Data are provisional and subject to change.
Produced by the Kentucky Injury Prevention and Research Center as bona fide agent for the Kentucky Department for Public Health, April 2021.

Opioid Overdoses are primarily attributed to fentanyl and fentanyl analogs. Fentanyl- and fentanyl-analog-related deaths increased by 75.7% from the beginning of 2017 through September 2020. This increase was accompanied by a concomitant decrease in heroin-related ED visits (42.2%) and inpatient hospitalizations (38.2%). In addition, methamphetamine-related overdose deaths among Kentucky residents more than doubled (108.3% increase) during this time and all involved polysubstance use. In total, Kentucky recorded nearly 3,700 drug-related events in its EDs and over 4,200 EMS-suspected overdose encounters in Quarter 3 of 2020 alone (Kentucky Substance Use Research & Enforcement, 2021). In addition, despite cocaine-related deaths decreasing by 13.5% from 2017 through quarter 2 of 2020, a 36.4% increase in cocaine-related deaths occurred from the second quarter of 2020 to the third quarter of 2020.



Data source: Kentucky Death Certificate Database, Kentucky Office of Vital Statistics, Cabinet for Health and Family Services.
Data are provisional and subject to change.
Produced by the Kentucky Injury Prevention and Research Center as bona fide agent for the Kentucky Department for Public Health, April 2021.

According to the Kentucky Housing Corporation (KHC, 2021), of the 4,011 homeless individuals in the commonwealth, 568 individuals self-reported having a substance use disorder (SUD) in the 2020 annual point-in-time count. Although this statistic does not necessarily reflect the number of individuals who meet diagnostic criteria for or who have been diagnosed with a SUD, rates of substance use are high among individuals who are homeless. Approximately 80% of those who are chronically homeless report lifetime substance use and more than one third (34.7%) of individuals experiencing homelessness report engaging in chronic substance use (SAMHSA, 2011).

According to the 2019 Neonatal Abstinence Syndrome (NAS) Reporting Registry Annual Report, there were 1,102 cases of newborns with signs and symptoms of NAS. This represents 20.9 of every 1,000 live births among Kentucky residents. NAS prevalence rates are highest in Appalachian regions of the state, with rates in some areas reaching 55 cases per 1,000 live births. These data indicate that rates of NAS rural counties are nearly double the rate observed in in urban counties in Kentucky. In comparison, the most recent national estimate for NAS was 7.3 cases per 1,000 live births (HCUP Fast Stats, 2020), placing Kentucky at nearly three (3) times above the National average. Buprenorphine (65%), heroin (22%), and methadone (11%) were the most frequently reported opioids. Other commonly used substances reported were amphetamines, including methamphetamine (32%), and cannabinoids (26%). All other substances were used by less than 12% of women in the registry. A majority of cases (~65%) were exposed to more than one substance during pregnancy, with an average of being exposed to three (3) substances. Although buprenorphine and methadone can produce NAS, these drugs are forms of MOUD used under medical supervision for the treatment of OUD, which is preferable to untreated OUD during pregnancy. Increased access to and utilization of MOUD may explain why these medications are two (2) of the most reported substances to the NAS registry.

Although opioid overdoses remain the leading cause of overdose deaths in Kentucky, overdose deaths related to stimulants and other drugs have also been on the rise. According to the Office of Drug Control Policy, methamphetamine was involved in 517 overdose deaths in 2019, an increase from 428 in 2018. Additionally, amphetamines were detected in 415 overdose deaths, gabapentin was detected in 292 overdose deaths, and cocaine was detected in 181 overdose deaths in 2019. Because resources have been primarily allocated to address OUD, Kentuckians with stimulant use disorders and other SUDs have limited options and resources for treatment and recovery. The influx of fentanyl and the uptick in methamphetamine and other stimulant use highlight the need for increased harm reduction outreach, improved crisis response services and access to naloxone among stimulant users.

Unmet needs and critical service gaps:

Current unmet service needs for individuals with substance use disorder in Kentucky include but are not limited to the following:

- Transitional housing;
- Transportation to access 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;
- Medication for opioid use disorder treatment programs that are effectively administered; and

- Limited access to Wi-Fi services.

The Kentucky Injury Prevention and Research Center (KIPRC, 2020) found specific needs and gaps regarding capacity of recovery housing. There is a greater need for housing supports in our rural areas, and lack of availability for parents with children and families.

In addition, during SFY 2021, DBH analyzed current and potential inequities in accessibility to programming for SUD. It was discovered during this data analysis that the pandemic had reduced in-reach into correctional institutions due to public health pandemic restrictions, resulting in negative impacts to accessing services for those experiencing re-entry.

Increased psychological distress stemming from the COVID-19 pandemic is associated with increased substance use and its consequences. Many people reported increases in stress, anxiety, and depressed mood as they lost employment and sources of income, had limited or no access to other supports systems and became more isolated due to social distancing and other necessary public health measures. These feelings are associated with increases in substance use including binge drinking, non-medical prescription drug use, and illicit drug use. In addition, research suggests that people with substance use disorders (SUDs) are more susceptible to COVID-19 and its complications. People diagnosed with SUD during their lifetime experienced worse health outcomes than individuals with no history of SUD, including increased rates of hospitalization and death.

The pandemic also exposed racial disparities in susceptibility and outcomes between African Americans and White individuals, with a lifetime substance use disorder diagnosis. A 2020 study found that African Americans who were recently diagnosed with SUD were more than twice as likely to contract COVID-19 and had higher rates of hospitalization and death relative to their white counterparts.

In addition, Infants with NAS are twice as likely to have a low birth weight and three (2) times as likely to be admitted to a neonatal intensive care unit. Tobacco use co-occurs with substance use at high rates, which could further affect the health and development of these infants. Infants with NAS are hospitalized approximately 3.5 times longer than infants without NAS at delivery (13.4 days versus 3.8 days, respectively). Infants who received pharmacological treatment (44%) had average hospital stays of 19.5 days. Among this group, the most common pharmacological treatments were morphine (89%) and clonidine (35%) with approximately 37% of infants with NAS receiving multiple medications.

Addressing the Need:

During 2021, the Adult Substance Abuse Treatment and Recovery Branch of DBH, provided technical assistance to the Kentucky Oxford House Outreach staff and began a strategic planning process to enhance equitable access to community-based recovery housing. To address the issue related to public health pandemic restrictions and correctional institutes, DBH staff provided informational resources to staff of the Department of Corrections to assist in connecting incarcerated individuals re-entering the community with Oxford House Outreach staff.

Kentucky's behavioral health system of care includes fourteen (14) Community Mental Health Centers (CMHCs) as well as multiple licensed and credentialed private providers as specified in the DBHDID provider directory. These providers provide access within the state to a full continuum of services, including education, screening, brief intervention, assessment, outpatient, intensive outpatient, residential, withdrawal management, and recovery supports. Kentucky is continuously identifying specific populations of need and works to provide targeted services to those populations. Those populations include Service Members, Veterans and their Families

(SMVF), adolescents, pregnant women and parenting persons, individuals experiencing homelessness, older individuals, individuals with co-occurring substance use and mental health disorders, and others as identified. Kentucky promotes the use of Medication for Opioid Use Disorder (MOUD) as an invaluable treatment tool through the twenty-eight (28), state-certified Narcotic Treatment Programs that dispense methadone or other FDA-approved forms of MOUD in tandem with treatment services. Kentucky also maintains comprehensive legislative regulations to support access to buprenorphine formularies. For example, Kentucky has removed prior authorizations for buprenorphine formularies including the long-acting injectable formulation, Sublocade. Additionally, Kentucky has established an online treatment locator platform called FindHelpNow.org that is a real-time substance use disorder treatment availability locator and information center. The locator lists treatment openings and providers including CMHCs, private, non-profit, and faith-based treatment providers, and providers of MOUD. Providers are encouraged to update their treatment availability and facility information daily. FindHelpNow.org also contains a multidisciplinary information center to help answer questions about substance use, treatment, and recovery resources. FindHelpNow.org was created by the Kentucky Department for Public Health in partnership with the Kentucky Office of Drug Control Policy, the DBHDID, and Operation UNITE.

To address NAS and the issues of families affected by substance use, the Kentucky Department for Public Health and the DBHDID plan to work on the following:

- Continuing to promote prenatal care;
- Promoting enrollment in MOUD programs;
- Implementing a plan of safe care initiative that includes educating parents and medical/child care providers on safe sleep, abusive head trauma, the effects of substance use on pregnant and parenting families, as well as child abuse and neglect;
- Enrollment in services such as WIC, substance use prevention and treatment programs, substance use recovery support services; and
- Improving access to long-acting reversible contraception.

Mothers of infants with NAS tend to have less education, be unmarried, and have more children, which may suggest lower socioeconomic status, a lack of social support, and/or reduced access to services. Two (2) key steps are to identify demographic patterns and address social determinants of health to reach these high-risk populations.

Work to address the needs of individuals with substance use disorder (SUD) in Kentucky continues. This includes concerted efforts to mitigate complications stemming from the COVID-19 pandemic and to foster the continued development and data-driven implementation of a recovery-oriented system of care (ROSC) that provides seamless integration of readily accessible, high quality, evidence-based services across systems.

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

Prevalence Data and Unmet Needs and Critical Service Gaps:

Substance use is an increasing concern for women. According to the 2019 National Survey on Drug Use and Health (NSDUH), 25.5 million women (ages 12 and older) in the U.S. used illicit substances in the past year, and 15.1 million women (ages 12 and older) used an illicit substance in the past month[i]. In 2019, 4.6 million women reported non-medical use of prescription pain relievers in the past year.

Pregnant women, who use substances, face tremendous stigma from their family, social networks, and society. This stigma creates barriers to seeking and accessing treatment.

According to the 2019 National Survey on Drug Use and Health (NSDUH), 5.8% of pregnant women, aged 15-44 used illegal substances and 9.5% reported using alcohol in the past month[ii].

In Kentucky, overdose deaths in women of childbearing age have increased dramatically over the past ten (10) years.

In 2019, the rate of drug-induced deaths among women (ages 18-44) years old in Kentucky was 38.8.[iii]

Pregnant women who chronically misuse prescription medications also have a greater risk for medical complications.

Kentucky is primarily a rural state, which creates challenges to both identifying the need for services and providing access to services in many remote areas of the Commonwealth. Excluding marijuana, rural Appalachian Kentucky has one of the highest occurrences of illicit substance use for persons age twelve (12) and older.

Stigma associated with pregnant women and substance use disorder continues to create barriers to identification and treatment of this population. To reduce stigma, ongoing training and consultation to professionals and community partners continues to be a crucial need.

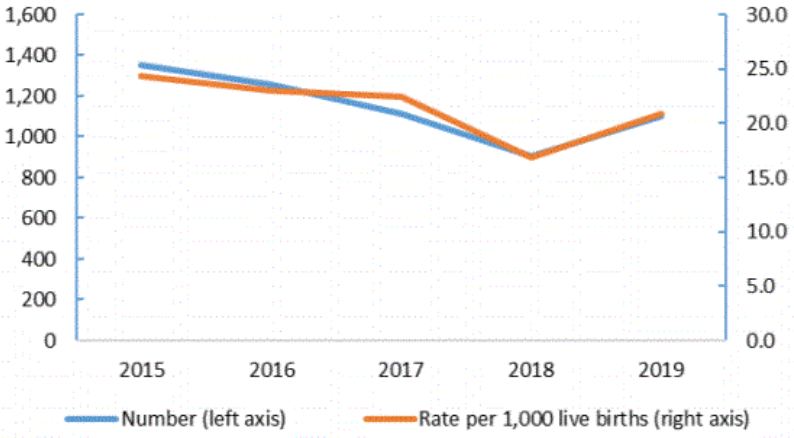
With the 2014 expansion of Medicaid services and the subsequent growth in behavioral health providers in the state, Kentucky has struggled to develop quality and comprehensive SUD services.

Despite recent increase in the availability of services for pregnant and parenting women, the opioid epidemic has placed a burden on Kentucky's system of care. There is a continuous need to increase and improve services for this population.

Kentucky lacks statewide criteria for screening of 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 substance-exposed infants, Fetal Alcohol Spectrum Disorders (FASD) and neonatal abstinence syndrome (NAS). The Health Insurance Portability and Accountability Act (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 the Substance Exposed Infant (SEI) and/or Neonatal Abstinence Syndrome (NAS) and screen the infant appropriately.

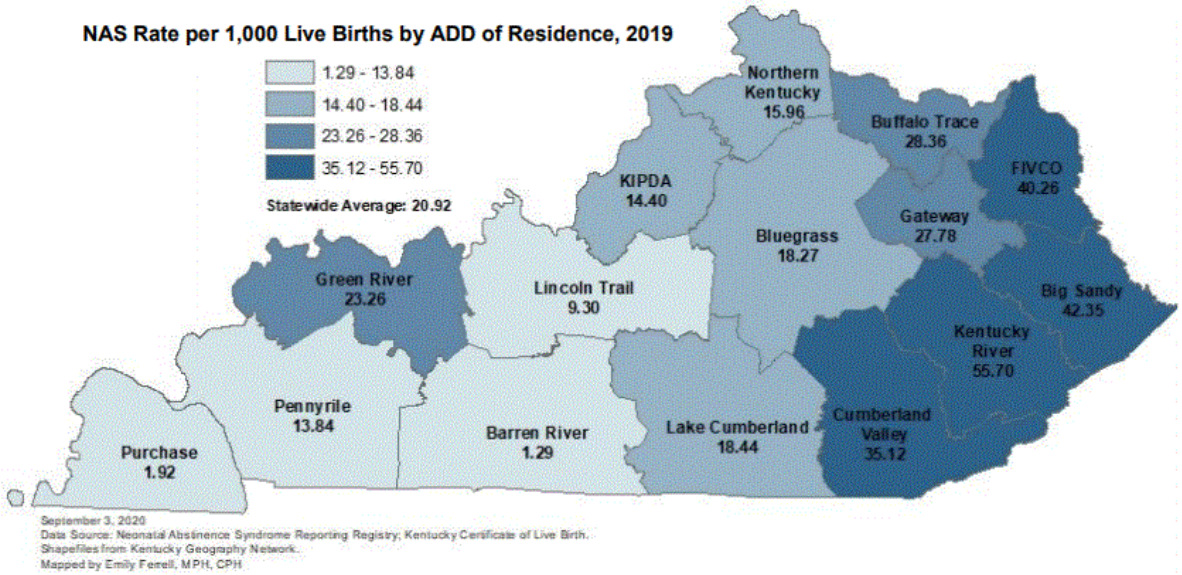
From 2000 to 2019, there has been a dramatic increase in the number of Kentucky infants hospitalized with NAS. In 2000, there were nineteen (19) babies with NAS hospitalized in the state. Since then, Kentucky's NAS rate has been higher than the national average. In 2019, the Kentucky NAS Registry shows 1,102 unduplicated cases, which was an increase from 2018. The most recent data available shows a 2019 rate of NAS/ Neonatal Opioid Withdrawal Syndrome (NOWS) in Kentucky as 23.6 cases per 1,000 hospital births.

Figure 1. Kentucky Resident NAS Cases, 2015-2019



Importantly, there are large discrepancies in NAS rates by Area Development Districts (ADD) across Kentucky. The rate of NAS in rural counties is nearly double the rate than in urban counties, with the highest rates in rural Appalachia (for example, 55.70 rate per 1,000 live births in 2019).[iv]

Figure 2. NAS Rate By ADD of Residence, 2019



Addressing the Need:

Kentucky implemented the Affordable Care Act and expanded Medicaid coverage in 2014 to a larger population. Most critical to pregnant women with mental health or SUD 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 a priority population in accordance with Center for Substance Abuse Treatment (CSAT) regulations. The Community Mental Health Centers (CMHC) screen for SUD at initial contact and provide care within twenty-four (24) hours. If no such facility has the capacity to admit and provide treatment, interim services are be made available within forty-eight (48) hours. The CMHCs now have an established protocol to inquire about pregnancy at first contact with new female clients, including adolescents.

Currently, Kentucky's statewide prevention and treatment infrastructure is growing. The statewide bed capacity of residential/transitional services for pregnant women is over 725. Some of these programs allow dependent children to live on-site with the mother during treatment and while transitioning through the continuum of care. There are thirty-seven (37) Intensive Outpatient Programs (IOP) or Outpatient programs serving this specific population.

Kentucky has over thirty (30), publicly funded programs that are designed specifically to serve pregnant and parenting women affected by substance use disorder. The goal of these programs is to provide a warm, nurturing environment to support treatment services for women affected by SUD, as well as their children and families. Some of the programs are listed below:

KY-Moms: Maternal Assistance Towards Recovery (MATR) engages pregnant and postpartum individuals in universal, selective, and indicated substance use prevention education services, as well as identifies, assesses, and links pregnant and postpartum individuals to substance use and/or mental health treatment, recovery supports, and other community resources**.** Engaging pregnant and postpartum individuals in intensive case management services provides an opportunity to increase readiness for treatment, while providing support for women with a mild, moderate, or severe SUD. Evidence-based practices (EBP) used include Screening, Brief Intervention, Referral and Treatment (SBIRT), Motivational Interviewing, Prime for Life (PRI) and a Contingency Management program. As part of the KIDS NOW Early Childhood Development Initiative, the Kentucky Behavioral Health, Adult Substance Abuse Treatment & Recovery Branch has implemented a statewide effort in all of the fourteen (14) CMHC regions that aims to increase the health of all Kentucky babies by decreasing the use of alcohol, tobacco, and other substances during pregnancy and the postpartum periods.

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 and children under five (5) years of age to reside with mothers during treatment.

Chrysalis House is a residential and transitional housing treatment program located in Lexington, Kentucky, with three (3) residential facilities, a (40) forty-unit apartment complex, eighteen (18) scattered-site apartments, an 18,000 square foot, multi-purpose community center, and two (2) 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 University of Kentucky Pathways and Beyond Birth clinics to provide obstetrics services, medication assisted treatment, and healthcare referrals for pediatric services at UK hospital.

Freedom House I II and III offer holistic and comprehensive programs that provide evidenced-based interventions and support for women affected by SUD. Their programs include residential, transitional housing, intensive outpatient, and medication-assisted treatment for pregnant and parenting women. The program accommodates infants and other children who may reside with the mother during treatment. The third Freedom House in Eastern Kentucky opened last year.

Serenity House is an eight (8) bed, residential treatment program for pregnant and parenting women with SUD. Residents can stay at Serenity House for up to nine (9) months during pregnancy and up to six (6) post-partum with their infant. Residents of Serenity House receive counseling for SUD and co-occurring mental health disorders, Trauma informed programming, Parenting classes, Peer Support Services, Targeted Case Management, Hazelden Betty-Ford Foundation's Comprehensive Opioid Response and 12 Step (COR-12) facilitation, self-help groups, and other recovery support services. Residents receive prenatal care and access to medications for opioid use disorder (MOUD) through partnerships with local providers as an essential part of their comprehensive treatment for OUD. Serenity House offers an array of services that promote maternal bonding, recovery, health, and wellness of both the mother and the infant.

The Addiction Recovery Center (ARC) is a residential and intensive outpatient program for pregnant and parenting women, in Louisville, Kentucky, operated by one (1) CMHC in that area, Seven Counties Services.

The Women's Renaissance Center (WRC) is an eight (8) bed residential facility that provides comprehensive services to pregnant and parenting women and their children. It is located in more rural Shelby county Kentucky. Seven Counties Services also operates this program**.**

Multiple therapeutic modalities are utilized in these programs, including the following evidence-based practices and programs:

- Medications for Opioid Use Disorder (MOUD);
- Trauma-Informed Care;
- Child-Parent Psychotherapy (CPP), which aims to support and strengthen the caregiver-child relationship through interaction and observation for trauma-exposed children ages 0-5;
- Incredible Years, a training series for parents to increase parent-child connectedness and promote the child's overall wellbeing. Participants gain important skills for reducing difficult behaviors;
- Life skills and parenting skills for a healthy and safe pregnancy for mother and child;
- Employment Supports;
- Peer Support Services (PSS) for Pregnant and Parenting Women, which offers recovery-focused, person-centered support from individuals who are in recovery from a mental health or substance use disorder with specific training to address the needs of this population;
- Transitional housing and supportive services as individuals and families move through the continuum of care. The goal of this program is to provide a warm, nurturing environment to support treatment services for women affected by SUD, as well as their children and families.

The **Office of Drug Control Policy** provided expansion grants that utilize state general funds to support services that address the needs of infants and families at risk for, or suffering from, Neonatal Abstinence Syndrome (NAS), including the following programs:

- Transitions, Inc. provides residential treatment and transitional housing services for pregnant and parenting women (PPW). The Recovery Treatment Center (RTC) has thirty (30) treatment beds for PPW that includes Medication-Assisted Treatment, on-site healthcare and OB/GYN services, transportation, targeted case management, services promoting child/parent bonding and recovery supports. Hope House, formerly Dayton Healthy Baby House, is a recovery center for women that provides a full complement of SUD services for women and children including Long-Term Residential Treatment, Medication-Assisted Treatment, Psychiatric Services, Recovery Housing, Outpatient Clinical Services, Targeted Case Management, Certified Peer Support, transportation assistance and Individual Placement Supports (IPS) Supported Employment;

- LifeSkills, Inc. Park Place Recovery Center for Women is a sixteen (16) bed residential facility specifically designed for pregnant and parenting women with SUD. Infants remain with their mothers while receiving SUD treatment to promote bonding and attachment with one another. Comprehensive services are provided for the family, including family therapy, mutual aid groups, trauma services, Person-Centered Treatment Planning, group therapy, and aftercare services. Medication-Assisted Treatment is included in this treatment model. Transitional services are also provided to assist the family upon completion of residential treatment;

- Haven4Change is owned and operated by LifeSkills, Inc. and is a twenty-four (24) bed transitional facility for parenting women and their children. Recovery support services include continuing education, job training and placement, skill building and integration back into the community. Aftercare services include support meetings, outpatient services, qualified community mental health services and Recovery Community Support groups such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Alanon and several Faith-Based groups;

- Communicare, Inc. owns and operates The Elizabethtown Alcohol and Substances Treatment (EAST) Center, which is an eight (8) bed recovery residence and intensive outpatient program for pregnant, post-partum and parenting women with OUD. 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;

- Passages Eastern Care Center is an eight (8) bed transitional recovery residence (including children) offers an Intensive Outpatient Program (IOP), Parent-Child Interactive Therapy (PCIT), Medication-Assisted Treatment (MAT), daily living skills, support for continuing education, job placement, childcare partnerships and recovery supports;

- Kentucky River Community Care established the Hollyberry House that operates as transitional living apartments with intensive treatment options that provide 24-hour support with parenting, addiction recovery, counseling for trauma and co-occurring mental health needs, along with options for long-term linkage to effective recovery models. They also provide support from early childhood specialty programs for NAS and

offer a holistic program that is sustainable with additional available resources. Hollyberry House is a Modified Treatment Community approach designed to assist pregnant and parenting women with SUD, who lack the necessary support systems in their community to sustain long-term recovery. Residents can have two (2) preschool children stay with them to support the family unit and to assist the resident in caring for her children while sustaining recovery;

- Pennyroyal Center's Pregnant and Parenting Women's Transitional Program offers four (4) beds to serve women as they transition to recovery services. Peer Support Services (PSS) for Pregnant and Parenting Women offers recovery-focused, person-centered support from individuals who are in recovery from a mental health or substance use disorder with specific training to address the needs of this population. Transitional housing and supportive services are available for individuals and families as they move through the continuum of care. Their goal is to provide a warm, nurturing environment for women with a substance use disorder, as well as their children and families;

- River Valley Amethyst House for Women is a six (6) bed, residential facility specifically designed for pregnant and parenting women with SUD. Infants remain with their mothers to promote bonding and attachment. Comprehensive services are provided for the family, including Medication-Assisted Treatment, family therapy, mutual aid groups, trauma services, Person-Centered Treatment Planning, group therapy, and aftercare services;

- Pathways, Inc. provides services to pregnant and parenting women with SUD. Women receive services as they move through the continuum of care, from specialized residential treatment to transitional living at A Mother's Journey House. Peer-Support Services (PSS) for Pregnant and Parenting Women offer recovery-focused, person-centered support from individuals who are in recovery from a mental health or substance use disorder with specific training to address the needs of this population. Life skills and parenting training assist families to re-enter their communities with skills and supports to help them maintain healthy recovery;

- UK Pathways-Morehead is a specialized track for prenatal care for mothers with co-occurring mental illness and OUD that is supported by a psychiatric nurse practitioner and a medication for opioid use disorder (MOUD) prescriber. This program offers services through the University-of-Kentucky-operated Women's Healthcare clinic in Morehead, KY; and

- The Pathways program at Polk Dalton Clinic in Lexington, KY (part of University of Kentucky Healthcare) provides evidence-based comprehensive care for pregnant women with OUD in a structured, clinic setting in which prenatal care, substance use counseling (including Medication-Assisted Treatment), and neonatology consultation are provided. This program delivers essential, comprehensive, coordinated services for a population that often has difficulty obtaining prenatal services.

Additional programming to support substance use disorder treatment for pregnant women include the following initiatives.

Recovery Housing:
Kentucky has established the Kentucky Recovery Housing Network (KRHN) to improve the quality and availability of recovery housing in Kentucky. KRHN certifies recovery residences according to the best-practice standards of the National Alliance for Recovery Residences (NARR). KRHN

evaluates residences across four (4) domains, ten (10) principles, and thirty-one (31) quality standards. Currently, KRHN has seven (7), certified residences that serve pregnant or parenting women, with fifty-one (51), certified recovery beds;

Plan of Safe Care Initiative:
The Child Abuse Prevention and Treatment Act (CAPTA), requires states to have policies to identify and provide services to infants and their families if the infant is affected by prenatal substance exposure. Nationally, in fiscal year 2019, over 86,000 children entering foster care had parental drug abuse as a circumstance of removal from the home (Children's Bureau, 2020). The Child Fatality and Near Fatality External Review Panel ("the Panel") conducts comprehensive, multidisciplinary reviews to discover risk factors and systems issues and recommend prevention measures (2019). Historically, a large proportion of cases, especially abusive head trauma cases, have had caregiver substance misuse as a risk factor. Programs are needed to provide coordinated and collaborative prevention, treatment, and recovery services to pregnant and/or postpartum individuals and their support person(s) to reduce the risk of harm associated with parental substance use/misuse.

Kentucky's Plan of Safe Care (POSC) initiative focuses on developing a coordinated System of Care for pregnant and parenting women affected by SUD, their infants and families. The focus of this effort is to develop a collaborative community response to address the needs of this population by promoting partnerships and linkages between service providers, stakeholders, community partners, individuals, and families to enhance services and improve outcomes. The initiative recognizes the relationship between trauma, adverse childhood experiences, SUD and mental illness. It seeks to ensure that services and supports are collaborative, coordinated, widely available, and accessible to this population.

There are seven (7) DBHDID-funded POSC Pilot sites led by the regional Community Mental Health Centers (CMHC) in partnership with their local Department for Community Based Services (DCBS), Child Protective Services, community partners and stakeholders. The pilot sites hold monthly collaboration meetings to develop a system of care for pregnant and parenting women, their children, and families that have been affected by substance use. One (1) new POSC Pilot site will begin work in SFY 2022, resulting in sites at eight (8) of the fourteen (14) CMHC's. The Department is working to expand this project to all 14 CMHC's.

A statewide workgroup identified best practice goals for this project including:

- Early identification, screening and engagement of pregnant women who are using substances
- Appropriate treatment for pregnant women, including timely, access to Medication for Opioid Used Disorder (MOUD)
- Best-practice guidelines and standards for treatment
- Consistent hospital screening of pregnant and postpartum women and their infants
- Consistent hospital notifications to DCBS
- Memoranda of Agreement for information sharing and monitoring infants and families across systems
- Ongoing care plans for mothers and their infants
- Collaboration and coordination of services across systems focused on the individual needs of families
- Provision of recovery support services

Chronic health conditions like high blood pressure, heart disease, diabetes, liver disease, and cancer are all more prevalent among people with mental illness compared to the general population. As a result, people with mental illness and serious mental illness die 10-25 years earlier than people without these conditions, often from preventable or treatable health conditions. These individuals have complex healthcare needs that are most effectively addressed by a coordinated team of primary care and behavioral health clinicians who work together to provide holistic, patient-centered care. Kentucky Care Integration (KCI) is a 5-year, $10-million dollar Promoting Integration of Primary and Behavioral Health Care (PIPBHC) grant that was awarded to the Kentucky Cabinet for Health and Family Services (CHFS), Department for Behavioral Health, Developmental & Intellectual Disabilities in 2017 by the Substance Abuse and Mental Health Services Administration (SAMHSA). KCI is a collaborative partnership between the Cabinet and two (2) community mental health centers, Seven Counties Services and Mountain Comprehensive Care Center, to establish and provide integrated care services to adults with mental illness, serious mental illness (SMI), and substance use disorders (SUD) who have (or are at-risk for developing) chronic health conditions in ten (10) Kentucky counties. To date, KCI sites have provided co-located, integrated services, including evidence-based screening/assessment, diagnosis, prevention, and treatment according to a shared, individualized care plan to over 800 adults with mental illness, serious mental illness, and/or SUD. Preliminary data show that KCI clients report improvements in overall health and daily functioning, reduced psychological distress, more stable living conditions, and markedly improved employment in the six (6) months following program intake.

In addition, the state of Kentucky currently has twenty-four (24) Narcotic Treatment Programs/Opioid Treatment Programs and four (4) Medication Stations that accept pregnant women, along with approximately eighteen hundred (1,800) Buprenorphine DATA 2000 waivered practitioners (MD, DO, NP, PA & CNS). Two (2) of the Narcotic Treatment Programs, the Methadone/Opiate Rehab and Education (M.O.R.E.) Center located in Louisville and the New Vista Medication-Assisted Recovery Program in Lexington, receive SAPT grant funding to assist in the treatment for this priority population. Pregnant women receive priority treatment at these programs.

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). Kentucky has strived to move forward with prevention and treatment measures to help improve quality of life for our residents and to develop a recovery-oriented system of care.

Multiple trainings have been provided across the state for 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 informed care, American Society of Addiction Medicine (ASAM), Motivational Interviewing (MI) and other Evidence-Based Practices.

To address NAS, DBHDID has worked in collaboration with the following agencies and organizations: The Kentucky Department for Public Health; Kentucky Perinatal Association, Norton Healthcare, University of Louisville, University of Kentucky Division of Neonatology, and the Kentucky Chapter of the American College of Obstetrics and Gynecology (ACOG). DBHDID has participated in the Department for Public Health's Kentucky Perinatal Quality Collaborative (KYPQC), which serves to enhance networking and collaboration with other statewide programs

that work to improve maternal and infant health throughout the state of Kentucky. The overall mission and vision of the KyPQC is to make Kentucky a great place for every woman to have a baby and a great place for every baby to be born.

Plans for the next two (2) years for this population include the following:

- Continue to monitor and support the CMHCs' compliance with screening for pregnancy on the first contact;
- Provide continued funding for services that support pregnant and postpartum women including: prevention, outpatient, residential services, case management, peer support, life skills, parenting, supported housing, employment assistance and other specified needs;
- Expand treatment capacity for pregnant and postpartum women, while strengthening the use of evidence-based practices in women's treatment programs;
- Coordinate the treatment and resources needs of infants and children with the services provided for the mother and family;
- Continue collaboration with the Department for Public Health, toward addressing the issue of safe sleep practices for infants and the reduction of maternal smoking during pregnancy:
- In collaboration with the Kentucky Chapters of the American College of Obstetrics and Gynecology (ACOG) and the American Medical Association (AMA), a statewide initiative to expand universal substance use screening and provide brief intervention and referral to treatment services (SBIRT) as a routine part of prenatal 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 permit earlier intervention, thus minimizing the adverse affects on the baby;
- Continue the collaborative work of the Kentucky Perinatal Quality Collaborative (KyPQC**)** which serves to enhance networking and collaboration with other statewide programs that work to improve maternal and infant health throughout the state of Kentucky. The KyPQC is comprised of three (3) workgroups: Obstetrics (OB), Neonatology (Neo) and Data & Analytics that develop goals and initiatives to improve maternal and infant health outcomes;
- Collaborate with the Department for Community Based Services (child protective services) to train front line staff on identifying substance use and misuse, along with identification of treatment opportunities and making appropriate referrals for treatment when working with pregnant and parenting mothers. Effective identification of the role of SUD in child abuse and neglect cases and improving access to services can improve the outcomes for affected children and their families;
- Enhance KY-Moms: Maternal Assistance Towards Recovery prevention and case management services, focusing on the use of evidence-based and evidence-informed practices. Expand substance use prevention services to women of childbearing age, both prior to, during, and after pregnancy. Focusing additional educational/prevention services on women prior to pregnancy creates the opportunity to educate them regarding the risks and complications associated with drug use. It is also important to explore the expansion of services for at least six (6) months postpartum. This expansion would also provide services and supports to the individual during the most critical and important time in a new parent's life;
- Continue to promote the development of a coordinated and collaborative system of care to address the needs of families affected by drug use. Improving intervention services before, during, and after pregnancy can result in service provision that is coordinated and collaborative; and

- Continue to support and collaborate with community partners on a statewide Plan of Safe Care initiative to enhance the ability of communities to provide evidence–based collaborative and coordinated services to families in need.

Data Sources Used:
Kentucky is working with many agencies and departments to collect data annually on substance-exposed infants. Kentucky data sources include, State Epidemiology Outcomes Workgroup (SEOW), Child Welfare data, and Vital Statistics data (Public NAS data collection). The Kentucky All Schedule Prescription Electronic Reporting (KASPER) system can provide statistics on the number of controlled substances dispensed to women of childbearing age to help identify potential substance exposure during pregnancy or risk of NAS. Additional data sources can be found below.

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

Prevalence Data:

The U.S. Department of Health & Human Services Children's Bureau "Child Maltreatment 2019" report — released in 2021— shows Kentucky had more than 20,000 abuse cases, meaning about twenty (20) out of every 1,000 children in the commonwealth experienced some type of abuse. By comparison, the second-highest state (West Virginia) had a rate of 18.7 per 1,000 kids. The U.S. average is 8.9. Experts are concerned the COVID-19 pandemic could lead to a spike in child abuse numbers for 2020. The pandemic left families faced with financial, emotional and other stresses — combined with spending long periods of time isolated at home with a lack of structure and support. These stressors can lead to potentially dangerous situations.

In Kentucky, substance abuse has increasingly negative effects on child and family well-being with increased misuse and abuse of prescription pain medications, heroin, and fentanyl along with resurgence of cocaine and methamphetamine, often laced with potent, synthetic opioids. Among young children entering Out Of Home Care (OOHC) in Kentucky, risks to child safety due to substance use are present in more than 76% of families. For children ages three (3) years and younger, nearly 83% of these children had parental substance use as a case characteristic. The increased use of opioids, including heroin, create additional challenges for frontline DCBS staff when providing specialized services for these families. Substance use was a risk factor in approximately 69% of open child abuse and neglect cases, of which 76% resulted in removal of the child from the home.

Ongoing Case Disposition for Reports of Child Abuse and/or Neglect with a Substantiated Finding - SFY 2020	***Substance Abuse Identified as a Case Characteristic****	***Substance Abuse NOT Identified as a Case Characteristic****	***Total***
TOTAL CASES	6649	3050	9699

PERCENTAGE OF TOTAL CASES	68.6%	31.4%	100.0%
ONGOING IN-HOME CASES	4856	2478	7334
PERCENTAGE OF IN-HOME CASES	66.2%	33.8%	100.0%
ONGOING OOHC CASES	1793	572	2365
PERCENTAGE OF OOHC CASES	75.8%	24.2%	100.0%

Case Characteristic indicates it was either indirectly contributing, directly contributing, or risk factor.

With the continued rise of opioid misuse and abuse, there has been an increase in reports of substance-exposed infants. In addition, Kentucky has seen a significant increase in infants hospitalized with Neonatal Abstinence Syndrome (NAS) due to opioid use during pregnancy.

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

- More than 90% of people who used heroin also used at least one other drug (CDC Vital Signs)
- Among new heroin users, approximately 75% report having misused prescription opioids before initiating heroin use.
- Heroin-related emergency department visits and inpatient hospitalizations increased by 66.2% and 101.4%, respectively, from the first quarter of 2020 through the second quarter of 2020 (Kentucky Substance Use Research & Enforcement, 2021).
- Opioid-related deaths among Kentucky residents increased by 62.1% from January 2017 through June 2020 (Kentucky Substance Use Research & Enforcement, 2021).
- Kentucky has the fourth highest opioid prescribing rate in the US at 128 opioid prescriptions for every 100 people (CDC National Prescription Audit 2012)
- In 2019, Kentucky's opioid dispensing rate was 72.3 per 100 persons (CDC, 2020b).
- In 2019, there were 1,102 unduplicated cases of Neonatal Abstinence Syndrome reported to the Kentucky Department for Public Health, which was an increase from 2018 (KCHFS, 2020).

Opioids continue to be the primary contributing factor in drug overdose deaths; however, a growing percentage of drug overdose deaths involve methamphetamine. As an example:

- In 2019, Kentucky ranked eighth in the nation with an overdose death rate of 32.5, compared to the national rate of 21.6 per 100,000 (CDC, 2021);

- In 2019, 84% of drug overdose deaths (unintentional and undetermined intent) in Kentucky involved an opioid drug, with the most frequently reported opioid being illicitly manufactured fentanyl (KIPRC, 2021);

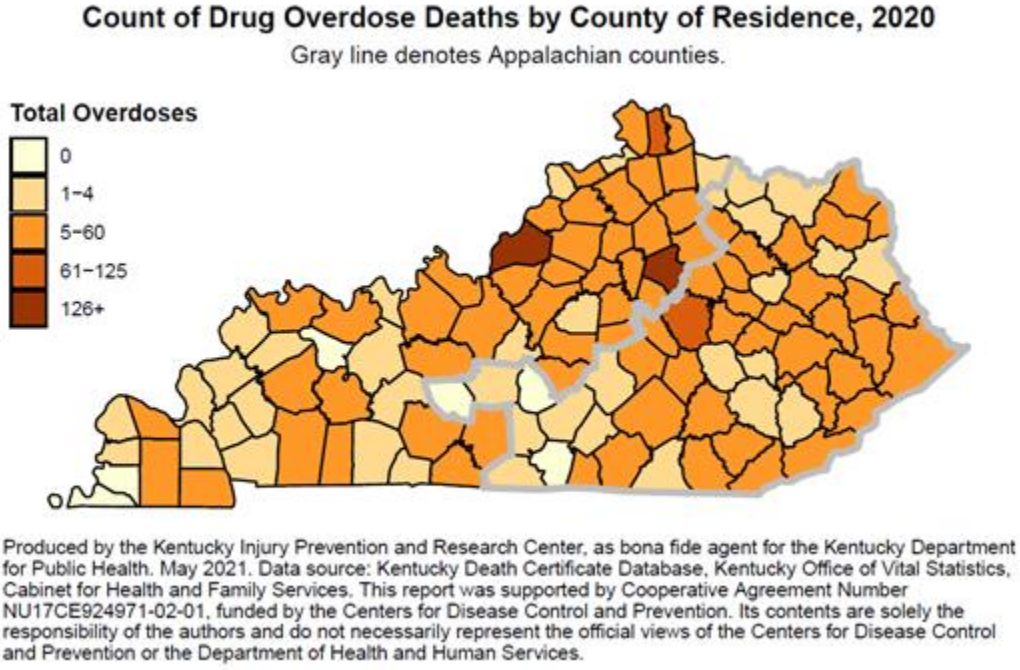
- Overall, there were 1,958 drug overdose deaths among Kentucky residents in 2020. This is an increase of 41.9% from the 1,380 deaths in 2019 in Kentucky (CDC, 2020a; KIPRC, 2021);

- Increases in overdose deaths were driven by the involvement of fentanyl followed by methamphetamine and both drugs in combination (KIPRC, 2021);

- Opioid-related emergency department visits increased by 53.2% from January 2017 through June 2020 and by 75.5% during the first two (2) quarters of 2020, which corresponded with the implementation of public health measures related to the COVID-19 pandemic (Kentucky Substance Use Research & Enforcement, 2021);

- Fentanyl was involved in 759 Kentucky resident overdose deaths in 2019. That accounts for 58 percent of all overdose deaths, up from 47 percent in 2016 (ODCP, 2020); and

- Fentanyl was involved in two-thirds of drug overdose deaths and methamphetamine was involved in more than one-fourth of drug overdose deaths in Kentucky in 2020 (Steel & Liford, 2021).



DBHDID participated in the SAMHSA Policy Academy in 2014 on prescription drug abuse and received 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, Department for Public Health, Office of Drug Control Policy, Medicaid, Office of the Inspector General, as well as Community Partners including Community Mental Health Centers (CMHC), Narcotic Treatment Programs, Veterans of America Freedom House, Chrysalis House and the University of Kentucky (UK) Polk Dalton Clinic.

As a result of the work associated with the Policy Academy, Kentucky applied for and was awarded the SAMHSA Medication-Assisted Treatment Prescription Drug and Opioid Abuse: (MAT-PDOA SMARTS) Grant. With this grant, Kentucky 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 disorder (OUD), through a partnership with two (2) CMHCs. Although the grant funding is no longer available, the model developed through this opportunity created the blueprint for developing comprehensive, coordinated, and collaborative SUD treatment services for parents with dependent children.

Kentucky has expanded Medicaid coverage to all Medicaid recipients. Kentucky's statewide prevention and treatment infrastructure is growing due to that expansion and the inclusion of SUD services. Medicaid services for SUD had historically only been available to pregnant and post-partum women (two (2) months post-delivery), including case management and prevention services. With Medicaid expansion, women with dependent children, fathers, husbands, boyfriends, and significant others can have access to substance use disorder treatment and recovery support services.

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

In SFY 2020 and SFY 2021, The General Assembly allocated funds to the Kentucky Agency for Substance Abuse Policy (KY-ASAP) to support the development and expansion of substance use treatment and recovery support services. As in the previous years, KY-ASAP partnered with the KDBHDID to distribute funds to Community Mental Health Centers through a competitive grant application process.

In SFY 2020, $3.2 million dollars was awarded to twelve (12) Community Mental Health Centers and in SFY 2021, $2.2 million dollars was awarded to nine (9) CMHCs to aid in treatment expansion and services.

Multiple programs that addressed specific needs within each community were supported with these funds. In 2020, a Quick Response Team was established in one (1) CMHC region, seven (7) housing assistance programs were established and five (5) programs to work in the Justice System for reintegration. Funding was provided to increase employment readiness programs as well.

In 2021, several intensive outpatient programs were established, and outreach strategies were implemented. A key focus for 2021 awards went to establish and expand six (6) CMHCs for crisis services and co-occurring disorders. A recovery housing program and a residential pregnant and parenting program were also funded.

Using the evidence-based Oxford House model, Kentucky has increased the capacity of community-based recovery housing that can support parents with dependent children. While greater housing resources are needed, the Commonwealth currently has eleven (11) Oxford Houses that are equipped to provide a stable and supportive living environment for a person in recovery with dependent children. Nine (9) houses for women with dependent children and three (3) houses for men with dependent children have been established across the state. Each home provides space for a parent to reside with their dependent(s) with rules regarding age of the child and supervision.

Kentucky has established the Kentucky Recovery Housing Network (KRHN) to improve the quality and availability of recovery housing in KY. KRHN certifies recovery residences according to the best practice standards of the National Alliance for Recovery Residences (NARR). KRHN evaluates residences across four (4) domains, ten (10) principles, and thirty-one (31) quality standards. Currently KRHN has seven (7), certified residences that serve women with dependent children, with a total of fifty-one (51), certified recovery beds.

The Neonatal Abstinence Syndrome Reporting Registry Annual Report states that in 2019, there were 1,102 cases of babies with signs and symptoms of NAS; this accounts for 20.9 of every 1,000 live births among Kentucky residents. Rates are highest in Appalachian areas of the state, in some areas reaching 55 cases per 1,000 live births. This indicates the rural counties in Kentucky are nearly twice the NAS rate than in urban counties. In comparison, the most recent national estimate for NAS was 7.3 cases per 1,000 live births (HCUP Fast Stats, 2020), placing Kentucky above the National average. The most frequent opioids reported were buprenorphine (65%), heroin (22%), and methadone (11%). Other commonly used substances are amphetamines, including methamphetamine (32%) and cannabinoids (26%). All other substances were used by less than 12% of women in the registry. Approximately 65% of cases were exposed to more than one (1) type of substance during pregnancy; for these cases, the average exposure was three (3) substances. While buprenorphine and methadone can be associated with NAS, they are used as a supervised MOUD and is preferable to untreated OUD during pregnancy. Increased access to MOUD may explain why they are two (2) of the most common substances reported to the NAS registry.

Infants with NAS are twice as likely to have a low birth weight and three (3) times as likely to be admitted to a neonatal intensive care unit. Tobacco use co-occurs with substance use at high rates, which could further affect the health and development of these infants. Infants with NAS had longer delivery hospitalizations: 13.4 days as compared to 3.8 days for infants without NAS. Infants who received pharmacological treatment (44%) had average stays of 19.5 days. Among this group, the most common treatment was morphine (89%), followed by clonidine (35%); about 37% received multiple medications.

In addressing NAS and the issues of families affected by substance use, the DBHDID recommends: continuing to promote prenatal care; promoting enrollment in MOUD programs; implementing a plan of safe care including educating parents and medical/child care providers on safe sleep, abusive head trauma, the effects of substance use on pregnant and parenting families, along with child abuse and neglect; enrollment in services such as WIC, substance use prevention and treatment programs, substance use recovery support services; and improving access to long-acting reversible contraception. Mothers of infants with NAS tend to have less education, be unmarried, and have more children, which may suggest lower socioeconomic status, a lack of social support, and/or reduced access to services. Two (2) very important steps are to identify demographic patterns and addressing social determinants of health to reach these high-risk populations.

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, parenting supports including parenting programs specific to families affected by SUD, supported housing, supported employment, peer support, transportation, and life skills.
- Enhanced communication, collaboration and coordination of services between DCBS, CMHCs and other community partners.
- More training focused on increasing the use of evidence-based practices in treatment programs to ensure the provision of effective and appropriate SUD treatment, particularly for individuals with opioid use disorders.
- Integration with primary care providers to identify, refer, and follow-up individuals at risk of or misusing substances, including pregnant women.

Addressing the Need:

- Continue to enhance the current system of care
- 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 and coordination of services among community partners.
- Increase Universal Screening by medical providers and other referring community partners using Screening, Brief Intervention and Referral to Treatment (SBIRT) principles.
- Enhance childcare and transportation services to increase accessibility.
- Continue to update and enhance FindHelpNowKY.org a web-based treatment locator program
- Provide ongoing education on substance use during pregnancy, NAS, Plans of Safe Care, and Medication for Opioid Use Disorder (MOUD).
- 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 2021/2022 priorities.
- Increase the availability of crisis response including Quick Response Teams (QRT) and mobile response services.

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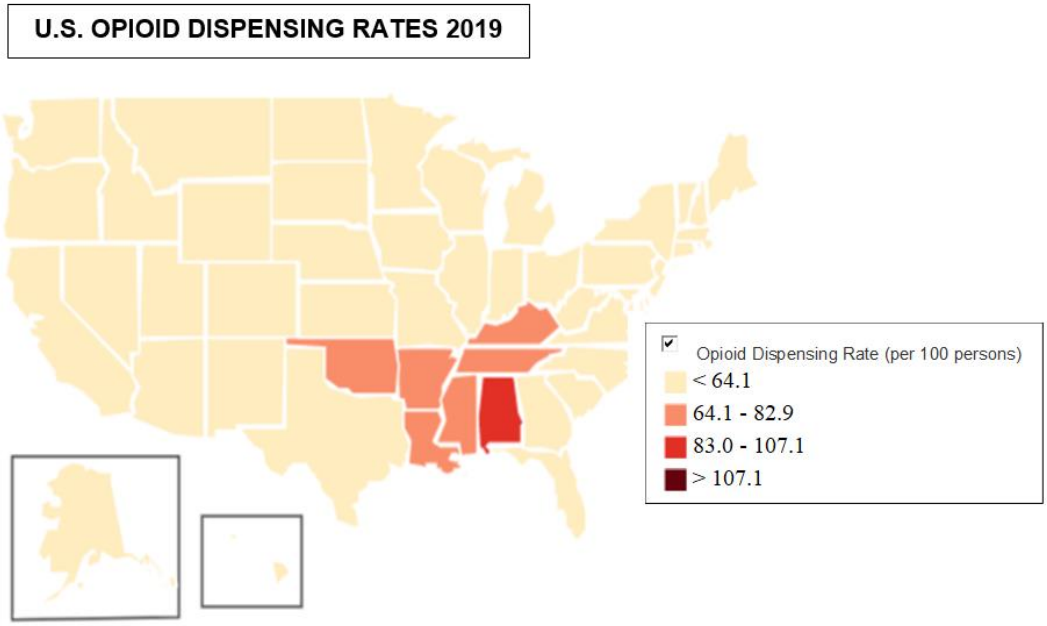
Persons who are Intravenous Drug Users (IDU)

Prevalence Data:

A 2014 Cabinet policy change included an expansion in the types of providers that could be reimbursed for Substance Use Disorder treatment services through the Kentucky Department for Medicaid. The full impact of this policy remains unseen; yet, the DBHDID is noticing a shift in service provision by its contracted CMHCs. Specifically between 2018 and 2020, Kentucky experienced an increase in the number of providers supported by the Department for Medicaid Services for the delivery of services to persons having Substance Use Disorder. The DBHDID data reflects this by showing a decline in the number of persons having Substance Use Disorder served by CMHCs. Specifically between 2018 and 2020, there was a decrease of 0.277% (5,806) in the overall number of persons having Substance Use Disorder that were served by CMHCs. Two (2) important subsets of that include persons served having intravenous drug use and persons having Opioid Use Disorder. Respectively, the percent of persons receiving treatment from CMHCs for intravenous drug use decreased by 9% (1,160) and persons served having Opioid Use Disorder decreased 16% (2,550) over the last three (3) full fiscal years (SFY 2019 – SFY 2020). The Department is attempting to improve its understanding of how policy changes continue to shift the provision of services for Kentuckians seeking state assistance with Substance Use Disorder treatment.

Like other states experiencing an Opioid Use Disorder crisis, the DBHDID has observed and is responding to an increase in the number of Opioid Use Disorder deaths. The Center for Disease Control ranked Kentucky the 5th highest in rate of opioid prescribing; this represents a rate of 72.3 opioid painkiller prescriptions for every 100 people (CDC, 2020e).



NOTE: Starting in 2019, prescriptions were based on the location of the prescriber, rather than the location of the pharmacy. For detailed information about these maps, including data sources, please visit the U.S. Opioid Dispensing Rate Maps page. (www.cdc.gov).

Misuse of prescription opioids is the greatest risk factor for progression to intravenous heroin use (CDC 2015). Persons with an opioid use disorder who use prescription opioids are 40 times more

likely to use heroin (CDC, 2015). Dispensing rates for opioids vary widely across states and counties (CDC, 2020c). Kentucky had the fifth highest rate of opioid prescribing in the US in 2019 at 72.3 opioid painkiller prescriptions for every 100 people (CDC, 2020e). In 2019, 55 Kentucky counties had opioid dispensing rates that were higher than the U.S. average rate of 46.7 prescriptions per 100 persons (CDC, 2020d, 2020e). Opioids continued to drive the increase in drug overdose deaths:

- In 2019, 84% of drug overdose deaths (unintentional and undetermined intent) in Kentucky involved any opioids, with the most frequently reported opioid being illicitly manufactured fentanyl (KIPRC, 2021).
- Kentucky ranked eighth in the nation at 32.5 (age-adjusted) drug overdose deaths per 100,000 in 2019 (CDC, 2021).
- Drug overdose deaths in Kentucky increased by 10.3% from 2016 to 2017 (Akers et al., 2018), but then decreased in 2018, before increasing by approximately 5% in 2019 (Kentucky Office of Drug Control Policy, 2020).
- There was a substantial increase in drug overdose deaths in 2020 in Kentucky (KIPRC, 2021). There were 1,958 drug overdose deaths among Kentucky residents in 2020. This is an increase of 41.9% from the 1,380 deaths in 2019 in Kentucky (CDC, 2020a; KIPRC, 2021)
- Fentanyl was the most frequently detected drug in toxicology testing for overdose deaths in 2019, found in 58% of overdose deaths. Acetyl fentanyl was detected in approximately 32% of all overdose deaths for the year (Kentucky Office of Drug Control Policy, 2020).
- Heroin-related emergency department visits and inpatient hospitalizations increased by 66.2% and 101.4%, respectively, from the first quarter of 2020 through the second quarter of 2020 (Kentucky Substance Use Research & Enforcement, 2021).

Unmet Needs and Critical Service Gaps:
Although Medications for Opioid Use Disorder (MOUD) services are more widely available across the state, there remains resistance and stigma in many communities, to the use of medications to treat substance use disorder, limited some client's access to person-centered services and a complete continuum of care.

With the number of individuals experiencing overdose due to opioid use, there is a need to provide immediate interventions that connect clients to SUD services.

Even with Medicaid expansion and an enhanced network of behavioral health providers in the state, Kentucky remains a mostly rural and mountainous state, with many of the available 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.

With the enhanced network of Medicaid providers for behavioral healthcare, data collection regarding these individuals continues to be a challenge.

Addressing the Need:
DBHDID will continue to ensure that all CMHCs screen for IV drug use on initial contact and refer clients to appropriate services. In addition, DBHDID will continue to work collaboratively with the Department for Public Health, and other advocacy groups and recovery organizations to increase the number of Syringe Exchange Programs (DBHDID will not use block grant funds to purchase syringes or for actual syringe exchange programs) and harm reduction efforts statewide. In

addition, DBHDID will work to enhance peer support access to these individuals as well as evidence-based OUD services, including MOUD.

In response to the business model changes occurring across Kentucky Medicaid providers, the DBHDID has progressively pursued additional grant awards that support the provision of services through the CMHCs as well as non-CMHC providers. Specifically, Kentucky pursued and was awarded grant funding intended to address the Opioid Use Disorder crisis. The DBHDID has observed and is responding to an increase in the number of Opioid Use Disorder deaths. With the newly dedicated funding, DBHDID had an initial focus to establish mechanisms to distribute funding to CMHC and non-CMHC providers of Opioid Use Disorder treatment services across the state. That work continues, and in addition, DBHDID will explore how best to coordinate the data collected from newer, non-CMHC partners with the data collected from CMHCs. DBHDID will continue its progressive efforts to address the Opioid Use Disorder crisis and better understand the full impact of funding additional providers.

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

Prevalence data:
In 2018, preliminary data on HIV diagnoses showed that of the 364 cases identified, 19.2% occurred among persons who inject drugs (Kentucky Budget Review Subcommittee on Human Resources, 2019). Of the 220 counties across the US identified as highly vulnerable to an HIV outbreak, 54 (24.5%) are in Kentucky (Kentucky Budget Review Subcommittee on Human Resources, 2019).

Hepatitis C (HCV)

Kentucky has relatively low rates of HIV/AIDS, but a much higher rate of Hepatitis C. Kentucky is one of four (4) states with high-rates of confirmed acute Hepatitis C from 2005 – 2018. In 2018, Kentucky had the second highest rate at 4.6 per 100,000, after West Virginia (Kentucky Budget Review Subcommittee on Human Resources, 2019). The rate for Hepatitis C in Kentucky in 2017 was 1.9 per 100,000 (CDC, 2020b). Based on the 2013-2016 annual average, there were an estimated 42,500 persons living with HCV in Kentucky, which is a rate of 1,270 (HepVu, n.d.).

The estimated prevalence of hepatitis C (HCV) among people who inject drugs is 67%, and only about half of persons who inject drugs know their HCV status (Kentucky Budget Review Subcommittee on Human Resources, 2019). Applying these percentages to the Kentucky population, it is estimated that about 77,850 persons who inject drugs have HCV (Kentucky Budget Review Subcommittee on Human Resources, 2019). Approximately 73% of young adults with hepatitis C report injection drug use as their principal risk factor.

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, and is mandated by state law to document and maintain the HIV/AIDS case reports data. The HIV/AIDS Program's primary goals is to promote the prevention of HIV transmission and associated morbidity and mortality. The programs works to accomplish this goal by ensuring that HIV/AIDS surveillance is 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:
DBH continues to assess for adherence, both contractually and regulatory mandates through the comprehensive, onsite reviews that are conducted biannually 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 will continue to work collaboratively with the department for Public Health to maintain the most current data on Kentucky's rates of newly diagnosed cases of HIV/AIDS so the most appropriate services may be coordinated. Kentucky recognizes that there

is a need to also address Hepatitis C more intensively in substance use services as well as increasing education about Hepatitis A and B.

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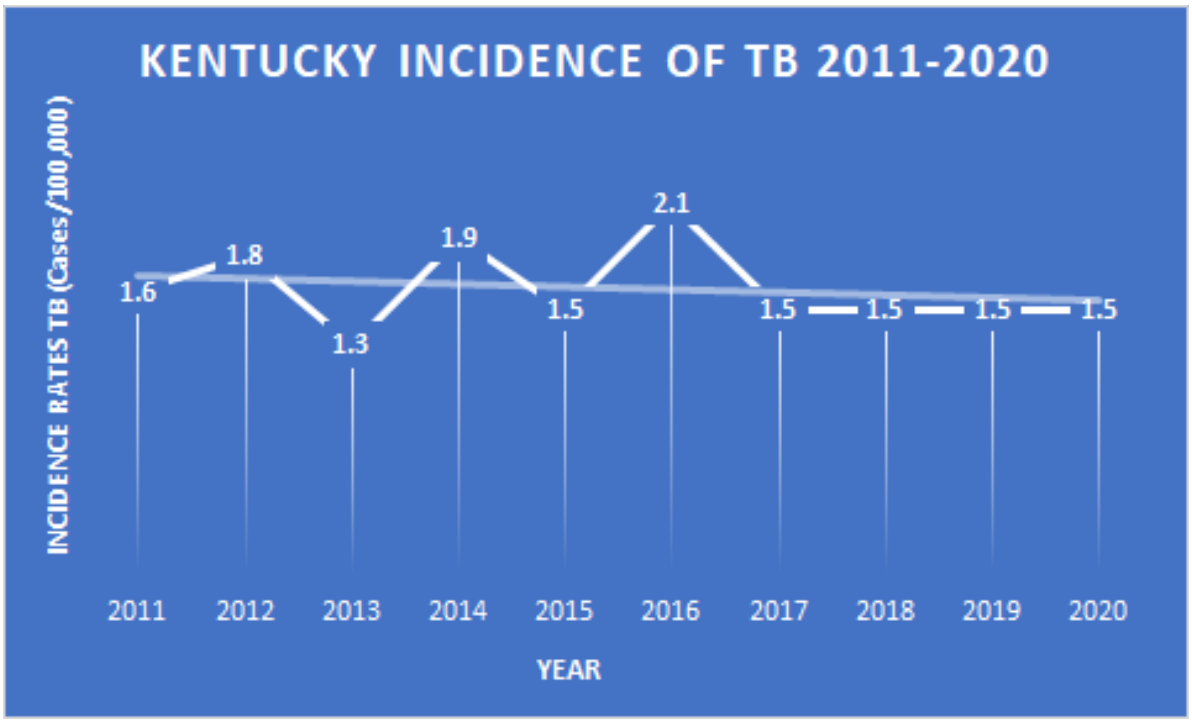
Individuals with Tuberculosis

Prevalence Rate:

Overall, rates of TB have been declining in the U.S. since 1993. Kentucky is considered a low-incidence state for TB, ranking 36th out of the 50 U.S. states, per the Centers for Disease Control & Prevention (CDC). As reported by the Kentucky Department for Public Health (DPH), a total of sixty-seven (67) cases of TB were reported statewide for 2020, which is a rate of 1.5 per 100,000 (population estimated at 4,471,710). This is below the national incidence rate for the U.S. in 2020 of 2.2 per 100,000 (population estimated at 328,239,523). Kentucky has seen a nearly continual reduction of cases of TB since 2000, when the rate was 3.7 per 100,000. Within the last 10 years, incidence rates of TB have remained relatively stable with slight spikes in 2012 (incidence rate of 1.8 per 100,000), 2014 (incidence rate of 1.9 per 100,000), and 2016 (incidence rate of 2.1 per 100,000). See Figure 1. However, despite the relatively low rates of TB in Kentucky, CDC advises that persons with weakened immune systems are at a higher risk of TB. This includes individuals experiencing Substance Use Disorders (SUDs). Kentucky ranks among the highest U.S. states for prevalence of substance misuse.

Figure 1.



Information obtained from the Kentucky Dept. Of Public Health - https://chfs.ky.gov/agencies/dph/dehp/idb/Pages/tbdata.aspx

Unmet Needs and Critical Service Gaps:

The Kentucky Tuberculosis (TB) Control Program is operated through the Cabinet for Health and Family Services (CHFS), 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. DBH 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.

Addressing the Need:

DBHDID works with the Community Mental Health Centers (CMHCs) to ensure that individuals who receive SUD services and have, or are at risk for TB, are screened appropriately and receive needed services. Strategies to attain this objective include continuing partnerships with DPH and the CMHCs to improve data collection, definitions and screening protocol for TB, ensuring that CMHCs are systematically screening for TB among individuals receiving services for SUD, and

offering CMHCs technical assistance in updating and improving their policies and procedures regarding TB screening and referral.

The Division of Behavioral Health (DBH) continues to assess for adherence to both contractual and regulatory mandates, and monitors the Community Mental Health Centers (CMHC) policies and procedures annually and at the licensed Opioid Treatment Programs (OTP) recertification reviews. 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.

DBH requires that all CMHCs submit their written policies and protocols detailing the process for screening and referral for all individuals seeking services for substance use disorders. To continue to enhance this process, CMHC's will begin submitting their specific written procedures, training processes, and training curriculum to the Department as part of the yearly reporting process. These written procedures will include the CMHC's training curriculum designed to ensure staff receive adequate instruction on effective and consistent implementation of the CMHC's TB protocols.

Data Sources Used:
Kentucky Department for Public Heath, Tuberculosis (TB) Prevention and Control Program - Cabinet for Health and Family Services (ky.gov), https://chfs.ky.gov/agencies/dph/dehp/idb/Pages/tuberculosis.aspx.

Kentucky Department for Public Health, Tuberculosis Data, https://chfs.ky.gov/agencies/dph/dehp/idb/Pages/tbdata.aspx.

Centers for Disease Control & Prevention, Tuberculosis, Reported Tuberculosis in the United States, 2019 , Table 28. Tuberculosis Cases and Case Rates per 100,000 Population: Reporting Areas, 2019 and 2018, *https://www.cdc.gov/tb/statistics/reports/2019/table28.htm*
Centers for Disease Control & Prevention, Tuberculosis, Basic TB Facts, Risk Factors, https://www.cdc.gov/tb/topic/basics/risk.htm

Deutsch-Feldman, M., Pratt, R.H., Price, S.F, Tsang, C.A., Self, J.L. Tuberculosis — United States, 2020. MMWR Morbidity & Mortality Weekly Report 2021; 70(12):,

https://www.cdc.gov/mmwr/volumes/70/wr/pdfs/mm7012a1-H.pdf

733939C239FD/0/AnnualReport_2021.pdf

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

Prevalence Data/Unmet Needs and Service Gaps:
Kentucky specific data reveal that among high school students:

- Approximately 28% report currently smoking cigarettes or cigars or using smokeless tobacco or electronic vapor products. (Youth Risk Behavior Surveillance (YRBS), 2019)
- 10% report binge drinking in the past month. (YRBS, 2019).
- 16% report using marijuana in the past month (YRBS, 2019)

- 11% report ever using taken prescription pain medicine without a doctor's prescription or differently than prescribed and 2% report ever using heroin

Further, among middle school students:

- 31% report ever using an electronic vapor product with 17% having used in the last 30 days
- 23% report ever using alcohol (12% prior to age 11)
- 10% report ever using marijuana

It is important to note that opioids have now become one of the most lethal and preferred drug for many individuals across the nation and Kentucky. Although alcohol, marijuana, and tobacco are still the top three drugs used by adolescents, results from the 2019 YRBS show that 2.1% of Kentucky high school students has tried heroin; 11% of high school and 9% of middle students has taken prescription pain medicine without a prescription or differently than prescribed, and among high school students 2% report ever using heroin and 2% has ever injected an illegal drug.

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.

Nationally, the CDC estimates a 30 percent increase in drug overdose deaths from October 2019 to October 2020. In contrast, the CDC estimates a 53.1 percent increase in drug overdose deaths in Kentucky. In 2018, Kentucky saw the first drop in overdose deaths in nearly a decade. In 2019, a slow increase was observed beginning in October 2019. However, overdoses in Kentucky increased at a rapid rate beginning in mid-March and peaking in April and May 2020 (Kentucky Injury Prevention and Research Center (KIPRC), 2020). Fatal and non-fatal overdoses remain significantly elevated over pre-pandemic levels as of June 2021. In 2019, 5% of drug overdoses occurred in individuals age 15 -24 (3% male). This percentage increased to at least 6% in 2020.

The Kentucky Opioid Response Effort (KORE), funded through SAMHSA State Opioid Response grant, is implementing a comprehensive targeted response to Kentucky's opioid crisis by expanding access to a full continuum of high quality, evidence-based opioid prevention, treatment, and recovery supports. It is also important to note that Kentucky has earmarked KORE funds for transition age youth and adolescent prevention, treatment, and recovery programming. This is indicative of transformation in thinking and leadership support for adolescent treatment services in the state.

Results of the 2018-2019 National Survey on Drug Use and Health (NSDUH) reveal further distressing statistics for Kentucky's youth. As noted in Table 1, both cigarette smoking and use of tobacco products by Kentucky's adolescents remains significantly higher than the national average. In addition, while similar to national percentages, the majority of young people who experienced a major depressive episode within the last year increased.

Table 1: 2018-2019 National Survey on Drug Use and Health - Kentucky vs. US		
ITEM	12- 17 KY	12-17 US
Past Month Marijuana Use	6.2%	7.0%
Past Month Alcohol Use	9.6%	9.1%
Past Month Cigarette Use	4.7%	2.5%
Past Month Tobacco Product Use	7.0%	4.0%

Had at least one major depressive episode (MDE) in the past year	15.2%	15.1%

When considered with the YRBS data, the NSDUH data illustrate the continued need for intervention at earlier ages and the urgent need for treatment and recovery supports for adolescents and transition-age youth.

The Kentucky Incentives for Prevention (KIP, 2018) survey, a school-administered survey that assesses the extent of alcohol, drug, and tobacco use among 11 to 18 year olds throughout Kentucky added questions about military connectedness. This is an attempt to determine whether the substance use prevention, treatment, and recovery needs of military-connected youth are different than for youth who are not in military-connected families. 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. Tenth 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. Recognizing the needs of this special population, the Kentucky Youth Treatment initiative includes military personnel of transition age and military-connected youth as special populations of focus

Table 2. Prevalence of Prescription Drug Use and Mental Health Correlates among 10th Graders from Military-Connected Families (KIP, 2018) *no update as KIP not administered in 2020 due to pandemic*

Family Member on Active Duty or Veteran			
	No/Don't Know N (%)	Yes, Exactly 1 N (%)	Yes, More than 1 N (%)
30-Day Prescription Drug Use			
Any prescription	384 (2.2)	129 (2.6)	229 (3.4)
Opioids	431 (2.5)	143 (2.8)	262 (3.9)
Tranquilizers	228 (1.3)	66 (1.3)	129 (1.9)
Stimulants	227 (1.3)	75 (1.5)	120 (1.8)
Any of above	705 (4.1)	232 (4.7)	392 (5.9)
Mental Health			
Serious Psychological Distress (past 30 days)	3,658 (20.6)	1,188 (23.3)	1,754 (25.4)
Self-harm (ever in lifetime)	3,122 (17.7)	1,073 (21.1)	1,578 (23.0)
Suicide ideation (past year)	2,541 (14.1)	897 (17.3)	1,291 (18.5)
Suicide plan (past year)	1,943 (10.8)	706 (13.6)	1,045 (15.0)
Suicide attempt (past year)	1,309 (7.3)	483 (9.3)	719 (10.3)

Starting with a system of care Children's Mental Health Initiative (CMHI) grant in 2004, Kentucky began a steady track to building an infrastructure for agencies and communities to support youth who are struggling with substance use issues. Funding for services and provision of quality services for youth has been a focus of the state. DBH has a full-time position for a 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. Beginning in state fiscal year 2022, DBHDID is supporting a full-time Youth Substance Use Treatment Coordinator staff position within each of the Community Mental Health Centers. The coordinator will be located within the CMHC's children's services division and shall serve as the regional subject matter expert in youth substance use and co-occurring substance use and mental health disorder treatment. The coordinator shall collaborate and coordinate with other CMHC programs that have contact with individuals (children, adolescents, and adults) with or at-risk of developing SUD, youth, and families. This position was created in response to information from CMHCs that they were not receiving referrals for youth with substance use issues and that there is a general lack of knowledge in communities regarding how to identify, screen for, and refer youth with substance use issues as well as a lack of awareness of what services and supports are available for these young people. The coordinator is charged with providing community education and outreach. During SFY 22, they will conduct a needs assessment related to youth substance use services and use it to create a training and outreach plan. The coordinator will also keep an inventory of clinicians within their agency that are trained to serve youth with substance use disorders. Results from a recent survey of CMHC children's directors and substance use directors show that across the fourteen (14) CMHCs, there is a total of 541 clinicians who are trained to and routinely serve youth with substance use disorders; thus provider capacity in serving the population is not an issue. This further supports the need for community education and engagement around identifying, screening, and appropriately referring youth with substance use issues.

Adolescent substance use services are eligible for state block grant dollars. However, Kentucky allocates the majority of these funds to adult SUD providers, with very little being earmarked for adolescents. Likewise, Early and Periodic Screening Diagnostic and Treatment (EPSDT) has been available to pay for residential SUD services for eligible youth, but this has been difficult to access. With a Medicaid state plan change in January of 2014 and the implementation of the Affordable Care Act, Kentucky's Medicaid services expanded to cover substance use treatment for eligible recipients of all ages, thereby allowing youth to obtain substance use treatment services without having to utilize EPSDT, thus making it easier for youth and their families to obtain substance use treatment services and supports. In addition to adding covered services, the changes to Kentucky Medicaid opened the Medicaid behavioral health provider network, making a wider variety of geographically accessible treatment options available. The above changes coupled with Kentucky having been the recipient of several SAMHSA/CSAT grants focused on adolescents and young adults, have enabled Kentucky to build services as well as improve the quality of those services available for youth in the Commonwealth. Finally, Kentucky has leveraged funding from other sources such as pharmaceutical settlement awards and SAMHSA State Opioid Response funding to continue to enhance the availability of and access to high quality substance use treatment services for adolescents while waiting for a set aside of Federal Block Grant dollars specifically for adolescent treatment services .

As funds specific to adolescent substance use treatment have become available, Kentucky has made great strides in promoting evidence-based practices (EBPs) by offering intensive learning collaboratives, resulting in the availability of clinicians trained in evidence-based services for adolescent substance use treatment across the state in various treatment milieus with both public and private providers. In addition to these learning collaboratives, statewide training has been

provided to behavioral health clinicians and other youth-serving staff 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 an adolescent track at the Kentucky School for Alcohol and Drug Studies. Clinicians and other youth-serving staff have been offered training opportunities in the following EBPs : Adolescent Community Reinforcement Approach, Motivational Interviewing, Seven Challenges, and Functional Family Therapy, as well as general adolescent provider competency-building such as group skills, gender-specific treatment, and brain development.

A comprehensive array of services for youth with substance use disorders is now available to varying degrees across Kentucky. 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 provide services for adolescents. Kentucky has recently updated their Alcohol and Other Drug Entity Licensing that now includes adolescent specific language, Kentucky to not only provide a more comprehensive array of behavioral health services and supports for children and youth that adhere to the system of care values and principles but also allows the SUD services to be more supportive of adolescent specific developmental treatment needs.

With support of several SAMHSA adolescent SUD grants, Kentucky has expanded access to developmentally appropriate, evidence-based assessment, treatment, and recovery support services for adolescents and transition-age youth. Most recently, between FFY16-19, Kentucky used funds from a SAMHSA State Adolescent Treatment – Implementation (SYT-I) for infrastructure improvement by training adolescent-specific clinical staff in the use of the Adolescent Community Reinforcement Approach and other evidence based practices. Using evidence based practices with fidelity allows for not only improved access to high quality services but also improved 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.

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. Data continue to reveal low numbers of youth who have a diagnosed substance use disorder and providers across the state express concerns that they have seen a decrease in youth and family seeking services as well as referrals for youth substance use assessment and treatment from agencies such as education, justice, and the courts. The lack of parental awareness and community partner referrals has decreased causing a gap in services for youth at a young age. There is a concern that youth then resurface at an older age with more serious SUD and SUD related issues, yet there is not yet data to support this theory, as this is a new phenomenon.

Infrastructure Needs and Plans to Address:

Through grant-supported training and collaborative efforts with agencies across the Commonwealth, many providers and social service agencies have been trained to screen for youth substance use issues. Unfortunately, the practice has not sustained over time and with staff turnover, is not standardized across the state. Continued work is needed to drive the implementation of a continuum of evidence-based screening, referral, assessment, and planning processes that support communication of results and recommendations across agencies so that youth, families, and providers have access to the most accurate information to inform treatment planning. It is hoped that current efforts related to such a process within the child welfare system will serve as a model for other populations of children, youth, and families.

Kentucky has been able to address and support evidence-based treatment and assessment, however, fidelity of implementation continues to be a struggle, especially due to staff movement and turnover rate. Moreover, there is a tendency for staff to be trained in but not continue the use of practices or implement with fidelity to the model. Kentucky is working to continue to support infrastructure in using evidence-based screening, assessment, and treatment by offering training in evidence-based practices that include of both coaching and fidelity monitoring, as well as train the trainer options so that the infrastructure maintains its strength. DBHDID will continue to provide specific training and coaching on the identification, diagnosis, and treatment for adolescents with substance use and co-occurring disorders to CMHC clinicians as well as to other adolescent substance abuse providers.

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). Youth Risk Behavior Surveillance. Available at http://www.cdc.gov/HealthyYouth/yrbs/index.htm
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- Substance Abuse and Mental Health Services Administration. National Survey on Drug Use and Health (NSDUH). Available at https://nsduhweb.rti.org/
- Kentucky Injury Prevention and Research Center https://kiprc.uky.edu/sites/default/files/2021-06/Unintentional%20and%20Undetermined%20Intent%20Drug%20Overdose%20Deaths%20in%20Ky%202019.pdf Slavova, Rock, Bush, Quesinberry, & Walsh, 2020. Signal of increased opioid overdose during COVID-19 from emergency medical services data. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7351024/

- [i] Center for Behavioral Health Statistics and Quality. (2020). *Results from the 2019 National Survey on Drug Use and Health: Detailed tables.* (Tables 1.23A and 1.24A). Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/
- [ii] Center for Behavioral Health Statistics and Quality. (2020). *Results from the 2019 National Survey on Drug Use and Health: Detailed tables*. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data.
- [iii] Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 2018-2019 on CDC WONDER Online Database, released in 2020. Data are from the Multiple Cause of Death Files, 2018-2019, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/mcd-icd10-expanded.html on Jul 2, 2021, 10:09:13 AM.

- [iv] Kentucky Cabinet for Health and Family Services (CHFS). (2020). *Neonatal Abstinence Syndrome in Kentucky: Annual Report on 2019 Public Health Neonatal Abstinence Syndrome (NAS) Reporting Registry*. Retrieved from https://chfs.ky.gov/agencies/dph/dmch/Documents/NASReport.pdf.
- Svetla Slavova, PHD;Dana Quesinberry, DRPH; Sarah Hargrove, MS; Peter Rock, MPH;Candace Brancto, MS; Patricia R Freeman, PHD; Sharon L. Walsh, PHD; JAMA Network Open , Trends in Drug Overdose Mortality Rates in Kentucky, 2019-2020.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Adults with SMI

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Maintain a rate of 8% or less of psychiatric hospital discharges to a personal care home where the admission living arrangement was not personal care home

Strategies to attain the goal:

The electronic medical records system utilized by state-operated/contracted psychiatric hospitals collects living arrangement at admission and discharge.
Maintain collaborative partnerships between the state-operated/contracted psychiatric hospitals and the CMHCs to facilitate referrals to community services.
Maintain contracts with CMHCs to provide evidence-based practices that assist individuals with SMI to live in the community: Assertive Community Treatment, Permanent Supportive Housing, Supported Employment and Peer Support services.
Provide training, technical assistance and fidelity monitoring to ensure most effective implementation of these evidence-based practices.
Provide technical assistance to the state-operated/contracted psychiatric hospitals and the CMHCs to address barriers to community placement.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Adults discharged from a state-operated/contracted psychiatric hospital to a personal care home where the admission living arrangement was not personal care home.

Baseline Measurement: The SFY 2020 percentage of adults discharged from a state-operated/contracted psychiatric hospital to a personal care home where the admission living arrangement was not personal care home was at 5% = 267/5,278.

First-year target/outcome measurement: By the end of SFY 2022, the percentage of adults discharged from a state-operated/contracted psychiatric hospital to a personal care home where the admission living arrangement was not personal care home will be maintained as less than 8%. This number will be calculated annually.

Second-year target/outcome measurement: By the end of SFY 2023, the percentage of adults discharged from a state-operated/contracted psychiatric hospital to a personal care home where the admission living arrangement was not personal care home will be maintained as less than 8%. This number will be calculated annually.

Data Source:

DBHDID Facility Data Set

Description of Data:

Data report to show per State Fiscal Year (SFY): Report ID: COC_10-DC-LA_Not_From_PCH
The total number of percentage of adults discharged from a state-operated psychiatric hospital to a personal care home where the admission living arrangement was not personal care home.
The report is based on SFY (July 1 - June 30). This report is updated monthly.
This report includes data for Central State Hospital, Western State Hospital, and Eastern State Hospital.

Data issues/caveats that affect outcome measures:

The electronic medical record system is the source of data. Technical issues that are unique to each facility's system sometimes occur. Troubleshooting technical issues with this system as they arise involves a third party vendor and a third party data management contract. In addition, this rate would be impacted if a significant or unusual change occurred to the total number of adults discharged

in any single year..
It is expected that adults needing the levels of care described in this indicator are experiencing SMI. However, the specific data sets for both state-operated/contracted psychiatric hospitals and personal care homes are not required to have a specific SMI market. Personal care home admissions are required to have a diagnosis of mental illness that is expected to last at least two (2) years, and individuals must need assistance with daily living/personal care functioning.

Priority #: 2

Priority Area: Early Serious Mental Illness/First Episode 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 psychosis (FEP).

Strategies to attain the goal:

Provide training and technical assistance to all outpatient sites funded to provide Coordinated Specialty Care (CSC) to this population.
Utilize consultation from national experts in the field.
Convene biannual meetings with all key contacts from CMHCs, regarding this population, to provide technical assistance/education regarding CSC and the ESMI/FEP population.
Embed rapid access measures and rationale into CMHC contract deliverables for CSC outpatient funded sites.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Young people will have access to available prescriber appointments within seven (7) days of admission into one of the eight (8) CSC programs. Young people served in CSC programs are not required to see a prescriber, but may choose to see a team prescriber, even if they do not wish to take medication. However, for ALL who choose to see a prescriber, rapid access is essential. Rapid access to care, including evidence-based medication management/education is a large part of the evidence base for CSC.

Baseline Measurement: As of the third quarter of SFY 2021, eight (8) CSC funded programs had team prescribers identified to see young people upon admission into CSC programming. There were 54 new young people admitted into CSC programs, 35 of those new admissions saw the team prescriber within 7 days upon admission, resulting in a statewide total of 65% of new admissions into CSC programs seeing team prescribers within 7 days of admission.

First-year target/outcome measurement: By the end of SFY 2022, the statewide total of new admissions into CSC programs seeing team prescribers within 7 days of admission will be 70 % of all new admissions who choose to see team prescribers.

Second-year target/outcome measurement: By the end of SFY 2023, the statewide total of new admissions into CSC programs seeing team prescribers within 7 days of admission will be 75% of all new admissions who choose to see team prescribers.

Data Source:

Department Periodic Report (DPR) form 113H/CMHC Contract Reporting Requirement. Additional CSC site level data as needed.

Description of Data:

DPR Form 113H. All CMHC CSC sites submit this form on a quarterly basis. Data are collected from this form regarding prescriber access, in addition to all new admissions.

Data issues/caveats that affect outcome measures:

It is best practice for all young people experiencing early signs of psychosis is to see a prescriber for education and consultation regardless whether they take medications. However, many young people choose to not see the prescriber. This indicator is intended to honor the choice of young people, so that choice will be taken into account as we calculate access rates.

Priority #: 3

Priority Area: Children with SED

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Increase access to evidence-based practices for children/youth with SED

Strategies to attain the goal:

CMHCs with Transition Age Youth specialized programming are required by contract to have peer support services available to children/youth being served.
Provide training and technical assistance to ensure that CMHCs understand how to recruit, retain, and support Youth and Family Peer Support Specialists in the workplace and how to appropriately document and bill for services.
Provide awareness activities and training regarding resiliency and recovery principles and guidance in the process of fully including Peer Support Specialists in the service delivery array.
Provide training and technical assistance regarding the supervision of Peer Support Specialists.
Provide 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 young people up to age 26, including those with SED.

Baseline Measurement: Total number of young people up to age 26 who received Youth or Family Peer Support (individual or group) during SFY 2020 was 1,416.

First-year target/outcome measurement: Increase by .25% the total number of young people up to age 26 who receive Youth or Family Peer Support services, from the CMHCs, during SFY 2022. At the end of SFY 2022, 1,420 young people should have received Youth or Family Peer Support services.

Second-year target/outcome measurement: Increase by .25% the total number of young people up to age 26 who receive Youth or Family Peer Support services, from the CMHCs, during SFY 2023. At the end of SFY 2023, 1,424 young people should have received Youth or Family Peer Support services.

Data Source:

DBHDID Client/Event Data Set

Description of Data:

Data report to show the total number of young people up to age 26 served by the CMHCs, who received Youth or Family Peer Support (individual or group peer support services). Report from AMART using the following filters: All MH served, statewide, in-region/out-of-region, status 1, 2, & 3, ages 1 through 25, units of service client count, service codes 147,148,149,150.

Data issues/caveats that affect outcome measures:

Due to the data intricacies involved in capturing all young people up to age 26 who are served with Peer Support services, this indicator will utilize reports of All MH served for measurement, which will include All SED children served, but will also include young people in the transition age youth category.

Priority #: 4

Priority Area: Primary Prevention

Priority Type: SAP

Population(s): PP

Goal of the priority area:

Reduce alcohol use and electronic cigarettes use among 10th graders in Kentucky.

Strategies to attain the goal:

1.1.1.- Educate youth, parents and educators about the harmful effects of electronic cigarette use.

1.1.2 - Provide training and technical assistance to schools and community organizations to update school and community smoke-free policies to address electronic cigarettes use.
1.1.3.- Conduct Reward/Remind type activities with retailers related to sale of electronic cigarettes to minors.
1.1.4 - Provide training and technical assistance to schools to support and enhance early prevention screening and assessment of adolescents.
1.2.1 - Education parents about "host parties" and the negative psychological effects of alcohol consumption by adolescents.
1.2.2.- Provide training and technical assistance to community coalitions to expand Social Host Ordinances implementation and enforcement.
1.2.3 - Implement and expand the "Keep a Lid on It" strategy to reduce youth access to alcohol-to-go-sales.
1.1.4 - Provide training and technical assistance to school to support and enhance early prevention screening and assessment of adolescents.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of 10th graders, who participate in the KIP survey who report "great risk" or "moderate risk" in use of e-cigarettes "some days but not every day?".

Baseline Measurement: 2018 KIP survey results indicate that 42.8% of 10th graders, who participate in the KIP survey reported that using electronic cigarettes on a regular basis had moderate to great risk. During SFY 2020, 4,905 Kentucky residents, under the age of 21, received prevention services targeting tobacco use.

First-year target/outcome measurement: The first year measure is a process measure based on total number of activities that address electronic cigarette use among youth as measured by data entered into the Prevention Data System (based on the 2018 KIP data analysis). First year measure for the block grant is to increase by 3% (to 5,052) the number of Kentucky residents, under the age of 21, who receive prevention services targeting tobacco use.

Second-year target/outcome measurement: Increase by 2% the percentage of 10th graders, who participate in the 2023 KIP Survey, who report use of electronic cigarettes on a regular basis as "moderate' to "great risk". (44.8%)

Data Source:

Kentucky Incentives for Prevention (KIP) Survey: Kentucky's Prevention Data System

Description of Data:

The KIP Survey provides information about student perceptions about the health dangers of electronic cigarettes and perceived accessibility of electronic cigarettes in the community. the 2018 survey included the addition of several new questions related to electronic cigarettes. 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, conducted every other year, in 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 use. In 2018, over 128,000 students representing 159 school districts (of the state's 173) completed the survey, and the information gathered provided an invaluable substance abuse prevention tool for these communities. Districts utilize their KIP results extensively for grand-writing purposes, prevention activities, and various other needs related to program planning.
The Prevention Data System is Kentucky's reporting system for activities delivered by primary prevention providers. Providers are required by contract to enter the activities that they have delivered in their communities within 30 days of the end date of the activity. the cloud-based system provides data for various SAMHSA Block Grant reporting requirements related to primary prevention.

Data issues/caveats that affect outcome measures:

The KIP Survey is conducted biannually, with the next iteration scheduled to occur in the fall of 2021. (the 2020 KIP survey did not occur due to the pandemic). Data is available approximately 6 months post administration.

Indicator #: 2

Indicator: Number of 10th graders, who participate in the KIP survey, who report past 30-day use of alcoholic beverages.

Baseline Measurement: 2018 KIP survey results indicate 16.8% of 10th graders answered that they consumed alcohol, on at least 1 occasion, in the past 30 days. SFY 2020 data reports 4,688 youth, under the age of 19, received prevention services targeting underage drinking.

First-year target/outcome measurement: The first year measure is a process measure based on the total number of activities that address underage drinking use among youth as measured by data entered into the Prevention Data System (based on the 2018 KIP data analysis). First-year measure for the block grant will increase by 3% (to 6,149) the number of youth, under the age of 19,

receiving prevention services targeting underage drinking.

Second-year target/outcome measurement: Decrease by 1% (to 16.5), the number of 10th graders that report having consumed alcohol on at least 1 occasion, in the past 30 days.

Data Source:

Kentucky Incentives for Prevention (KIP) Survey; Kentucky's Prevention Data System

Description of Data:

The KIP survey, conducted every other year, 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 use. In 2018, over 128,000 students representing 159 school districts (of the state's 173) completed the survey, and the information gathered provided an invaluable substance abuse prevention tool for these communities. Districts utilize their KIP results extensively for grant-writing purposes, prevention activities, and various other needs related to program planning.
The Prevention Data System if Kentucky's reporting system for activities delivered by primary prevention providers. Providers are required by contract to enter the activities that they have delivered in their communities within 30 days of the end data of the activity. The cloud-based system provides data for various SAMHSA Block Grant reporting requirement related to primary prevention.

Data issues/caveats that affect outcome measures:

The KIP Survey is conducted biannually, with the next iteration scheduled to occur in the fall of 2021 (the 2020 KIP Survey did not occur due to the pandemic). Data is available approximately 6 months post administration.

Priority #: 5

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

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Simultaneously protect infants who are affected by prenatal substance use and support mothers and families in their capacity to provide care for infants following birth/hospital discharges.

Strategies to attain the goal:

Identify services and supports to be provided to the mother and infant, and delineate who is responsible for ensuring that the mother is aware of, and accesses needed services and supports.
Recognize the important role of trauma and adverse childhood experiences in this population.
Stabilize the mother in the post-partum period and provide ongoing supports for positive parenting and a safe home environment for the infant.
Create opportunities to reduce adverse childhood experiences for the infant, thereby improving long-term outcomes, and reducing the risks of repeating the cycle of substance use as they grow into their teenage years.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Plan of Safe Care (POSC) implmentation

Baseline Measurement: As of the end of SFY 2021, there are seven (7) POSC sites to serve PWWDC with SUDs.

First-year target/outcome measurement: At the end of SFY 2022, one (1) additional Community Mental Health Center (CMHC) will become a POSC site.

Second-year target/outcome measurement: At the end of SFY 2023, one (1) additional Community Mental Health Center (CMHC) will become a POSC site.

Data Source:

Opioid STR Table B2 (KORE funding and CMHC contract reporting requirement); Annual Statement of Revenues and Expenditures.

Description of Data:

The total number of POSC sites within Community Mental Health Centers (CMHCs).

Data issues/caveats that affect outcome measures:

Expected outcome measure for the 2 year period equals nine (9) total POSC sites by the end of SFY 2023.

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 Services Programs (SSPs) statewide.

Strategies to attain the goal:

Collaborate with the Office of Drug Control Policy, the Harm Reduction Coalition and the Kentucky Department for Public Health to educate communities about the benefits of syringe services programs.
Encourage the increase of local ordinances to create local syringe services programs.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of syringe services programs (SSPs) in place across the state.

Baseline Measurement: At the end of SFY 2021 there are 74 SSPs across the state.

First-year target/outcome measurement: At the send of SFY 2022, there will be one (1) additional SSP in the state. This is a comparison across consecutive years.

Second-year target/outcome measurement: At the end of SFY 2023, there will be one (1) additional SSP in the state. This is a comparison across consecutive years.

Data Source:

The Kentucky Department for Public Health Surveillance data, Kentucky Office of Drug Control Policy (ODCP), Kentucky Harm Reduction Coalition, and DBHDID.
https://chfs.ky.gov/agencies/dph/dehp/hab/Pages/kyseps.aspx

Description of Data:

The Kentucky Department for Public Health monitors the number of SSPs statewide and also posts to their website the days/hours of operation for each program. The ODCP and the Kentucky Harm Reduction Coalition and DBHDID work to educate individuals and communities about the cost, benefits, myths, and best practice guidelines for initiating and maintaining SSPs. The target for the end of SFY 2023 is 76 SSPs in Kentucky.

Data issues/caveats that affect outcome measures:

SSPs have existed and been studied extensively in the United States since 1988. The SSPs are community-based programs that provide access to sterile needles and syringes free of cost, facilitate safe disposal of used needles and syringes, and other safe injection education. the SSPs in Kentucky also provide linkages to critical services and programs including substance use disorder treatment programs, overdoes prevention education, screening, care and treatment for HIV and viral hepatitis, prevention of mother-to-child transmission, hepatitis A and 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 Department for Public Health has published guidelines for local health departments implementing harm reduction and syringe exchange programs. NO SABG FUNDS WILL BE USED TO SUPPORT THE SSPs.

Priority #: 7

Priority Area: Individuals who receive Substance Use Disorder 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 SUD.

Strategies to attain the goal:

Continue partnering with the Kentucky Department for Public Health and the CMHCs to improve data collection definitions and screening protocols for TB.
Ensure that CMHCs are systematically screening for TB among individuals receiving services for SUDs.
Offer CMHCs technical assistance in updating and improving their policies and procedures regarding TB screening and referral.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Screen persons who present for substance use services at the fourteen (14) CMHCs for TB.
Baseline Measurement:	At the end of SFY 2021, all 14 CMHCs have submitted written policies regarding screening all individuals seeking services for SUDs for TB. However, at the end of SFY 2021, CMHCs do not have written procedures outlining specific methods of screening and subsequent referrals, including written procedures of how staff will be trained to follow the written policies/procedures.
First-year target/outcome measurement:	At the end of SFY 2022, four (4) of the CMHCs will submit written procedures detailing the process for TB screening and subsequent referral as indicated, for all individuals seeking services for SUDs, to include staff training processes and training curriculum that ensures effective and consistent implementation of policies and procedures.
Second-year target/outcome measurement:	At the end of SFY 2023, two (2) additional CMHCs will submit written procedures detailing the process for TB screening and subsequent referral as indicated, for all individuals seeking services for SUDs, to include staff training processes and training curriculum that ensures effective and consistent implementation of policies and procedures.

Data Source:

Submission of TB-related procedures, including training processes and curriculum, by CMHCs, through the Plan and Budget process.

Description of Data:

At the end of SFY 2023, six (6) CMHCs will have submitted written procedures regarding TB screening and subsequent referral as indicated, to include staff training and training curriculum.

Data issues/caveats that affect outcome measures:

N/A

Priority #: 8

Priority Area: Adults with SMI

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Maintain a rate of 8% or less of psychiatric hospital discharges to a personal care home where the admission living arrangement was not personal care home.

Strategies to attain the goal:

The electronic medical record system utilized by state-operated/contracted psychiatric hospitals collected living arrangement at admission and discharge.
Maintain collaborative partnerships between the state-operated/contracted psychiatric hospitals and the CMHCs to facilitate referrals to community services.
Maintain contracts with CMHCs to provide evidence-based practices that assists individuals with SMI to live in the community: Assertive Community Treatment, Permanent Supportive Housing, Supported Employment and Peer Support services.
Provide training, technical assistance and fidelity monitoring to ensure most effect implementation of these evidence-based practices.
Provide technical assistance to the state-operated/contracted psychiatric hospitals and the CMHCs to address barriers to community placement.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Adults discharged from a state-operated/contracted psychiatric hospital to a personal care home where the admission living arrangement was not personal care home.

Baseline Measurement: The SFY 2020 percentage of adults discharged from a state-operated/contracted psychiatric hospital to a personal care home where the admission living arrangement was not personal care home was at 5% = 267/5,278.

First-year target/outcome measurement: By the end of SFY 2022, the percentage of adults discharged from a state-operated/contracted psychiatric hospital to a personal care home where the admission living arrangement was not personal care home will be maintained as less than 8%. This number will be calculated annually.

Second-year target/outcome measurement: By the end of SFY 2023, the percentage of adults discharged from a state-operated/contracted psychiatric hospital to a personal care home where the admission living arrangement was not personal care home will be maintained as less than 8%. This number will be calculated annually.

Data Source:

DBHDID Facility Data Set

Description of Data:

Data report to show per State Fiscal Year (SFY): Report ID: COC_10-DC-LA_Not_From_PCH
The total number of percentage of adults discharged from a state-operated/contracted psychiatric hospital to a personal care home where the admission living arrangement was not personal care home.
The report is based on SFY (July 1 - June 30). This report is updated monthly.
The report includes data for Central State Hospital, Western State Hospital, and Eastern State Hospital.

Data issues/caveats that affect outcome measures:

The electronic medical record system is the source of data. Technical issues that are unique to each facility's system sometimes occur. Troubleshooting technical issues with this system as they arise involves a third party vendor and a third party data management contract. In addition, this rate would be impacted if a significant or unusual change occurred to the total number discharged in any single year.
It is expected that adults meeting the levels of care described in this indicator are experiencing SMI. However, the specific data sets for both state-operated/contracted psychiatric hospitals and personal care homes are not required to have a specific SMI marker. Personal care home admissions are required to have a diagnosis of mental illness that is expected to last at least 2 years, and individuals must need assistance with daily living/personal care functioning.

Priority #: 9

Priority Area: Early Serious Mental Illness/First Episode 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 psychosis (FEP).

Strategies to attain the goal:

Provide training and technical assistance to all outpatient sites funded to provide Coordinated Specialty Care (CSC) to this population.
Utilize consultation from national experts in the field.
Convene biannual meetings with all key contacts from CMHCs regarding this population to provide technical assistance/education regarding CSC and the ESMI/FEP population.
Embed rapid access measures and rationale into CMHC contract deliverables for CSC outpatient funded sites.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator:	Young people will have access to available prescriber appointments within seven (7) days of admission into one of the eight (8) CSC programs. Young people served in CSC programs are not required to see a prescriber, but may choose to see a team prescriber, even if they do not wish to take medication. However, for ALL who choose to see a prescriber, rapid access is essential. Rapid access to care, including evidence-based medication management/education is a large part of the evidence base for CSC.
Baseline Measurement:	As of the third quarter of SFY 2021, eight (8) CSC funded programs had team prescribers identified to see young people upon admission into CSC programming. There were 54 new young people admitted into CSC programs, 35 of those new admissions saw the team prescriber within 7 days upon admission, resulting in a statewide total of 65% of new admissions into CSC programs seeing team prescribers within 7 days of admission.
First-year target/outcome measurement:	By the end of SFY 2022, the statewide total of new admissions into CSC programs seeing team prescribers within 7 days of admission will be 70 % of all new admissions who choose to see team prescribers.
Second-year target/outcome measurement:	By the end of SFY 2023, the statewide total of new admissions into CSC programs seeing team prescribers within 7 days of admission will be 75% of all new admissions who choose to see team prescribers.

Data Source:

Department Periodic Report (DPR) form 113H/CMHC Contract Reporting Requirement. Additional CSC site level data as needed.

Description of Data:

DPR form 113H. All CMHC CSC sites submit this form quarterly. Data are collected from this form regarding prescriber access, in addition to all new admissions.

Data issues/caveats that affect outcome measures:

It is best practice for all young people experiencing early signs of psychosis is to see a prescriber for education and consultation regardless whether they take medications. However, many young people choose to not see the prescriber. This indicator is intended to honor the choice of young people, so that choice will be taken into account as we calculate access rates.

Priority #: 10

Priority Area: Children with SED

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Increase access to evidence-based practices for children/youth with SED.

Strategies to attain the goal:

CMHCs with Transition Age Youth specialized programming are required by contract to have Peer Support services available to children/youth being served.
Provide training and technical assistance to ensure that CMHCs understand how to recruit, retain and support Youth and Family Peer Support Specialists in the workplace and how to appropriately document and bill for services.
Provide awareness activities and training regarding resiliency and recovery principles and guidance in the process of fully including Peer Support Specialists in the service delivery array.
Provide training and technical assistance regarding the supervision of Peer Support Specialists.
Provide 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 young people up to age 26, including those with SED.
Baseline Measurement:	Total number of young people up to age 26 who received Youth or Family Peer Support (individual or group) during SFY 2020 was 1,416.
First-year target/outcome measurement:	Increase by .25% the total number of young people up to age 26 who receive Youth or

Family Peer Support services, from the CMHCs, during SFY 2022. At the end of SFY 2022, 1,420 young people should have received Youth or Family Peer Support services.

Second-year target/outcome measurement: Increase by .25% the total number of young people up to age 26 who receive Youth or Family Peer Support services, from the CMHCs, during SFY 2023. At the end of SFY 2023, 1,424 young people should have received Youth or Family Peer Support services.

Data Source:

Client/Event Data Set used by DBHDID and the CMHCs.

Description of Data:

Data report to show the total number of young people up to age 26 served by the CMHCs, who received Youth or Family Peer Support services in each respective state fiscal year (includes counts for individual and group peer support services) Report form AMART using the following filters: All MH served, statewide, in-region/out-of-region, status 1, 2, & 3, ages 1 through 25, units of service client count, service codes 147,148,149 150.

Data issues/caveats that affect outcome measures:

Due to the data intricacies involved in capturing all young people up to age 26 who are served with Peer Support services, this indicator will utilize reports of All MH served for measurement, which will include All SED served, but will also include young people included in the transition age youth category.

Priority #: 11

Priority Area: Primary Prevention

Priority Type: SAP

Population(s): PP

Goal of the priority area:

Reduce alcohol use and electronic cigarette use among 10th graders in Kentucky.

Strategies to attain the goal:

1.1.1.- Educate youth, parents and educators about the harmful effects of electronic cigarette use.
1.1.2 - Provide training and technical assistance to schools and community organizations to update school and community smoke-free policies to address electronic cigarettes use.
1.1.3.- Conduct reward/remind type activities with retailers related to sale of electronic cigarettes to minors.
1.1.4 - Provide training and technical assistance to schools to support and enhance early prevention screening and assessment of adolescents.
1.2.1 - Educate parents about "host parties" and the negative psychological effects of alcohol consumption by adolescents.
1.2.2. - Provide training and technical assistance to community coalitions to expand Social Host Ordinances implementation and enforcement.
1.2.3 - Implement and expand the "Keep a Lid on It" strategy to reduce youth access to alcohol-to-go sales.
1.1.4 - Provide training and technical assistance to school to support and enhance early prevention screening and assessment of adolescents.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of 10th graders, who participate in the KIP survey who report "great risk" or "moderate risk" in use of e-cigarettes "some days but not every day?".

Baseline Measurement: 2018 KIP survey results indicate that 42.8% of 10th graders, who participate in the KIP survey reported that using electronic cigarettes on a regular basis had moderate to great risk. During SFY 2020, 4,905 Kentucky residents, under the age of 21, received prevention services targeting tobacco use.

First-year target/outcome measurement: The first year measure is a process measure based on total number of activities that address electronic cigarette use among youth as measured by data entered into the Prevention Data System (based on the 2018 KIP data analysis). First year measure for the block grant is to increase by 3% (to 5,052) the number of Kentucky residents, under the age of 21, who receive prevention services targeting tobacco use.

Second-year target/outcome measurement: Increase by 2% the percentage of 10th graders, who participate in the 2023 KIP Survey, who report use of electronic cigarettes on a regular basis as "moderate' to "great risk". (44.8%)

Data Source:

Kentucky Incentives for Prevention (KIP) Survey, Kentucky's Prevention Data System

Description of Data:

The KIP Survey provides information about student perceptions about the health dangers of electronic cigarettes and perceived accessibility of electronic cigarettes in the community. The 2018 Survey included the addition of several new questions related to electronic cigarettes. 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, conducted every other year, 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 use. In 2018, over 128,000 students representing 159 school districts (of the state's 173) completed the survey, and the information gathered provided an invaluable substance abuse prevention tool for these communities. Districts utilize their KIP results extensively for grant-writing purposes, prevention activities, and various other needs related to program planning.
The Prevention Data System is Kentucky's reporting system for activities delivered by primary prevention providers. Providers are required by contract to enter the activities that they have delivered in their communities within 30 days of the end date of the activity. The cloud-based system provides data for various SAMHS Block Grant reporting requirements related to primary prevention.

Data issues/caveats that affect outcome measures:

The KIP Survey is conducted biannually, with the next iteration scheduled to occur in the fall of 2021 (the 2020 KIP Survey did not occur due to the pandemic). Data is available approximately 6 months post administration.

Indicator #:	2
Indicator:	Number of 10th graders, who participate in the KIP survey, who report past 30-day use of alcoholic beverages.
Baseline Measurement:	2018 KIP survey results indicate 16.8% of 10th graders answered that they consumed alcohol, on at least 1 occasion, in the past 30 days. SFY 2020 data reports 4,688 youth, under the age of 19, received prevention services targeting underage drinking.
First-year target/outcome measurement:	The first year measure is a process measure based on the total number of activities that address underage drinking use among youth as measured by data entered into the Prevention Data System (based on the 2018 KIP data analysis). First-year measure for the block grant will increase by 3% (to 6,149) the number of youth, under the age of 19, receiving prevention services targeting underage drinking.
Second-year target/outcome measurement:	Decrease by 1% (to 16.5), the number of 10th graders that report having consumed alcohol on at least 1 occasion, in the past 30 days.

Data Source:

Kentucky Incentives for Prevention (KIP) Survey; Kentucky's Prevention Data System.

Description of Data:

The KIP Survey, conducted every other year, 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 use. In 2018, over 128,000 students representing 159 school districts (of the state's 173) completed the survey, and the information gathered provided an invaluable substance abuse prevention tool for these communities. Districts utilize their KIP results extensively for grant-writing purposes, prevention activities, and various other needs related to program planning.
The Prevention Data System is Kentucky's reporting system for activities delivered by primary prevention providers. Providers are required by contract to enter the activities that they have delivered in their communities within 30 days of the end date of the activity. The cloud-based system provides data for various SAMHSA Block Grant reporting requirements related to primary prevention.

Data issues/caveats that affect outcome measures:

The KIP Survey is conducted biannually, with the next iteration scheduled to occur in the fall of 2021 (the 2020 KIP Survey did not occur due to the pandemic). Data is available approximately 6 months post administration.

Priority #: 12

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

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Simultaneously protect infants who are affected by prenatal substance use and support mothers and families in their capacity to provide care for infants following birth/hospital discharges

Strategies to attain the goal:

Identify services and supports to be provided to the mother and infant, and delineate who is responsible for ensuring that the mother is aware of, and accesses needed services and supports.
Recognize the important role of trauma and adverse childhood experiences in this population.
Stabilize the mother in the post-partum period and provide ongoing supports for positive parenting and a safe home environment for the infant.
Create opportunities to reduce adverse childhood experiences for the infant, thereby improving long-term outcomes, and reducing the risks of repeating the cycle of substance use as they grow into their teenage years.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Plan of Safe Care (POSC) implementation

Baseline Measurement: As of the end of SFY 2021, there are seven (7) POSC sites to serve PWWDC with SUDs.

First-year target/outcome measurement: At the end of SFY 2022, one (1) additional Community Mental Health Center (CMHC) will become a POSC site.

Second-year target/outcome measurement: At the end of SFY 2023, one (1) additional Community Mental Health Center (CMHC) will become a POSC site.

Data Source:

Opioid STR Table B2 (KORE funding and CMHC contract reporting requirement, Annual Statement of Revenues and Expenditures.

Description of Data:

The total number of POSC sites within the Community Mental Health Centers.

Data issues/caveats that affect outcome measures:

Expected outcome measure for the 2 year period equals nine (9) total POSC sites by the end of SFY 2023.

Priority #: 13

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 Services Programs (SSPs) statewide.

Strategies to attain the goal:

Collaborate with the Office of Drug Control Policy, the Harm Reduction Coalition, and the Kentucky Department for Public Health to educate communities about the benefits of syringe services programs.
Encourage the increase of local ordinances to create local syringe services programs.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of syringe services programs (SSPs) in place across the state.

Baseline Measurement: As of the end of 2021, there are 74 SSPS across the state.

First-year target/outcome measurement: At the end of SFY 2022, there will be one (1) additional SSP in the state. This is a comparison

across consecutive years.

Second-year target/outcome measurement: At the end of SFY 2023, there will be one (1) additional SSP in the state. This is a comparison across consecutive years.

Data Source:

The Kentucky Department for Public Health Surveillance data, Kentucky Office of Drug Control Policy (ODCP), Kentucky Harm Reduction Coalition, DBHDID.
https://chfs.ky.gov/agencies/dph/dehp/hab/Pages/kyseps.aspx

Description of Data:

The Kentucky Department for Public Health monitors the number of SSPs statewide and also posts to their website the days/hours of operation for each program. The ODCP and the Kentucky Harm Reduction Coalition and DBHDID work to educate individuals and communities about the cost, benefits, myths and best practice guidelines for initiating and maintaining SSPs. The target for the end of SFY 2023 is 76 SSPs in Kentucky.

Data issues/caveats that affect outcome measures:

SSPS have existed and been studied extensively in the United States since 1988. The SSPs are community-based programs that provide access to sterile needles and syringes free of cost, facilitate safe disposal of used needles and syringes and other safe injection education. The SSPs 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 B vaccination, screening for other sexually transmitted diseases and tuberculosis, partner services and other medical, social and mental health services.
In response to Senate Bill 192, enacted during the 2015 regular legislative session, the Department for Public Health has published guidelines for local health departments implementing harm reduction and syringe exchange programs. NO SABG FUNDS WILL BE USED TO SUPPORT THE SSPs.

Priority #: 14

Priority Area: Individuals who receive Substance Use Disorder 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.

Strategies to attain the goal:

Continue partnering with the Kentucky Department for Public Health and the CMHCs to improve data collection definitions and screening protocols for TB.
Ensure that CMHCs are systematically screening for TB among individuals receiving services for SUDs.
Offer CMHCs technical assistance in updating and improving their policies and procedures regarding TB screening and referral.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Screen persons who present for substance use services at the fourteen (14) CMHCs for TB.

Baseline Measurement: At the end of SFY 2021, all 14 CMHCs have submitted written policies regarding screening all individuals seeking services for SUDs for TB. However, at the end of SFY 2021, CMHCs do not have written procedures outlining specific methods of screening and subsequent referrals, including written procedures of how staff will be trained to follow the written policies/procedures.

First-year target/outcome measurement: At the end of SFY 2022, four (4) of the CMHCs will submit written procedures detailing the process for TB screening and subsequent referral as indicated, for all individuals seeking services for SUDs, to include staff training processes and training curriculum that ensures effective and consistent implementation of policies and procedures.

Second-year target/outcome measurement: At the end of SFY 2023, two (2) additional CMHCs will submit written procedures detailing the process for TB screening and subsequent referral as indicated, for all individuals seeking services for SUDs, to include staff training processes and training curriculum that

ensures effective and consistent implementation of policies and procedures.

Data Source:

Submission of TB-related procedures, including training processes and curriculum, by CMHCs, through the Plan and Budget process.

Description of Data:

At the end of SFY 2023, 6 CMHCs will have submitted written procedures regarding TB screening and subsequent referral as indicated, to include staff training processes and training curriculum.

Data issues/caveats that affect outcome measures:

N/A

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2022/2023.
ONLY include funds expended by the executive branch agency administering the SABG.

Planning Period Start Date: 7/1/2021 Planning Period End Date: 6/30/2023

Activity (See instructions for using Row 1.)	Source of Funds									
	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	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SABG)[a]	J. ARP Funds (SABG)[b]
1. Substance Abuse Prevention[c] and Treatment	$32,291,994.00		$0.00	$71,098,362.00	$26,527,104.00	$0.00	$0.00		$14,134,614.00	$3,256,076.00
a. Pregnant Women and Women with Dependent Children[c]	$8,312,843.00				$1,891,000.00				$764,050.00	$332,500.00
b. All Other	$23,979,151.00			$71,098,362.00	$24,636,104.00				$13,370,564.00	$2,923,576.00
2. Primary Prevention[d]	$8,787,560.00		$0.00	$8,058,804.00	$1,232,129.00	$0.00	$0.00		$4,011,170.00	$1,048,193.00
a. Substance Abuse Primary Prevention	$8,787,560.00			$8,058,804.00	$1,232,129.00				$4,011,170.00	$1,048,193.00
b. Mental Health Primary Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Tuberculosis Services										
5. Early Intervention Services for HIV										
6. State Hospital										
7. Other 24-Hour Care										
8. Ambulatory/Community Non-24 Hour Care										
9. Administration (excluding program/provider level) MHBG and SABG must be reported separately	$1,765,972.00			$3,454,400.00	$1,813,600.00				$955,040.00	$412,404.00
10. Crisis Services (5 percent set-aside)										
11. Total	**$42,845,526.00**	**$0.00**	**$0.00**	**$82,611,566.00**	**$29,572,833.00**	**$0.00**	**$0.00**	**$0.00**	**$19,100,824.00**	**$4,716,673.00**

[a] The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between July 1, 2021 – March 14, 2023 should be entered in Column I.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between September 1, 2021 and June 30, 2023 should be entered in Column J.

[c] Prevention other than primary prevention

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

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2022/2023.
Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

Planning Period Start Date: 7/1/2021 Planning Period End Date: 6/30/2023

Activity (See instructions for using Row 1.)	Source of Funds									
	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	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SABG)	J. ARP Funds (MHBG)[b]
1. Substance Abuse Prevention and Treatment										
a. Pregnant Women and Women with Dependent Children										
b. All Other										
2. Primary Prevention										
a. Substance Abuse Primary Prevention										
b. Mental Health Primary Prevention[e]										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[d]		$2,486,000.00						$1,175,000.00		$1,162,000.00
4. Tuberculosis Services										
5. Early Intervention Services for HIV										
6. State Hospital			$81,793,000.00	$49,584,400.00	$126,681,400.00		$1,833,400.00			
7. Other 24-Hour Care			$34,362,400.00	$4,660,200.00	$10,900,500.00		$28,000.00			
8. Ambulatory/Community Non-24 Hour Care		$16,273,167.00	$1,800,000.00	$32,654,000.00	$76,983,100.00			$5,782,078.00		$4,781,500.00
9. Administration (excluding program/provider level)[f] MHBG and SABG must be reported separately		$298,768.00	$230,900.00	$1,341,000.00	$4,890,800.00			$536,720.00		$150,000.00
10. Crisis Services (5 percent set-aside)[g]		$1,003,049.00						$3,241,000.00		$812,000.00
11. Total	**$0.00**	**$20,060,984.00**	**$118,186,300.00**	**$88,239,600.00**	**$219,455,800.00**	**$0.00**	**$1,861,400.00**	**$10,734,798.00**	**$0.00**	**$6,905,500.00**

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard SABG expenditures are for the state planned expenditure period of July 1, 2021 – June 30, 2023, for most states.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025,** which is different from expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A-G are for the state planned expenditure period of July 1, 2021 - June 30, 2022, for most states

[d] Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside.

[e] While a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

[f] Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

[g] Row 10 should include Crisis Services programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

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Footnotes:

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	4,028	172
2. Women with Dependent Children	24,716	2,648
3. Individuals with a co-occurring M/SUD	43,671	15,142
4. Persons who inject drugs	10,379	5,299
5. Persons experiencing homelessness	622	2,212

Please provide an explanation for any data cells for which the state does not have a data source.
Kentucky funds a homeless shelter in the largest metropolitan area for men with SUD, thus the aggregate number in treatment might seem inflated. It also seems likely that the homelessness number of 622 is low due to obtaining data by self report. In need Estimates UK CDAR data source. In treatment Estimates: AMART SFY 2020 Data Report source.
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Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Expenditure Category	FFY 2022 SA Block Grant Award	COVID-19 Award[1]	ARP Award[2]	FFY 2023 SA Block Grant Award	COVID-19 Award[1]	ARP Award[2]
1 . Substance Use Disorder Prevention and Treatment[3]	$15,413,385.00	$14,134,605.00	$12,207,166.00	$15,413,385.00	$10,834,605.00	$2,416,076.00
2 . Primary Substance Use Disorder Prevention	$4,315,629.00	$4,011,170.00	$3,464,193.00	$4,315,629.00	$3,011,170.00	$698,193.00
3 . Early Intervention Services for HIV[4]				$0.00	$0.00	$0.00
4 . Tuberculosis Services				$0.00	$0.00	$0.00
5 . Administration (SSA Level Only)	$821,600.00	$955,040.00	$824,800.00	$821,600.00	$825,040.00	$392,404.00
6. Total	**$20,550,614.00**	**$19,100,815.00**	**$16,496,159.00**	**$20,550,614.00**	**$14,670,815.00**	**$3,506,673.00**

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in this column.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in this column.

[3]Prevention other than Primary Prevention

[4]For the purpose of determining which states and jurisdictions 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 (SABG); 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 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 required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services 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'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 do so.

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Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

A		B			B		
Strategy	IOM Target	FFY 2022			FFY 2023		
		SA Block Grant Award	COVID-19 Award[1]	ARP Award[2]	SA Block Grant Award	COVID-19 Award[4]	ARP Award[5]
1. Information Dissemination	Universal	$1,081,239	$1,191,719	$1,029,212	$1,060,442	$894,619	$207,434
	Selected	$72,786	$80,223	$69,284	$71,386	$60,223	$13,964
	Indicated	$36,393	$40,112	$34,642	$35,693	$30,112	$6,982
	Unspecified	$0	$0	$0	$0	$0	$0
	Total	**$1,190,418**	**$1,312,054**	**$1,133,138**	**$1,167,521**	**$984,954**	**$228,380**
2. Education	Universal	$33,038	$36,414	$31,449	$32,403	$27,336	$6,338
	Selected	$36,393	$40,112	$34,642	$35,693	$30,112	$6,982
	Indicated	$1,588	$1,751	$1,512	$1,558	$1,314	$305
	Unspecified	$0	$0	$0	$0	$0	$0
	Total	**$71,019**	**$78,277**	**$67,603**	**$69,654**	**$58,762**	**$13,625**
3. Alternatives	Universal	$9,098	$10,028	$8,660	$8,923	$7,528	$1,745
	Selected	$0	$0	$0	$0	$0	$0
	Indicated	$0	$0	$0	$0	$0	$0
	Unspecified	$0	$0	$0	$0	$0	$0
	Total	**$9,098**	**$10,028**	**$8,660**	**$8,923**	**$7,528**	**$1,745**
4. Problem Identification and Referral	Universal	$39,616	$43,663	$37,709	$38,854	$32,778	$7,600
	Selected	$181,965	$200,559	$173,210	$178,465	$150,558	$34,910
	Indicated	$218,358	$240,670	$207,852	$214,158	$180,670	$41,891
	Unspecified	$0	$0	$0	$0	$0	$0
	Total	**$439,939**	**$484,892**	**$418,771**	**$431,477**	**$364,006**	**$84,401**
	Universal	$1,455,724	$1,604,467	$1,385,676	$1,427,723	$1,204,468	$279,277

5. Community-Based Processes	Selected	$72,786	$80,223	$69,284	$71,386	$60,223	$13,964
	Indicated	$36,393	$40,112	$34,642	$35,693	$30,112	$6,982
	Unspecified	$0	$0	$0	$0	$0	$0
	Total	**$1,564,903**	**$1,724,802**	**$1,489,602**	**$1,534,802**	**$1,294,803**	**$300,223**
6. Environmental	Universal	$363,931	$401,117	$346,419	$356,931	$301,117	$69,819
	Selected	$0	$0	$0	$0	$0	$0
	Indicated	$0	$0	$0	$0	$0	$0
	Unspecified	$0	$0	$0	$0	$0	$0
	Total	**$363,931**	**$401,117**	**$346,419**	**$356,931**	**$301,117**	**$69,819**
7. Section 1926 Tobacco	Universal	$0	$0	$0	$0	$0	$0
	Selected	$0	$0	$0	$0	$0	$0
	Indicated	$0	$0	$0	$0	$0	$0
	Unspecified	$0	$0	$0	$0	$0	$0
	Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
8. Other	Universal	$0	$0	$0	$0	$0	$0
	Selected	$0	$0	$0	$0	$0	$0
	Indicated	$0	$0	$0	$0	$0	$0
	Unspecified	$0	$0	$0	$0	$0	$0
	Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Prevention Expenditures		**$3,639,308**	**$4,011,170**	**$3,464,193**	**$3,569,308**	**$3,011,170**	**$698,193**
Total SABG Award[3]		**$20,550,614**	**$19,100,815**	**$16,496,159**	**$20,550,614**	**$14,670,815**	**$3,506,673**
Planned Primary Prevention Percentage		**17.71 %**	**21.00 %**	**21.00 %**	**17.37 %**	**20.52 %**	**19.91 %**

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. Per the instructions, the FFY 2022 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures reflecting the President's FY 2022 enacted budget for the FFY 2022 SABG Award year that is October 1, 2021 - September 30, 2022. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 and September 30, 2022 should be entered in this column.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**. Per the instructions, the FFY 2022 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures reflecting the President's FY 2022 enacted budget for the FFY 2022 SABG Award year that is October 1, 2021 - September 30, 2022. For purposes of this table, all planned ARP expenditures between October 1, 2021 and September 30, 2022 should be entered in this column.

[3]Total SABG Award is populated from Table 4 - SABG Planned Expenditures

[4]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. Per the instructions, the FFY 2023 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures, also reflecting the President's FY 2022 enacted budget for the FFY 2023 SABG Award that is October 1, 2022 - September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2022 and September 30, 2023 should be entered in this column.

[5]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**. Per the instructions, the FFY 2023 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures, also reflecting the President's FY 2022 enacted budget for the FFY 2023 SABG Award that is October 1, 2022 - September 30, 2023. For purposes of this table, all planned ARP expenditures between October 1, 2022 and September 30, 2023 should be entered in this column.

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Footnotes:

The FFY 2022 SA Block Grant Award for Primary Prevention of $4,315,629 from Table 4 Column B, Line 2 includes $3,639,308 noted in tables 5a and 5b plus the Primary Prevention Total on Table 6 Column 2, line 8 of $676,321. ($3,639,308+$676,321=$4,315,629)

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Activity	FFY 2022 SA Block Grant Award	FFY 2022 COVID-19 Award[1]	FFY 2022 ARP Award[2]	FFY 2023 SA Block Grant Award	FFY 2023 COVID-19 Award[3]	FFY 2023 ARP Award[4]
Universal Direct	$809,614	$892,340	$770,657	$794,041	$669,876	$155,323
Universal Indirect	$2,173,030	$2,395,069	$2,068,470	$2,131,234	$1,797,969	$416,891
Selected	$363,931	$401,117	$346,419	$356,931	$301,117	$69,819
Indicated	$292,733	$322,644	$278,647	$287,102	$242,208	$56,160
Column Total	**$3,639,308**	**$4,011,170**	**$3,464,193**	**$3,569,308**	**$3,011,170**	**$698,193**
Total SABG Award[5]	**$20,550,614**	**$19,100,815**	**$16,496,159**	**$20,550,614**	**$14,670,815**	**$3,506,673**
Planned Primary Prevention Percentage	**17.71 %**	**21.00 %**	**21.00 %**	**17.37 %**	**20.52 %**	**19.91 %**

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. Per the instructions, the FFY 2022 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures reflecting the President's FY 2022 enacted budget for the FFY 2022 SABG Award year that is October 1, 2021 - September 30, 2022. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 and September 30, 2022 should be entered in this column.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**. Per the instructions, the FFY 2022 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures reflecting the President's FY 2022 enacted budget for the FFY 2022 SABG Award year that is October 1, 2021 - September 30, 2022. For purposes of this table, all planned ARP expenditures between October 1, 2021 and September 30, 2022 should be entered in this column.

[3]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. Per the instructions, the FFY 2023 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures, also reflecting the President's FY 2022 enacted budget for the FFY 2023 SABG Award that is October 1, 2022 - September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2022 and September 30, 2023 should be entered in this column.

[4]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**. Per the instructions, the FFY 2023 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures, also reflecting the President's FY 2022 enacted budget for the FFY 2023 SABG Award that is October 1, 2022 - September 30, 2023. For purposes of this table, all planned ARP expenditures between October 1, 2022 and September 30, 2023 should be entered in this column.

[5]Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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Footnotes:

The FFY 2022 SA Block Grant Award for Primary Prevention of $4,315,629 from Table 4 Column B, Line 2 includes $3,639,308 noted in tables 5a and 5b plus the Primary Prevention Total on Table 6 Column 2, line 8 of $676,321. ($3,639,308+$676,321=$4,315,629)

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2022 and FFY 2023 SABG awards.

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

	SABG Award	COVID-19 Award[1]	ARP Award[2]
Targeted Substances			
Alcohol	☑	☑	☑
Tobacco	☑	☑	☑
Marijuana	☑	☑	☑
Prescription Drugs	☑	☑	☑
Cocaine	☑	☑	☑
Heroin	☑	☑	☑
Inhalants	☑	☑	☑
Methamphetamine	☑	☑	☑
Bath salts, Spice, K2)	☑	☑	☑
Targeted Populations			
Students in College	☐	☐	☐
Military Families	☑	☑	☑
LGBTQ	☑	☑	☑
American Indians/Alaska Natives	☐	☐	☐
African American	☑	☑	☑
Hispanic	☑	☑	☑
Homeless	☐	☐	☐
Native Hawaiian/Other Pacific Islanders	☐	☐	☐
Asian	☐	☐	☐
Rural	☑	☑	☑

Underserved Racial and Ethnic Minorities	☑	☑	☑

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023.

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Footnotes:

Planning Tables

Table 6 Non-Direct Services/System Development [SA]

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

	FFY 2022					FFY 2023				
Activity	A. SABG Treatment	B. SABG Prevention	C. SABG Integrated[1]	D. COVID -19[2]	E. ARP[3]	A. SABG Treatment	B. SABG Prevention	C. SABG Integrated[1]	D. COVID -19[2]	E. ARP[3]
1. Information Systems	$250,000.00	$120,000.00		$60,000.00		$310,000.00	$120,000.00	$0.00	$120,000.00	$20,000.00
2. Infrastructure Support	$33,333.00					$166,619.00	$0.00	$0.00	$250,000.00	$0.00
3. Partnerships, community outreach, and needs assessment	$812,500.00	$196,321.00				$160,246.00	$196,321.00	$0.00	$315,158.00	$135,000.00
4. Planning Council Activities (MHBG required, SABG optional)	$0.00	$0.00				$0.00	$0.00	$0.00	$0.00	$0.00
5. Quality										

Assurance and Improvement	$250,000.00	$100,000.00		$91,840.00		$250,000.00	$100,000.00	$0.00	$0.00	$0.00
6. Research and Evaluation	$114,571.00	$200,000.00		$100,000.00		$114,571.00	$200,000.00	$0.00	$0.00	$0.00
7. Training and Education	$480,300.00	$60,000.00		$50,000.00	$35,000.00	$430,300.00	$130,000.00	$0.00	$0.00	$108,193.00
8. Total	**$1,940,704.00**	**$676,321.00**	**$0.00**	**$301,840.00**	**$35,000.00**	**$1,431,736.00**	**$746,321.00**	**$0.00**	**$685,158.00**	**$263,193.00**

[1]Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

[2]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in Column D.

[3]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in Column E.

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Footnotes:

These planned funds reported are for only FY 2022.
Funds for FY 2023 have not yet been planned.
COVID -19 & ARP funding in Columns D. and E. of this table are for Prevention.
There are no revisions to this table
Column 8, Line 8: Non-direct prevention funding is utilized to build capacity and sustainability of the workforce through training and education, provide continuous quality improvement to ensure implementation fidelity, and support data collection for required funder reporting.

Planning Tables

Table 6 Non-Direct-Services/System Development [MH]

MHBG Planning Period Start Date: 07/01/2021 MHBG Planning Period End Date: 06/30/2023

Activity	FFY 2022 Block Grant	FFY 2022[1] COVID Funds	FFY 2022[2] ARP Funds	FFY 2023 Block Grant	FFY 2023[1] COVID Funds	FFY 2023[2] ARP Funds	FFY 2023[3] BSCA Funds
1. Information Systems	$200,000.00			$200,000.00	$608,251.00	$20,000.00	
2. Infrastructure Support	$465,977.00			$520,798.00	$0.00	$500,000.00	$55,240.00
3. Partnerships, community outreach, and needs assessment	$450,190.00	$386,800.00		$450,190.00	$135,000.00	$225,346.00	$110,000.00
4. Planning Council Activities (MHBG required, SABG optional)	$6,850.00			$6,850.00	$0.00	$0.00	
5. Quality Assurance and Improvement	$175,000.00	$100,000.00		$56,643.00	$0.00	$0.00	$83,299.00
6. Research and Evaluation				$0.00	$0.00	$0.00	
7. Training and Education	$383,000.00	$162,500.00	$20,000.00	$433,000.00	$125,000.00	$0.00	$250,450.00
8. Total	**$1,681,017.00**	**$649,300.00**	**$20,000.00**	**$1,667,481.00**	**$868,251.00**	**$745,346.00**	**$498,989.00**

[1] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

[2] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

[3] The expenditure period for the Bipartisan Safer Communities Act (BSCA) supplemental funding is **October 17, 2022 - October 16, 2024**, which is different from the normal block grant expenditure period. Column K should reflect the spending for the state reporting period. The total may reflect the BSCA allotment portion used during the state reporting period.

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Footnotes:

These planned funds being reported are for FY 2022 only.
Funds to be planned for FY 2023 are still pending.
There are no revisions to this table

Environmental Factors and Plan

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

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[22] 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.[23] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[24]

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.[25] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[26] 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.[27]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD 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.[28]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[29] 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 M/SUD include: developing models for inclusion of M/SUD 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.[30] 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 M/SUD 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[31] and ACOs[32] may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting M/SUD 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.[33] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[34]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[35] 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.[36] 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.[37] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[38] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD 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.[39] 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 M/SUD 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.[40]
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.[41] 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.

[22] BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, Bulletin of the World Health Organization, 2013; 91:102-123 **http://www.who.int/bulletin/volumes/91/2/12-108282.pdf**; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, World Psychiatry. Feb 2011; 10(1): 52-77

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[24] Comorbidity: Addiction and other mental illnesses, **http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses** Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, JAMA Psychiatry. 2014; 71 (3):248-254. doi:10.1001/jamapsychiatry.2013.3726; **https://www.samhsa.gov/find-help/disorders**

[25] Social Determinants of Health, Healthy People 2020, **http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39**; **https://www.cdc.gov/nchhstp/socialdeterminants/index.html**

[26] **https://www.samhsa.gov/behavioral-health-equity/quality-practice-workforce-development**

[27] **http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/**

[28] Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. **https://www.integration.samhsa.gov/integrated-care-models/FG-Integrating_12.22.pdf**; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, **https://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf**; Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. **http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf**; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, **http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf**; American Psychiatric Association, **http://www.psych.org/practice/professional-interests/integrated-care**; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, **http://books.nap.edu/openbook.php?record_id=11470&page=210**; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, **http://nasadad.org/nasadad-reports**

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[30] Health Information Technology (HIT), http://www.integration.samhsa.gov/operations-administration/hit; Characteristics of State Mental Health Agency Data Systems, Telebehavioral Health and Technical Assistance Series, **https://www.integration.samhsa.gov/operations-administration/telebehavioral-health**; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, **http://www.americantelemed.org/home**; National Telehealth Policy Resource Center, **https://www.cchpca.org/topic/overview/**;

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[32] New financing models, **https://www.integration.samhsa.gov/financing**

[33] Waivers, **http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html**; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, **http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf**

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[37] BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

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[40] About the National Quality Strategy, **http://www.ahrq.gov/workingforquality/about.htm**;

[41] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, **http://www.cms.gov/cciio/resources/letters/index.html**; Affordable Care Act, Indian Health Service, **http://www.ihs.gov/ACA/**

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.

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

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

Some areas of Kentucky are currently providing co-located, integrated services, including evidence based screening and assessments, diagnosis, prevention, and treatment according to a shared, individualized care plan, as well as outreach, engagement and retention strategies.

3. **a)** Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through Qualified Health Plans? ○ Yes ◉ No

b) and Medicaid? ○ Yes ◉ No

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

DBHDID and several other entities monitor access to services but there is not a comprehensive plan in place to date.

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

6. Do the M/SUD providers screen and refer for:

a) Prevention and wellness education ◉ Yes ○ No

b) Health risks such as

ii) heart disease ◉ Yes ○ No

iii) hypertension ◉ Yes ○ No

iv) high cholesterol ◉ Yes ○ No

v) 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?

Ensuring that public personnel at relevant state agencies (e.g. Department for Medicaid Services, Department of Insurance) and others remain aware of parity provisions, and how to respond when access does not occur as required, are often the greatest obstacles.

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

Since 2017, DBHDID has been involved with integrated care through a SAMHSA grant, Promoting Integration of Primary and Behavioral Health Care. This cooperative agreement, called Kentucky Care Integration (KCI) was designed to promote full integration and collaboration in clinical practice between primary and behavioral healthcare and support the improvement of integrated care models for primary care and behavioral health care to improve the overall wellness and physical health status of adults with serious mental illness, substance use disorder and for children with a serious emotional disturbance. DBHDID implemented KCI via collaborative clinical practice, improved care models, and a comprehensive service continuum for focus populations who have physical health conditions or have or at risk of developing chronic diseases. The KCI selected two (2) CMHCs, Seven Counties Services and Mountain Comprehensive Care. Seven Counties partnered with the federally qualified health center (FQHC) Family Health Centers (FHC) to serve the seven (7) counties in their service area. Mountain provided services through the HomePlace Clinics FQHC to serve three (3) counties in their service area. KCI has provided co-located, integrated services, including evidence-based screening/assessment, diagnosis, prevention, and treatment, according to a share, individualized care plan, as well as outreach, engagement and retention strategies. This grant is active through the end of September 2022 and is expected to impact approximately 1,125 individuals.

Please indicate areas of technical assistance needed related to this section

N/A

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Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[42], **Healthy People, 2020**[43], **National Stakeholder Strategy for Achieving Health Equity**[44], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD 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)[45].

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."[46]

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[47]. 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[48]. 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, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD 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.

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

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

[44] **https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf**

[45] **http://www.ThinkCulturalHealth.hhs.gov**

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

[47] https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status

[48] https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf

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, sexual orientation, gender identity, 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 M/SUD 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) Standards? ( ) Yes ( ) No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? ( ) Yes (•) No

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

There is a department-wide Racial Equity Action Plan focused on disaggregating data by race then taking actionable steps within each Division and Branch. There has also been progress in creating inclusive data points regarding gender, gender identity and sexual orientation.

The DBHDID is applying the principles of intersectionality and targeted universalism throughout our efforts. It is acknowledged that Black, Brown, Indigenous, and other people of color also belong to communities of various gender identities and sexual orientations. Thus, it is anticipated, that efforts will produce benefits beyond a spectrum inclusive of race and ethnicity but also as it relates to equitable outcomes for Kentuckians who represent the full spectrum of gender identity and sexual orientation. As we continue to disaggregate data in our Racial Equity Action Plan we will work to identify and address disparities for these populations as well.

DBH has collaboratively staffed a statewide Mental Health and Aging Coalition with representatives from CMHCs, other state departments related to aging, local Mental Health and Aging Coalitions across the state, and older adults comprising its membership, since 2000. Additional information regarding older adults and mental health can be found under Criterion 4 in Environmental Factor #9 (Statutory Criterion for MHBG).

The Adult Substance Abuse Treatment and Recovery Services Branch in DBH oversees some specialty programs related to pregnant women and women with dependent children, and focuses on services across the lifespan, including older adults.
In addition, the State Epidemiological Outcomes Workgroup (SEOW), which includes DBH staff, analyzes data to determine where health disparities exist in order to guide primary prevention intervention delivery.

While no formal workforce-training plan exists to date, much work in this area has been done over the last year, including:

• The Cabinet for Health and Family Services, including DBHDID, held monthly panels to address Racial Equity beginning the summer 2020. The topics focus on issues of importance to state employees.

• Several Federal grant funded programs overseen by DBHDID, are engaging in training of involved workforces around racial equity, identifying disparities, and creating more equitable systems of care.

• The DBHDID Executive Advisor has developed and presented the following training:
o Racial Equity 101 Mandatory Training for Supervisors: Description of tools and resources supervisors can use to support their

teams in responding to racial trauma as well as thinking about racial equity in their daily work.
o Racial Equity 101 Mandatory Training for All Staff: Review of shared terms, definitions, and language as it relates to Racial Equity. Discussed organizational change strategy and opportunities for engagement.

• DBH contracted with the Collective Care Center at Spalding University to train up to 200 staff at Community Mental Health Centers and state operated/contracted facilities in Racial Trauma Therapy. Participants completed online modules and virtual coaching sessions with Dr. Steven Kniffley, the session expert, over the course of a year, in order to become certified in the Racial Trauma Therapy approach. More information can be found here: https://drstevenkniffleyjr.com/racial-trauma-therapy-training/.

• The Deaf and Hard of Hearing Services (DHHS) program hosts regular online meetings for Community Mental Health Center partners on addressing the needs of the population. Recent topics included On Video vs. In Person interpreting and meeting the needs of individuals who are hard of hearing. Two (2) ASL classes were taught by a peer and included information on making recovery services more accessible. Partnership with Kentucky's Opioid Response Effort (KORE) also allowed for extensive overviews of language access needs for providers and education on opioids and overdose prevention for the Deaf community.

• DBHDID vision for 2021 and beyond includes a goal to "mitigate adverse behavioral health outcomes exacerbated by the pandemic and racial inequity while preserving and enhancing the behavioral health safety network", which includes the fourteen (14) CMHCs.

During the past two (2) years, DBHDID has greatly increased its efforts around health equity. Staff moved from being participants on committees and workgroups such as 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 of the State Interagency Council, to being leaders in state government around racial equity efforts.

During SFY 2019/2020, DBHDID hired an executive advisor to the Commissioner's office to focus on health equality. During SFY 2020, racial equity communities of practice were created with state operated/contracted psychiatric facilities and contracted community providers. Racial equity change teams were convened, comprised of leaders in each DBHDID Division. A racial equity tool was developed and is being utilized internally and with some community partners to both guide discussions on racial equity and to drive the development of dynamic SMART (Specific, Measurable, Attainable, Relevant, Timely) goals.

Block grant funds have been used to further the goal of increasing access to behavioral health treatment and recovery services for individuals who are Deaf, Hard of Hearing, or Deaf-Blind and experience SED, SMI, and/or SUD. Some projects include:

• Four (4) new Deaf Certified Peer Support Specialists were trained and started providing services both virtually and in-person during the pandemic.
• Through a partnership with the Kentucky Injury Prevention and Research Center (KIPRC), a video was created in ASL with captioning and voiceover to assist individuals in finding substance use treatment.
https://youtu.be/bmqQhFahaow.
• Partnering with KY Hands & Voices allowed us to train Parent Café facilitators to promote the Protective Factors and adapt the curriculum to highlight the importance of effective communication with children who are Deaf, Hard of Hearing, or Deaf-Blind and experience behavioral health challenges.
• Mini Grants using block grant and state general funds helped our Deaf and Hard of Hearing Services Point People at the Community Mental Health Centers learn more about the unique needs of individuals who are Hard of Hearing. Resources, made easily accessible through Google Drive, were provided along with general training and case consultation from a Peer Mentor. A Mini Grant also helped fifty (50) families receive resources to better interact with their children who are Deaf-Blind, with behavioral health challenges, while home during the pandemic.

DBHDID worked with data partners, Quality Management and Outcomes Team (QMOT), Joint Committee for Information Continuity (JCIC), and the Data Users Group (DUG), to expand inclusive client data fields regarding gender, gender identity and sexual orientation. These changes take effect July 1, 2021, and require all contracted providers across the state to begin collecting this data on all clients.

Data Management Specialists with the Cabinet's Office of Health and Data Analytics are members of the Division's equity team; these team members are able to analyze data that is not accessible to DBHDID staff.

Please indicate areas of technical assistance needed related to this section

Technical Assistance related to implementation of the National Standards for the Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS) is requested.

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its 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 M/SUD 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 M/SUD 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. SAMHSA's Evidence Based Practices Resource Center 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. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

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,[49] The New Freedom Commission on Mental Health,[50] the IOM,[51] NQF,and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).[52]. 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."[53] 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 M/SUD 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)**[54] are best practice guidelines for the SUD treatment. SAMHSA 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)**[55] was developed to help move the latest information available on effective M/SUD 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 M/SUD practices that work. KIT 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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[49] 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

[50] 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.

[51] 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.

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

[53] **http://psychiatryonline.org/**

[54] **http://store.samhsa.gov**

[55] **https://store.samhsa.gov/sites/default/files/d7/priv/ebp-kit-how-to-use-the-ebp-kit-10112019_0.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 focused on consumer outcomes rather than care processes.
- **g)** ☑ Involvement in CMS or commercial insurance value based purchasing programs (health homes, accountable care organization, all payer/global payments, pay for performance (P4P)).
- **h)** ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

3. 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

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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 service efforts 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 outcomes 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.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

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). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. 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 Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG 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 (NIRN) 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:
-Coordinated Specialty Care (CSC) – Kentucky is following the Early Assessment and Support Alliance (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 has been providing CSC in Oregon for many years and is consulting with several states on CSC implementation, in addition to Kentucky. EASA is providing overall technical assistance for CSC within Kentucky, including guidance on program implementation, differential diagnoses, feedback-informed treatment approaches, multi-family group psychoeducation, and ongoing, site-specific technical assistance. Kentucky's CSC model utilizes a transdisciplinary team providing the following services: outreach, medication management, purposeful coordination with physical health care, therapy, case management, peer support, supported employment/education, family psychoeducation, and

occupational therapy.
-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. DBH has been implementing IPS across the state since receiving a Dartmouth IPS grant in 2010. DBHDID recently collaborated with the University of Kentucky on the submission of a SAMHSA grant proposal related to enhancing IPS supported employment/education for transition age youth.
-Specialized Screening and Assessment Tools – training and support specific to first episode of psychosis programming tools are continuously being provided to designated staff across the state. These tools include the Prodromal Questionnaire Brief (PQB), the PRIME Screen, 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 early psychosis.
-Cognitive Behavioral Therapy for Psychosis (CBTp) – A 3-day CBTp skills training was initially provided to key CMHC staff across the state. Additional 2-day and 3-day CBTp trainings have been provided to CSC teams as well as other outpatient staff across the state during the last two (2) years, some of which occurred in a virtual format due to the pandemic. CSC staff received additional consultation on CBTp. Additional CBTp trainings and consultation will be provided in a virtual format. 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 early psychosis.
-Applied Suicide Intervention Skills Training (ASIST) – for community partners. DBHDID recently created the Community Behavioral Health Training Program, which began through new Kentucky legislation that addresses educating communities across the state in basic skills needed to identify and offer assistance to individuals dealing with mental health and/or substance use challenges. ASIST training occurs on a regular basis through this DBHDID initiative, as well as Mental Health First Aid training for Adults and Youth and Question, Persuade and Refer (QPR) gatekeeper training for suicide prevention.
-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.
-Multi Family Psychoeducation Groups (MFG) – an evidence-based combination of family therapy and family education and support sessions with several families at one time, focusing on specific diagnostic categories, in this case focusing on early psychosis.

3. How does the state promote the use of evidence-based practices for individuals with 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. The CSC model implemented in Kentucky, and included in CHMC contracts, includes a requirement for purposeful coordination with primary care physicians and nurses for all CSC participants. In addition, DBH is working to integrate more purposefully with substance use disorder programming, both at the state level and at the local level. Adolescent SUD local leaders have been identified at each CMHC to be included in statewide planning meetings for programming to address early psychosis.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with 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 (CSC) an as evidence-based practice for the 10% set-aside for ESMI. Kentucky is modeling 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 for psychosis, 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. Also see Number 2 above.

8. Please describe the planned activities for FFY 2022 and FFY 2023 for your state's ESMI programs including psychosis?

All fourteen (14) community mental health centers are required to designated two (2) key contacts (one (1) from the adult mental health system of care and one (1) from the children's mental health system of care) within their agency for first episode psychosis programming, as well as to begin including one (1) key contact from substance use programming. These individuals will attend statewide meetings twice a year regarding first episode psychosis programming, and will be responsible for disseminating information on first episode psychosis as well as planning locally for strategic training and education. At present, eight (8) community mental health centers provide Coordinated Specialty Care with funding from DBH. These programs are called iHOPE (Helping Others Pursue Excellence). DBH will continue to coordinate monthly consultation calls with each iHOPE site with EASA. DBH will provide technical assistance, education and support to these iHOPE sites through statewide iHOPE meetings twice a

year, as well as individual site contact on a regular basis. DBH will coordinate a training calendar for the year that includes the following on a regular basis for iHOPE and other key staff: Coordinated Specialty Care overview training, the Structured Clinical Interview for DSM 5 (SCID-5), Multi Family Psychoeducation Group (MFG) with follow-up coaching and consultation, Cultural Formulation Interview webinar, and Differential Diagnosis training through EASA staff; Cognitive Behavioral Therapy for Psychosis (CBTp) with follow-up coaching and consultation; and Structured Interview for Psychosis Risk Syndromes (SIPS) with follow-up coaching and refreshers as needed. All iHOPE programs, with the exception of one site, has had baseline fidelity reviews. This site was scheduled for a baseline review but the pandemic and subsequent closure of in-person meetings prevented that review. Kentucky is working with EASA and others to finalize a fidelity review process (either virtual, or in person or hybrid process) and will provide one (1) baseline review and seven (7) additional fidelity reviews during FFY 2022 and 2023. DBH expects all iHOPE teams to work on fidelity self-assessments as an awareness and preparation tool.

During SFY 2021, DBH hired a full time program administrator to coordinate early interventions for first episode psychosis programming. This program administrator is located in the Division of Behavioral Health Director's office and coordinates with DBH team members across adult services, children's services, substance use treatment and prevention branches. This position was created due to the importance of this programming, and Kentucky's charge to begin identifying individuals with first episode psychosis early in their illness and to provide effective early interventions.

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 and client level data on 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. Kentucky's ultimate plans are to create mechanisms to gather data outcome measures that are better aligned with national outcome measures for this population, including the Core Assessment Battery (CAB) at EPINET. For FFY 2022 and FFY 2023, Kentucky will work to create more meaningful outcome data for first episode psychosis programming.

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 diagnosis of schizophrenia spectrum disorder, and including other psychotic disorders 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). In addition, Kentucky has targeted Coordinated Specialty Care to serve youth and young adults between the ages of 15 – 30 with early serious mental illness who are diagnosed with the following Affective Disorders with psychosis as identified in the DSM-5. (Major Depressive Disorder with psychotic features (single or recurrent), Bipolar I with psychotic features (manic or depressed), as well as Post Traumatic Stress Disorder. Kentucky is focusing on youth and young adults who have experienced a first episode of psychosis within the last year.

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

N/A

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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 team 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, education, 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.

Kentucky does not have a formal policy related to person centered planning in behavioral health. However, DBH has done extensive work over several years to educate providers and partners about the principles and practice of person centered planning. Kentucky DBH will continue work on this initiative and will continue annual fidelity review processes.

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

Kentucky has a very active Behavioral Health Planning and Advisory Council (BHPAC) that includes many people with lived experience and many family members of people with lived experience. Council meetings throughout the year offer opportunities for open communication about behavioral health services across the state. New and existing programming provides presentations to BHPAC regarding services and rationale.

Kentucky also has a very active State Interagency Council (SIAC) that consists of partners from child serving agencies and organizations across the state. This group meets on a regular basis and has several working subcommittees. There are several young adults and family members with lived experience that interact within this committee who have a voice in services that affect individuals with behavioral health disorders in Kentucky.

In addition, DBH employs several individuals with lived experience who are involved in programming decisions and bring a wealth of knowledge regarding engagement and treatment for individuals with behavioral health disorders. DBH also contracts with several consumer and family advocacy organizations who provide training events and other consultation regarding services and programming across the state.

DBH encourages all providers to utilize the recovery principles and incorporate the DBH Person Centered Recovery Planning (PCRP) model into their treatment planning process. Peers specialists are required on treatment teams to enhance engagement with clients and to facilitate active participation of clients in setting goals and strategies for achieving the goals. As part of the PCRP model, clients are encouraged to include family members, supporters, and other community members in their treatment planning process. In accordance with the PCRP model, goals are in the individual's own words, strengths are incorporated into strategies for addressing goals, and goals and objectives are written in recovery-oriented, first person language. The PCRP process ensures the client and included family/supporters are active members of the treatment plan. Treatment planning is a partnership between providers and the client/family/supporters. The PCRP model ensures simple language agreed upon with the client with a clear understanding of how each service provided seeks to address an identified goal on the plan. Although treatment plans have client signatures, their signature alone is not the only way to ensure participation.

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

During SFY 2015, DBH hired national consultants (Janis Tondora, Psy.D, and Diane Grieder, M.Ed.) from Alipar to train CMHC/DBH staff in concepts of Person-Centered Planning for behavioral health treatment, and specifically in how to transform service delivery into a recovery-oriented, shared decision-making service system, based on the strengths of each individual. This project began as part of the Settlement Agreement entered into with Kentucky Protection and Advocacy, regarding adults with SMI living in personal care homes transitioning to community living. Person centered planning was a requirement in the Settlement Agreement and DBH chose to educate and train all providers. DBH worked with CMHCs to identify lead trainers in each region for training and continuing consultation. This "train the trainer" model was incorporated in the four (4) state psychiatric hospital Catchment areas across the state, with identified regional leads from each CMHC attending two (2) day training events to learn principles and

processes. Alipar created a Person Centered Planning fidelity tool and DBH staff worked to monitor the person centered planning process across the state. Embedded in this training and consultation was technical assistance regarding how to structure the treatment planning process in way that was person centered but that also met medical necessity needs. In addition, Alipar trained other partners in this model including Kentucky Protection and Advocacy, the Department for Aging and Independent Living (DAIL), Department for Community Based Services (DCBS), Department for Medicaid, and the contracted Managed Care Organizations (MCOs).

Kentucky uses the term Person-Centered Recovery Planning (PCRP) as we follow behavioral health recovery principles, and a collaborative process to assist individuals with SMI in reaching individualized recovery goals. This process balances person-centered approaches with medical necessity in creative ways with the goal of moving forward in partnerships with individuals seeking recovery. The ultimate result is creation of a PCRP that honors the person AND satisfies requirements of payors.

Alipar provides additional trainings and technical assistance. New staff, as well as existing staff, from the Community Mental Health Centers (CMHCs) attend a “skills training”, and there is a separate training for supervisors. The CMHCs are required by contract to provide person-centered recovery planning, and there is a yearly assessment of fidelity to the PCRP model.

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

N/A

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Footnotes:

Environmental Factors and Plan

6. 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 M/SUD 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 M/SUD 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 M/SUD 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 program requirements, including quality and safety standards? (●) Yes ( ) No

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

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

- Regulation/legislative review;
- Business information/intelligence gathering, analysis, and reporting;
- Contract monitoring;
- Risk Management
- Driving Under the Influence (DUI) regulation; and
- Training support and facilitation.

Within this Division are three (3) branches – the Data Analytics Branch, the Program Support Branch, and the Substance Use Disorder Program Licensure Branch.

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

Office of Technology.

Program Support Branch: This branch is composed of four primary work units:
• Contract Monitoring,
• Education/Event Coordination,
• Risk Management, and
• Legislation/Regulations.

A Team Leader leads each work unit in the branch, and staff works with other Divisions to ensure the delivery of high-quality products, accountability, and transparency. Activities and services for the Program Support Branch 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 legislative review, updates and drafting.

Substance Use Disorder Program Licensure Branch: This branch monitors and regulates the statewide network of Driving Under the Influence (DUI) programs that are licensed and certified by the CHFS to provide alcohol and other drug assessments, education and treatment services to persons convicted of DUI. This branch was created to fulfill obligations in 908 KAR 1:310, https://apps.legislature.ky.gov/law/kar/908/001/310.pdf in accordance with the provisions of Kentucky Revised Statute 189A00. Kentucky Revised Statutes - Chapter 189A. These statutes and regulations govern the regulation process for DUI programming in Kentucky. A current DUI program directory, listing all of the DUI licensed and certified programs across the state, can be accessed from the DBHDID website. Kentucky Cabinet for Health and Family Resources.

Please indicate areas of technical assistance needed related to this section

N/A

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

Environmental Factors and Plan

7. 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**[56] 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.

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

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

0

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

N/A

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

No federally recognized Tribes or Tribal Lands exist within the Commonwealth of Kentucky. However, the Division of Behavioral Health continues its dialogue with the Kentucky Council on Native American Heritage. Staff within the Division continue to work with the Kentucky Incentives for Prevention Survey statistician to obtain cross tabulation on Native American's past 30-day 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.

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

N/A

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Footnotes:

Environmental Factors and Plan

8. 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:

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

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

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

- **a)** ☑ Data on consequences of substance-using behaviors
- **b)** ☑ Substance-using behaviors
- **c)** ☑ Intervening variables (including risk and protective factors)
- **d)** ☑ Other (please list)

  Prescription Drug Monitoring Programs (PDMP) data from Kentucky All Scheduled Prescription Electronic Reporting System (KASPER)

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)

  Service Members, Veterans and Families

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

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

i. Kentucky All Schedule Prescription Electronic Reporting (KASPER)
ii. Kentucky Violent Death Reporting System
iii. CDC Wonder
iv. Kentucky State Police Data
v. Kentucky Center for School Safety
vi. Kentucky Poison Control
vii. Kentucky Injury Prevention & Research Center
viii. County Health Rankings
ix. Kentucky Kids Count
x. Kentucky Office of Drug Control Policy
xi. Kentucky Office of Vital Statistics
xii. Prevention Data System
xiii. Kentucky Incentives for Prevention (KIP)
xiv. Client Data, Community Mental Health Centers

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:

Every three (3) years, a statewide needs assessment is conducted using a standardized template to guide local assessments for consistency and accuracy, but also to create a state level guide for work. Beginning in State Fiscal Year 22, this process is being redesigned to include provision of data related to incidence and prevalence through a dashboard that will guide county-level assessments. The dashboard and data will be utilized to develop risk indexes for alcohol, tobacco, marijuana, opioids, stimulants, and mental health issues taking into consideration incidence, prevalence, morbidity, mortality, community contexts (poverty, lack of housing, discrimination) and health disparities. Once the index is established, RPC staff will share with community members to identify their agreement with the issues in the community and conduct key stakeholder and focus group qualitative data collection to further identify local contexts that contribute to substance use and mental health issues, creating a focused action plan for each Kentucky county. They will also assess the readiness and capacity of the community to implement the identified strategies and guide communities in selecting those that are aligned with the community's current readiness level. Additionally, an analysis of the activities delivered to each county will be conducted to determine if they have the strength and reach necessary to create change in that community (i.e., is the dosage high enough to help change behavior?).

The needs assessment data is used primarily to determine priorities and allocate discretionary funding opportunities, and one-time Block Grant funding (such as the Coronavirus Response and Relief Appropriations Act (CARA) and American Rescue Plan Act (ARPA) funds distributed in 2021). The majority of regular Block Grant funding is allocated to Kentucky's fourteen (14) Regional Prevention Centers (RPC) based on a historical funding formula. Each RPC is required to conduct biannual needs assessments 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 not required the RPCs to allocate SABG primary prevention funds based on a state needs assessment but is working on improving submitted activity data and identifying disparities to develop allocations and fee-based reimbursement processes.

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) lens, and using the six (6) 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, a research and evaluation center. Since the inception in 2010, the SEOW has worked to support the implementation of a public health approach to substance use/misuse 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 reducing risk factors and improving protective factors that can influence substance use/misuse and mental health issues. The SEOW systematically evaluates the correlates and consequences of Alcohol, Tobacco, and Other Drug (ATOD) usage as well as mental health issues including suicide throughout Kentucky. These evaluations serve to advise the DBHDID as well as facilitate the continued surveillance, analysis, and reporting of ATOD usage, mental health issues, and suicide. 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 DBHDID Division of Behavioral Health (DBH). 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:
• Dr. Patti Clark Branch Manager, Prevention & Promotion Branch, DBH
• Steve Cambron Division of Behavioral Health (DBH)
• Phyllis Millspaugh Assistant Director, DBH
• Van Ingram Executive Director, Kentucky Office of Drug Control Policy
• Dr. Teresa McGeeney Epidemiologist, REACH of Louisville
• Dr. Vestena Robbins Executive Advisor, DBH
• Monica Clouse Child Fatality Review Team
• Dana Quesinberry KY Injury Prevention & Research Center, Department of Health Policy and Program Evaluator
• Genia McKee Coordinator, KY Safe Communities, Kentucky Injury Prevention and Research Center
• Dr. Sabrina Brown Principal Investigator, KY Violent Death Reporting System
• Dr. Sarojini Kanotra, Epidemiologist, KY 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, KY Department of Education
• Cathy Prothro KY Suicide Prevention Enhancement Site Coordinator, DBH
• Hope Beatty Behavioral Health Services Information System Coordinator/DBH
• Ben Birkby Senior Evaluation Researcher, REACH
• Adam Barrones Epidemiologist, KASPER (KY PDMP)
• Dr. Michelyn Bhandari Interim Program Director, Eastern KY University Department of Public Health
• Dr. Brittany Allen State Opioid Coordinator, DBHDID
• Paula Brown RPC Liaison/DBHDID
• Dr. Ashley Bush KY Safety and Prevention Alignment Network
• Dr. Richard Clayton Professor Emeritus, UK Dept of Health, Behavior & Society
• Eileen Recktenwald Executive Director, KY Association of Sexual Assault Programs
• Jacqueline Seals Project Manager, KY Violent Death Reporting System
• Margaret Pennington Director of Policy, Evaluation, and Consultation Services, REACH
• Dr. Nicholas Peiper Research Scientist, Pacific Institute for Research and Evaluation
• Pete Alderman ISC Manager, Appalachian High Intensity Drug Trafficking Area

• Kimberly Lester Alcohol and Drug Control Officer, Ky Air National Guard
• Tiffany Quarles Prevention Enhancement System Program Administration, DBH
• Dr. Richard Wilson Retired faculty, Department of Health Promotion and Behavioral Sciences, University of Louisville
• Sara Roberson Office of Vital Statistics, KY Department of Public Health
• Maik Schutze Chief Analytics Officer, Cabinet for Health & Family Services
• Shelly Steiner SOR Prevention Implementation Specialist, DBH
• Angela Taylor Biomed Informatics Data Architect, Cabinet for Health & Family Services
• Claudia Valdivieso Epidemiologist, KY Department of Public Health
• Kate Wagoner Program Administrator, DBH
• Beck Whipple KY State Suicide Prevention Coordinator, DBH
• Steven Bullard Executive Director, KY Commission on Military Affairs

Narratve Question

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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.

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce? (●) Yes ( ) 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 requirements for the individual to sit for the Certified Prevention Specialist (CPS) exam. 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 also more importantly, assures the quality of service to the individuals and communities served by approximately 80 certified prevention specialists across the Commonwealth. Quality of services, competence, professional growth, ethical conduct, and continuing education are all benefits of certification. All state-level staff are expected to meet the requirements to become certified as is required of our contracted providers to set an example for our providers.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce? (●) Yes ( ) 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, state-level staff 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 Prevention Technology Transfer Center, and Prevention Solutions (formerly the CAPT), including the Substance Use Prevention Skills Training (SAPST), online courses and webinars. The focus throughout SFY 2020 and 2021 has been on increasing the capacity of the prevention workforce to utilize the SPF and develop comprehensive plans to meet the needs of the communities they serve. This focus will continue to increase and then maintain the capacity of providers to deliver programming with fidelity to the Strategic Prevention Framework (SPF) model.

o Kentucky School for Alcohol and Other Studies was cancelled in 2020 and 2021 because of COVID-19. The annual school will be revised in 2022 and will include a prevention-specific track.
o DBHDID has developed an onboarding system that includes a series of 41 sessions that build a foundational knowledge of prevention delivery for all prevention specialists within the Kentucky system. The sessions will be delivered both online and in-person as the state reopens following COVID-19. The sessions will be delivered by state and national level subject matter experts

and will utilize a learning management system to facilitate the Certified Prevention Specialist process.
o 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. Each subsequent offering will include a series of customized trainings to meet the needs of the community-level providers in delivering services.
o DBHDID accesses national-level subject matter experts and technical assistance providers, such as the Prevention Training and Technical Assistance Center (PTTC) to support the delivery of training and technical assistance to prevention providers and their key stakeholders at the community level.
o Kentucky Prevention Network annual conference was cancelled in the fall of 2020 because of COVID-19. The annual conference is scheduled for the fall of 2021 and will focus on shared risk and protective factors for substance use, suicide, and other related consequences. Final sessions have not been determined, but are expected to include environmental strategies, educational programs, substance specific trends, and other related offerings. The statewide prevention network offered three (3) virtual trainings focused on marijuana in the spring of 2021 to support prevention providers. The session topics included marijuana legislation, effects on mental health, and local advocacy.
o Substance Abuse Prevention Skills Training (SAPST) is provided to new staff twice year. In 2020, the training was transitioned to virtual deliver to meet social isolation requirements. One (1) training was offered in the fall of 2020 and another in the spring of 2021. A third is scheduled for the fall of 2021. Family Youth Resource Center and school staff, Drug Free Communities Coordinators, Regional Prevention Center Staff as well as discretionary grant staff are the usual attendees.
o Prevention Ethics is delivered twice a year. DBHDID has two (2) internal trainers for the curriculum and it is provided virtually to prevention providers to support certification twice a year.

• Internal Technical Assistance: In addition to technical assistance from the PTTC and Prevention Solutions, Kentucky state-level staff provide one-on-one and system-wide training and technical assistance including training on the new Prevention Data System and the needs assessment process. Identified gaps drive the requested services from national TA providers.

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 for each community they serve. Each local provider completed a readiness assessment during SFY 2018/2019 utilizing the Tri-Ethnic Community Readiness Model. A follow-up readiness and resource assessment will be conducted and included as part of the needs assessment process beginning in SFY 22. Center staff have received additional training in the assessment process. Additional analysis support is provided through the evaluation contract for the prevention portion of the Block Grant by REACH Evaluation. The readiness components are included in the RPCs' work plans, which are monitored by state staff.

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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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

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 strategies to be implemented with SABG primary prevention funds? (●) Yes ( ) No

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

Kentucky's Evidence-Based Work Group is comprised of the RPC and DBH prevention professionals with more than 100 combined years prevention experience. The group is coordinated by a Department of Behavioral Health Prevention Branch state employee who also serves as the RPC Liaison. The Evidence-Based Work Group meets monthly to discuss how best to capture prevention activities in our electronic database, the Prevention Data System, so that we can use the data to report back to our funders, as well as evaluate efforts. The evidence-based database has recently been updated in coordination with the evaluation agency REACH of Louisville. Each program, practice or policy included in the list of approved state approaches is identified as evidence-based, evidence-informed, best practice, or no evidence, as a way of guiding prevention providers in selecting the best strategy to meet

the community's needs. The process is also used to evaluate new state approaches to be added to the list of approved programs, practices, and policies.

The prevention team will meet in November 2021 to update and develop a new two-year strategic plan.

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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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 funds the fourteen (14) Regional Prevention Centers to implement CSAPs strategies in each county of their regions based on local needs resource and readiness assessments. These needs assessments are part of the annual RPC Work Plans. 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. Some examples of strategies that are being funded by block grant dollars under each of the six strategies are as follows:
• 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 and Referral: Prevention providers currently utilize TEG TAP, Question, Persuade and Refer (QPR);

Prime for Life and Zero Tolerance – a youth DUI screening program, to increase awareness of the harmful effects of substance use. If, during the educational delivery, the prevention provider becomes aware of an individual who needs additional services, they are aware of and equipped to make the appropriate referral to treatment providers for delivery.

e) Community-Based Processes:

• Community-Based Process: Delivery of technical assistance and trainings on coalition building, stakeholder engagement, policy development, military culture, and the strategic prevention framework to prevent or delay the initiation of alcohol, marijuana, and tobacco use among youth and reduce the consequences of all substances across the lifespan.

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, responsible beverage server training, alcohol and tobacco environmental scans, training for law enforcement on best practices for conducting Party Patrols – surveillance, disruption and follow up regarding underage drinking parties, Sources of Strength.

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

DBHDID employs a program administrator who regularly reviews all expenditures charged to prevention funds to ensure they are utilized for primary prevention not funded through other means. Any irregularities are identified and the Chief Financial Officer (CFO) that oversees the RPC corrects any funding errors.

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:

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

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

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):

I. Activity Type
II. IOM intervention type (universal direct, universal indirect, selective, indicated)
III. Staff Time
IV. Partners
V. 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):

i. Risk factors (suspension, weapons, drug sales, car theft, aggression)
ii. Age of onset
iii. School safety
iv. Problems at school
v. Mental health
vi. Accessibility
vii. Lifetime use
viii. Bullying
ix. Violence
x. Extracurricular activities/school connectedness
xi. Sleep
xii. Social media use

Over the past two years, 26% of the positions within Kentucky's prevention system have experienced turnover and 49% of prevention specialists within the system have less than two (2) years' experience. This represents a nearly $300,000 loss in funds over the course of two (2) years potentially related to the inability to keep staff to complete contract deliverables in a timely fashion, according to research. Research also shows that employees who experience a negative onboarding experience are two (2) times more likely to seek other employment. Without a strong upstream prevention plan to address the loss Kentucky's Prevention system has experienced we could see additional capacity issues that will erode our ability to meet the needs of our communities' prevention needs.

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. As new staff members are hired, efforts are being made to provide training and technical assistance to retain those staff members. Training and technical assistance is focused on rebuilding and sustaining the infrastructure of the prevention delivery system to use the SPF process. A training and onboarding system is being developed and includes 41 sessions focused to build foundational and advanced prevention skills. The sessions will be delivered in-person and virtually and will be conducted by state and national-level subject matter experts.
A plan will be developed in the spring of 2022 based on the upcoming strategic plan and needs assessment.

A plan will be developed in the spring of 2022 based on the upcoming strategic plan and needs assessment.

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

a. Developing appropriate job descriptions that attract qualified prevention providers
b. Conducting resume analysis to identify appropriate candidates
c. Conducting behavioral interviews to select appropriate candidates
d. Developing provider-level onboarding systems to complement the state-level onboarding systems
e. Increasing capacity of identified providers to onboard quickly but develop foundational prevention skills and knowledge
f. Identifying alternative/additional sustainable funding sources to support workforce recruitment and retention (i.e. higher salaries to increase tenure and experience of candidates).

Footnotes:

Behavioral Health Prevention & Promotion Branch
Strategic Plan

Cabinet for Health & Family Services
Department for Behavioral Health, Developmental & Intellectual Disabilities
Division of Behavioral Health

OUTLINE

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IV. Branch Context

V. Summary of Core Strategies

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VII. Business Model

VIII. Organizational Capacity Development Plans

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EXECUTIVE SUMMARY

The Behavioral Health Prevention & Promotion Branch is housed in the Kentucky Cabinet for Health & Family Services and the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities. The mission of the Department is to provide leadership, in partnership with key stakeholders, to prevent disability, build resilience in individuals and their communities, and facilitate recovery for people whose lives have been affected by substance use/misuse, mental illness, intellectual disability or other developmental disability. Within this definition, the Behavioral Health Prevention & Promotion Branch seeks to empower Kentucky communities to implement evidence-based and evidence-informed interventions in an effort to reduce or eliminate the consequences of substance use, suicidal behavior, or problem gambling in Kentucky.

In this strategic plan, we commit to:

- Strengthen internal operations and infrastructure
- Increase awareness of the effectiveness and need for prevention throughout Kentucky
- Nurture partnerships, key stakeholder and community relationships
- Address programmatic opportunities and needs

Mission Statement

The Behavioral Health Prevention and Promotion Branch (BHPP) improves health outcomes for all by empowering communities to address local problems through a comprehensive system of evidence-based prevention strategies.

Vision Statement

We envision healthy Kentucky communities free from substance use and suicide.

BRANCH CONTEXT

Founded: Department of Mental Health (1952); Community Mental Health Centers (1963); SA Prevention (1992); Behavioral Health Prevention & Promotion Branch (2012)

Current Operations:

Current Budget: $7.1 million contracted to key partners across the state, including the Regional Prevention Centers through the Community Health Centers.

Programs and Tools:

Regional Prevention Center (RPCs): RPCs provide training and technical assistance to community-level stakeholders and coalitions with a focus on increasing prevention capacity. RPC efforts focus on utilizing data to assess behavioral health issues – specifically substance use/misuse and suicidal behavior – within each region, and develop a comprehensive plan of evidence-based and evidence-informed interventions to decrease the risk factors and increase protective factors related to substance use and suicide rates. Kentucky's 14 Regional Prevention Centers are integrated within the Community Mental Health Centers to cover all 120 counties across the state. RPCs are described in the Kentucky Administrative Regulations (908 KAR 1:380-400).

Synar Program: The Synar Program is a requirement of the Substance Abuse and Mental Health Services Administration (SAMHSA) and applies to every state receiving federal funds for substance abuse prevention and treatment, of which Kentucky does.. The Synar Program requires states to reduce the availability of tobacco products to underage youth by enacting and enforcing laws prohibiting the sale and distribution of tobacco products to minors. The Synar Program also requires states to conduct annual random, unannounced inspections of tobacco outlets and report these findings to the Secretary of the U.S. Department of Health and Human Services. States must maintain a 20% or lower violation rate for their annual inspections of tobacco outlets.If the violation rate is greater than 20% the state could lose 40% of its federal substance use/misuse prevention and treatment funding.

Youth Empowerment System Grant (YES): The YES grant sponsors work of young people in middle and high school across Kentucky, encouraging them to take ownership of substance use prevention by designing and implementing prevention efforts to be carried out in their communities.

Partnership for Success 2015 (PFS): This five-year, federal discretionary grant serves to reduce non-medical use of prescription drugs (NMUPD), heroin and suicides among youth and adults, with a special focus on service members, veterans (aged 18-25) and families. The goals of PFS 2015 are to reduce:

- Past 30-day non-medical use of prescription drugs
- Past 30-day heroin use
- Prescription drug-related emergency room visits
- Prescription drug-related overdoses

Suicide Prevention: Suicide Prevention efforts coordinated through the Branch promote collaborative partnerships to provide comprehensive, life-span strategies through community-level stakeholders.

Kentucky Initiative for Zero Suicide (KIZS): The KIZS program is a five-year federal discretionary grant with goals of developing and implementing statewide evidence-based youth (ages 10 – 24) suicide prevention and intervention strategies. The grant goals also promote and implement a system of suicide intervention, treatment and recovery utilizing the seven elements of the Zero Suicide Framework across youth-serving behavioral health care providers across the state. This program has two resource positions to engage the needed stakeholders for developing a suicide free community.

- PES – The Suicide Prevention Enhancement Site Coordinator will serve as the liaison and technical assistance coordinator to support the pilot site in planning and implementation of suicide safer communities, regional training and marketing strategies, and disseminate statewide. The PES will assure the project's goals are met through needed prevention technical assistance.
- TES - The Treatment Enhancement Site Coordinator will serve as the liaison and technical assistance coordinator to support the pilot site in planning and implementation of suicide safer communities, regional training and marketing strategies and then dissemination of concepts statewide. The TES will assure the project's goals are met through needed treatment technical assistance.

Prevention Enhancement Sites (PES): PES are statewide content matter specialists - Alcohol, Tobacco, Marijuana, Faith-Based, Suicide, and Substance Exposed Infants– hosted within RPC's. As experts, they provide technical assistance to state- and community-level stakeholders on the latest research, evidence-based practices, data trends, legislation, and training opportunities in their respective subject matter. PES disseminate updates to the statewide prevention network via email, trainings, and webinars. PES respond to information requests from many different agencies across the state, and integrate their work within the RPC work plans, ensuring efforts are aligned with identified needs within the individual RPCs and across the prevention system.

KY Alliance of Boys & Girls Clubs (B&GC): The Kentucky Alliance of Boys & Girls Clubs represents participating Boys & Girls Club-affiliated organizations across the Commonwealth. The Alliance provides substance use prevention education to youth who are members of the Club, using the SMART Moves curriculum. The SMART Moves curriculum is a multi-session, resiliency-based curriculum designed for elementary through high school-aged students, with an additional parent component provided. The Branch works with the B&GC to ensure that the chosen curriculum is implemented with fidelity and that quarterly programmatic data are collected and financial reports are accurate and timely.

Kentucky Council on Problem Gambling (KYCPG): The Kentucky Council on Problem Gambling is a collaborative that provides evidence-based gambling prevention information and education to all ages through an annual education and awareness conference, and via their website. The Branch partners with KYCPG in its conference planning, keeps the RPCs aware of the shared risk and protective factors connecting problem gambling and substance use and strives to include substance prevention stakeholders in KYCPG's efforts.

Zero Tolerance (ZT): The Zero Tolerance program focuses on implementing the Zero Tolerance requirements outlined in Kentucky Administrative Regulations (908 KAR 1:315) for those individuals under 21 who are found to be in control of a motor vehicle with a blood alcohol concentration (BAC) of .02 to .08. Currently this program has no funding. The Branch considers this program an example of an Indicated Prevention approach (i.e., a universal prevention approach with groups of individuals who have been identified as exhibiting early warning signs of problems). It is developing a provider network and assessing the availability of the program across the state.

Prevention Data System (PDS): The PDS is a data collection and planning tool utilized by Kentucky's RPCs and PES to document their annual work plan, as well as record activities that occur in their communities to support that work plan. The resulting information supports BHPP Branch's grant writing, grant reporting and communication efforts, and assists RPCs in tracking outcomes of prevention work done in their communities.

REACH Evaluation: REACH has been the evaluation component of the Prevention Branch since 2002. REACH Evaluation is the contractor responsible for administration, scoring, and dissemination of results of the Kentucky Incentives for Prevention (KIP) survey - 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. The survey is offered every other year, with REACH responsible for eight survey administrations in 2003, 2004, 2006, 2008, 2010, 2012, 2014, and 2016. 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. In 2016, over 110,000 students representing 149 school districts completed the survey, and the information gathered provided an invaluable substance abuse prevention tool for those communities. Districts utilize their KIP results extensively for grant-writing purposes, prevention activities, and various other needs related to program planning. RPCs also heavily rely on KIP Survey data to inform their required Needs Assessment process.

State Epidemiological Outcomes Workgroup (SEOW): REACH Evaluation assumes the primary role in managing and coordinating all SEOW activities, including production of all major deliverables. Currently, staff at REACH Evaluation has worked closely with the SEOW members to produce comprehensive state and community profiles as well as a series of short reports highlighting priority substance abuse and mental health issues. The SEOW utilizes a public health approach to prevent substance abuse and its consequences in Kentucky as originally outlined by the Strategic Prevention Framework (SPF). The SEOW also expands the focus of data-driven monitoring and surveillance of substance abuse to include mental and behavioral health correlates through comprehensive analyses of state and local data. The SEOW consists of approximately 20 representatives from a variety of government, state, and academic entities such as the Office of Drug Control Policy, Department for Public Health, State Workforce Cabinet, University of Louisville, and University of Kentucky.

CORE FUTURE GOALS

1. Strengthen internal operations and infrastructure

In order to support progress toward Branch goals, team members must be trained and focus on maximizing all resources, including funding and time. To accomplish this, we must:

- ➢ Provide cross training for Branch staff
- ➢ Support staff members in becoming Certified Prevention Specialists
- ➢ Establish a consistent internal and external communication process
- ➢ Add a Statewide Substance Use Prevention Strategic Planning component to the Branch's Strategic Plan

2. Increase awareness of the effectiveness and need for prevention throughout Kentucky

Prevention changes lives. This team uses an evidence-based, data-driven approach to inform its work. To increase the state's prevention capacity, the Branch will increase the effectiveness of prevention strategies in Kentucky by pursuing training and technical assistance activities and opportunities that are used to improve the existing stakeholders' use of evidence based strategies. By enlisting and engaging additional partners to implement universal, selective and indicated prevention strategies, the Branch will work toward creating a broader understanding of the impacts evidence-based, data –driven approaches can have on the behavioral and physical health of communities.

3. Nurture partnerships and community relationships

To successfully promote a model of shared risk and protective factors, our team must maintain or establish strong ties among stakeholders serving through governmental agencies and nonprofit organizations within the communities that we serve. The foundation of this work is in establishing consistent messaging for the prevention system, in order to create sustainable efforts and partnerships.

4. Proactively address programmatic opportunities and needs

In order to effectively utilize resources within the Kentucky prevention system, the team must identify needs and opportunities and then seek funding opportunities that support these identified capacity gaps. By proactively determining areas of need and opportunity, the team will have a sense of the big picture and will be able to make informed decisions about the pursuit of future funding opportunities and its impact on the system as a whole.

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Core Strategy: Strengthen internal operations and infrastructure

Program/Focus Area	Goal(s)	Long-Term Objectives
Human Resources	Attract and retain qualified staff for all services and activities.	● Hire an administrative assistant or program coordinator position ● Pursue formation of an AmeriCorps VISTA position for the Branch ● Apply for a Center for Substance Abuse Prevention Fellow position for the Branch ● Maintain relationships with local practicum placement universities for future possible intern placement ● Update job descriptions to capture each position's role ● Hire a marketing position to coordinate outcomes, stories of success, useful tools, etc. ● Develop onboarding toolkit to guide RPCs in hiring process that results in staff who meet the skill sets required in regulation and align with the Department's goals.
Information Technology & Management Information Systems	Increase the operations, management efficiency and effectiveness of the Branch efforts. Strengthen existing partnership with REACH by intentionally leveraging existing and future contracts.	● Improve the current Prevention Data System (PDS) for tracking all necessary information required for funding sources and management decision-making ● Improve the output capabilities of the PDS to include standard reports available for all users ● Provide RPCs with regular analysis reports of the data that they have entered ● Implement system of incentives and consequences for RPC data entry ● Build technological capacity within the Branch

Organizational Structure and Culture	Sustain an organizational structure and culture that supports clear lines of accountability and a culture that rewards creativity and new ways of doing things.	● Establish an efficient meeting structure ● Continue to promote Prevention Power Hours as an opportunity for learning about new topics and introduce them as an opportunity for connecting with partners ● Promote and support opportunities within each position to expand and enhance managed programs ● Encourage creative and research supported approaches to address identified barriers ● Create program evaluation opportunities for managed programs to improve practice and policy
Fund Development	Establish a funding mechanism based on need and data collected in the PDS. Maintain current government funding (e.g., block grant) Pursue new funding opportunities (federal discretionary funding opportunities)	● Partner on KORE and other appropriate grants within and across Branches to better leverage funding dollars. ● Transition RPC budgets from a fixed annual allocation to a performance-based model ● Adopt a list of “shovel-ready” programs for new funding opportunities ● Increase RPC/prevention providers' capacity to support the Branch's attainment of funding goals.
Cost Management	Improve cost accounting and reporting to team members, RPCs, and PES.	● Establish regular financial and programmatic review meetings for managed programs ● Develop quarterly financial analysis tools to assess the status of contracts and expenditures ● Provide guidance to RPCs on contract language prior to finalization

		● Provide guidance to RPCs and CMHC CFOs on required financial forms and reporting expectations ● Develop and disseminate a staffing form to RPCs and provide guidance on requirements for updates

Core Strategy: Increase awareness of the effectiveness and need for prevention throughout Kentucky		
Program/Focus Area	**Goal(s)**	**Long-Term Objectives**
Prevention Enhancement Sites (PES)	Adopt a model of data-informed decision making PES recognized as subject matter experts Evaluate PES – what value do they add to the prevention system by the RPCs Possible restructuring of subject matter (i.e., adding a sustainability PES)	● Promote PES at local and national conferences to highlight their expertise ● PES embed their work plans within the RPC work plans, acting as a resource for RPCs by deepening the existing work being done statewide in their respective subject area ● Increase capacity of PES staff to be viewed as subject matter experts in their focus area ● Encourage participation in training opportunities that increase subject matter expertise of PES ● Create guidance documents that outline the specific requirements needed to qualify as a PES (contact hours prior to hire, CPS within 2 years, etc.), job duties, and constituents ● RPCs actively seek out and utilize PES expertise ● Create a process to be used when filling a vacant PES position ● Update marketing materials for PES distribution ● Strengthen relationships between PES, YES, and RPC.
Program Evaluation	Effectively leverage standing data	● Create a new state profile

	partnership with REACH	● Implement an evaluation of the SMART Moves program ● Establish a regular cycle of program evaluation across program areas ● Increase use of the State Epidemiological Outcomes Workgroup's (SEOW) data and data interpretation expertise in developing state and regional substance use priorities
Branch	Create a statewide prevention plan that reflects a comprehensive set of strategies to address substance use prevention and suicidal behavior through the lens of risk and protective (resiliency) factors	● Establish a timeline for completing a needs assessment ● Create an example of a comprehensive work plan for substance use ● Use the SPF framework to inform the prevention planning

Core Strategy: Nurture partnerships and community relationships		
Program/Focus Area	**Goal(s)**	**Long-Term Objectives**
External Communications	Advocate for the branch by increasing the visibility and community awareness of BHPP. Make sure the BHPP is properly recognized for its achievements and closely identified as a critical component in the efforts to make Kentucky a healthier state for all. Manage sharing of the story of prevention -- both the positive outcomes of having it and negative consequences for avoiding it.	● Develop a consistent message describing the work of the prevention system sponsored by the Branch. ● Update existing messaging materials. ● Establish a communications plan that consistently promotes the successes of the Branch to internal and external partners by leveraging national attention. ● Create online repository of stories, tools, and examples that communities can use in their work ● Regularly update intranet and internet with prevention system messaging, education materials, success stories, and calendar events. ● Establish a recurring newsletter to partners.

		● Celebrate and share the successes of RPCs/prevention providers ● Leverage current Kentucky School award system to spotlight positive prevention work being done in Kentucky. ● Establish regular communication mechanism between REACH and Branch staff
Resource and Business Development	Strengthen partnerships	● Use stories of effective partnerships to make the case to potential new partners ● Foster a relationship with the Department of Public Health ● Foster a relationship with the Department of Education ● Foster a relationship with the Family Resource and Youth Service Centers ● Foster a relationship with the Administrative Office of the Courts (CDW) ● Foster a relationship with the Department of Juvenile Justice ● Foster a relationship with the Kentucky Association of Sexual Assault Programs (KASAP) ● Foster a relationship with the Center for School Safety

Core Strategy: Proactively address programmatic opportunities and needs		
Program/Focus Area	**Goal(s)**	**Long-Term Objectives**
Prevention Enhancement Sites (PES)	Strengthen the autonomy and viability of each PES position	● Create an annual work plan for PES to follow ● Leverage webinar technology for PES trainings ● Establish schedule of training topics and themes to advance all PES roles ● Establish clear purpose and goals for the statewide work of the PES

Youth Empowerment System Grant (YES)	Increase the number of youth engaged in YES programs Prioritize an evidence based prevention perspective in all YES outcomes	● Build relationships with youth through the Branch and RPCs ● Align application to meet prevention perspective guidelines ● Establish connections between YES and other Branch programs (ex: Synar, Suicide Prevention) ● Add 'connecting with adult sponsors of YES funding' into RPC duties ● Implement trainings as a qualification for potential grantees
KY Alliance of Boys & Girls Clubs (B&GC)	Increase attendance of SMART Moves trainings	● Establish an ongoing evaluation process with REACH ● Encourage the implementation of the parent curriculum ● Connect RPCs with clubs in their region
Zero Tolerance (ZT)	Implement state regulations as written for the betterment of the community	● Assess the placement of the ZT program in the Branch ● Strengthen relationships with judges (or improve their knowledge of what is needed) ● Increase marketing to promote comprehensive primary prevention ● Create an annual budget for the program
Kentucky Council on Problem Gambling (KYCPG)	Continue to support the KYCPG annual conference	● Encourage PES to use the conference as a platform for sharing their expertise ● Support gambling prevention efforts to other prevention providers by promoting the shared risk and protective factors between gambling and substance use
Kentucky Initiative for Zero Suicide (KIZS)	Increase utilization of the Zero Suicide Framework among behavioral health service providers in Kentucky Reach more practitioners	● Build additional Kentucky Suicide Prevention Coalitions ● Work collaboratively through shared risk and protective factors ● Relaunch the Suicide Prevention Consortium of Kentucky ● Create a set of marketing toolkits that highlight ways other sectors play a role in suicide prevention

Synar Grant	Increase the number of tobacco clerks who are trained through the TRUST Program Maintain a retail violation rate of below 10% for annual Synar Tobacco Retail inspections. Build state-level capacity for a tobacco retail licensing law.	● Engage communities to promote the TRUST Program to local tobacco retailers. ● Promote non-adversarial relationships between local tobacco prevention coalitions and tobacco retailers. ● Support local efforts to conduct tobacco inspections.
Partnership for Success 2015 (PFS)	Reduce prescription drug and heroin overdoses & non-medical use of prescription drugs, heroin and suicides among 12-25 year-olds with a special focus on service members, veterans and family members.	● Increase RPC capacity to address non-medical use of prescription drug, heroin and suicides. ● Increase RPC capacity to deliver prevention services to service members, veterans and family members.
Regional Prevention Center (RPC) Network	Strengthen and build capacity of the RPC network	● Maintain a tracking system for staffing, to include certifications ● Implement data-driven decision making model that uses the SPF process and is supplemented by information entered into the PDS ● Implement an performance-based funding formula ● Assess opportunities for RPCs to have more financial independence in their work ● Identify alternative approaches to staffing RPCs and RPC program delivery ● Reimagine the RPC job description and create plan for implementing proposed changes
REACH Evaluation	Strengthen and extend the connections with the Branch's primary evaluation partner	● Work to improve the number of school districts participating in the Kentucky Incentives for Prevention (KIP) Survey to increase the Branch's understanding of youth substance use trends ● Integrate REACH staff into Branch meetings on a regular basis to improve communication regarding current and future projects.
State Epidemiological Outcomes Workgroup (SEOW)	Strengthen and extend the data-driven monitoring and surveillance of substance abuse activities conducted in the Division of	● Increase the Branch's involvement with the State Epidemiological Outcomes Workgroup (SEOW) to improve its data collection and

	Behavioral Health	interpretation activities.

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for 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 recovery-oriented, resilience-based, comprehensive, community-based system of behavioral health care for adults with serious mental illness (SMI), children and youth with severe emotional disturbances (SED) and their families, and adults and youth with co-occurring substance use disorders (SUD), through contracts with Kentucky's Regional Boards, also known as Community Mental Health Centers (CMHCs). 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 use and prevention services. Together, the fourteen (14) Community Mental Health Centers (CMHCs) serve all 120 Kentucky counties. A Regional Board has been established, pursuant to KRS 210.370 – 210.480, 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 their 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.
DBHDID works with Kentucky Department for Medicaid Services so that basic services, like outpatient and rehabilitation services, are available and have similar requirements for Medicaid and non-Medicaid eligible individuals.
DBHDID contracts with fourteen (14) private, not-for-profit CMHCs to provide services to individuals in all 120 counties in the state. CMHCs are required to describe, in detail, their current system of care for children with SED, adults with SMI, and Transition Age Youth (TAY), and to submit their plans for development regarding key system components, within the annual Plan and Budget process.
For adults with SMI, these key components include: consumer and family support; emergency services; behavioral health treatment services, including co-occurring integrated treatment for Mental Health/Substance Use Disorders; targeted case management; rehabilitation services such as therapeutic rehabilitation programs, supported employment/education, peer support, assertive community treatment, and comprehensive community supports; intensive outpatient therapy programs for mental health issues; housing support such as supportive housing services, residential supports and housing development; physical health interface, continuity of care, including community medication management programs; homeless outreach; and rural outreach.
For children and youth with SED, these key components include: screening, assessment and outpatient treatment; medication management; school based services; intensive in home services; intensive outpatient programs for mental health issues; day treatment; partial hospitalization programs, integrated treatment for mental/substance use disorders; specialized summer programs; respite care; therapeutic foster case; recovery supports; youth and family/parent peer support services; individual placement and support (IPS) supported employment and education services; targeted case management; high fidelity wraparound services; comprehensive community support services; early childhood programs; specific transition age youth programming, including medication assisted treatment, coordinated specialty care for first episode psychosis, and drop in centers staffed with youth peer specialists.
DBHDID is committed to working collaboratively with CMHCs to continuously enhance continuity of care, service effectiveness and accountability.

2. Does your state coordinate 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 or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

Adults with SMI

HEALTH

Kentucky is a relatively unhealthy state and struggles with poor health outcomes overall. The interface between the physical healthcare systems and the mental health system is of growing importance to providers of behavioral health services. It is well known that a significant amount of behavioral health services is provided in the physical healthcare arena. Continuity of care across those systems is critical for individual recovery and success in establishing chosen roles in the community.

The National Diabetes Statistics Report, 2017, from the Center for Disease Control (CDC), analyzed health data through 2015. This report acknowledges that 30.3 million Americans have diabetes, and 84.1 million American adults have prediabetes. The southern and Appalachian regions, which include some parts of Kentucky, had the highest proportion of diagnosed diabetes. Nearly 16% of adults diagnosed with diabetes were smokers, nearly 90% were overweight, and more than 40% were physically inactive. These results are representative of some Kentuckians, and many Kentuckians with SMI.

PHYSICAL HEALTH

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

Kentucky's CMHCs are now able to provide Medicaid reimbursable primary health care services to individuals who are eligible through the Medicaid program. The Medicaid state regulation that outlines the program requirements for providing this level of care can be found here: https://apps.legislature.ky.gov/law/kar/907/001/047.pdf. SFY 2022 Plan and Budget submissions indicated six (6) of the fourteen (14) regions are currently providing primary care services to individuals they are serving in their programs, one (1) additional is in development, and three (3) provide minimal services such as physicals or contract out to physical health providers.

In addition, all fourteen (14) regions reported having some type of formal agreement with a least one (1) health care provider in their area. Many regions also reported numerous informal agreements with health care providers in their area, such as agreements with local medical facilities to offer mobile health services, collaboration with private hospitals to provide assessments and healthcare for individuals being served through CMHCs, nutrition work with local health centers for individuals receiving treatment at CMHC, in addition to numerous agreements regarding screening and assessment.

One (1) region in eastern Kentucky (Mountain) was awarded a grant in SFY 2013 regarding health care for individuals who are homeless. The first "Homeplace Clinic" was located in the lower level of the CMHC outpatient clinic in Johnson County, a very rural location in Kentucky, and provided services to individuals from surrounding counties. This project has made an integrated, holistic approach possible for individuals served in this area. Services provided thus far include preventative care, disease management, basic laboratory services, health education, medication management, patient assistance programs, mental health and substance use services (collaboration includes co-location of behavioral health providers), as well as referrals to other medical providers for dental, vision, and specialized medical care. Mountain currently has expanded to five (5) Homeplace Clinics, one that targets individuals with SMI.

Another region in southeastern Kentucky (Kentucky River) manages a physical health clinic in Knott County. This health care center provides integrated care to clients and referrals to more intensive programs for clients with more complex needs.

Another region in northern Kentucky (NorthKey) operates three (3) primary physical health care clinics in Covington, Florence and Carrolton. NorthKey therapists and case managers make internal referrals to the clinics to help clients with quick access to a health assessment. The clinics address the significant physical health needs of SMI and SUD clients, including high blood pressure, managing diabetes, and other illnesses and conditions.

For dental care, access to low or no cost services are provided by the dental schools of the University of Louisville and the University of Kentucky (in Lexington). They serve individuals in the clinics located in Lexington and Louisville. The University of Kentucky also provides mobile dental services that reach out to uninsured families in eastern Kentucky (those who do not make enough money to pay for dental care but who make too much money to qualify for Medicaid assistance). There are four (4) dental vans from the University of Kentucky. Several faith-based organizations have provided the financial

support needed to start these services and to keep them operating. In addition, some faith-based groups have opened free clinics in church buildings, which are staffed by volunteer dentists who come to the region from all over the state for weeklong mission trips. Others hold dental events in Walmart parking lots, handing out free samples of toothpaste, dental floss and toothbrushes to anyone who wants them. Still, targeted case managers and clinicians that have knowledge of local resources and well-developed relationships with local providers tend to lead to better access to dental services. There are, in many communities, those dentists who will serve individuals in need who have no ability to pay. However, overall access to dental care is generally considered poor.

MENTAL HEALTH

The grid below demonstrates the availability of the wide array of services for adults with SMI in each of the fourteen (14) Regional Boards. The grid is updated annually based on required Plan and Budget submissions. This grid is populated from April 2021 submissions.

Adult Mental Health Services Array for SFY 2022 (X-available in region, D-in development)

ADULT SERVICES ARRAY REGIONAL AVAILABILITY OF COMMUNITY SUPPORT SERVICES

SERVICES REGIONS

1 2 3 4 5 6 7 8 10 11 12 13 14 15

Consumer and Family Support

Consumer Support Groups X X X X X X X X X

Consumer Operated Services Program (COSP) X X X X X X X D X

Social-Club Drop-In X X X X D

Local NAMI Kentucky Affiliates X X X X X X X X X X X X X

Consumer Conferences X D X X

Crisis Services

Emergency-Help Line X X X X X X X X X X X X X

Walk-In Crisis Services X X X X X X X X X X X X X

Other Crisis Intervention Services X X X X X X X X X

Mobile Crisis Services X X X X X X X X X X X X X

Residential Crisis Stabilization X X X X X X X X X

Mental Health Treatment

Community Medications Support Program X X X X X X X X X X

Specialized Co-Occurring Disorders Services X X X X X X X X X

Intensive Outpatient Program for MH X D X X

Targeted Case Management (TCM)

TCM for Adults with SMI X X X X X X X X X X X X X

TCM for SMI + Physical Health X X X X X X X X D

Flexible Funds for SMI (Wraparound Funds) X X X X X X X X X X X X X X

Payee Services X X X X X X X X

Rehabilitation Services

Therapeutic Rehabilitation X X X X X X X X X X X

IPS Supported Employment (IPS) X X X X X X X X X X X X

Educational Services (Supported Education) X X

Illness, Management and Recovery (IMR) X X X X X X X X X

Adult Peer Support Services X X X X X X X X X X X X X

Assertive Community Treatment X X X X X X X X X X X X

Comprehensive Community Supports X X X X X X X X X X X

Housing Options

Supportive Housing Program X X X X X X X X X X X

Residential Support X X X X X X X

Housing Development X X X X X

MENTAL HEALTH TREATMENT

Each regional board provides a full array of outpatient services including, but not limited to, individual psychotherapy, group psychotherapy, psychiatric evaluations, walk-in emergency appointments, psychopharmacology, medication education and peer support services. Every effort is made to place these outpatient clinics within close geographic proximity for individuals in order to assure easy access to needed services. Additional areas of focus include:

• Recognizing the need to provide assertive outreach so fewer appointments are missed although most regions do report having a system for following up with misses appointments;

• Assuring medication continuity within the agency when level of care changes;

• Addressing shortages of professional staff, especially prescribers, increasing waiting periods for appointments;

• Assuring continuity of care between Regional Boards and inpatient settings or other community providers, thereby ensuring quality, holistic care;

• Screening adequately for substance use disorders/co-occurring disorders; and

• Providing opportunities for staff training in co-occurring mental health and substance use disorders (screening, assessment and treatment).

In January of 2014, a Kentucky Medicaid state plan amendment was approved by CMS. Included as part of the Medicaid billable package of service available for adults with SMI were such services as Assertive Community Treatment, Peer

Support Services, Comprehensive Community Support Services, and Intensive Outpatient Treatment for Mental Health. The DBHDID restructured CMHC contracts to include many of these services as requirements. For example, each CMHC is now required to provide Assertive Community Treatment and Peer Support Services to individuals with SMI who qualify for those services.

SUBSTANCE ABUSE TREATMENT AND PREVENTION

Medicaid billable services for individuals with substance use disorders (SUD) was approved in the state plan amendment active January 2014. Billable services for these individuals include Residential Services for Substance Use Disorders, Screening, Brief Intervention and Referral to Treatment (SBIRT), Medication Assisted Treatment, and peer support. In addition, services such as Individual Therapy, Group Therapy, Intensive Outpatient Therapy for SUD, and an array of crisis services including Crisis Intervention, Residential Crisis Stabilization Services, and Mobile Crisis Services became available for individuals with SUD. In response to these changes, the DBHDID restructured contracts, restructured data systems to define and collect data for all new services, and has been working to provide continued guidance to providers through the development of service standards and other technical assistance.

Substance use specific services provided through contracts with Regional Boards include:

• Prevention programming to communities offered through fourteen (14) Regional Prevention Centers;
• Juvenile diversion programs, DUI assessment and education programs;
• Consultation with businesses on the development of a drug-free workplace and Employee Assistance Programs;
• Detoxification centers, residential treatment programs, intensive outpatient treatment services, other outpatient services including peer support and targeted case management;
• Specialized treatment services for pregnant women, adolescents and intravenous drug users, and
• Medication assisted treatment to opiate dependent persons who are high-risk for HIV disease due to their intravenous drug use.

Training, consultation and individual evaluations are made available, within budget limitations, to criminal justice agencies and other agencies within the Cabinet for Health and Family Services for individuals with substance use issues.

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

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

CO-OCCURRING DISORDERS

In 2009, the Division of Mental Health and Substance Abuse was renamed the Division of Behavioral Health. Formal steps have been taken by the KDBHDID towards the integration of mental health and substance use services across the Commonwealth.

Steps that have been taken by the Division include:

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

Between SFY 2009 and SFY 2015, a team of integration specialists was created by DBHDID to use DDCAT and DDMHT tools and to visit regional programming and assess co-occurring capabilities. All programs were offered the opportunity to use the data from their DDCAT/DDMHT reviews to make changes using the Network for Improvement of Addiction Treatment (NIATx) process improvement model to raise any scores below the score of three (3), which is considered co-occurring capable. The DBHDID provided technical assistance, regarding change projects as well as DDCAT/DDMHT fidelity assessments. A Transformation Transfer Initiative (TTI) grant, as well as securing a national consultant (Heather Gotham, co-creator of the tools), were instrumental in supporting regions in working towards co-occurring capability in their programming for adults. The DBHDID continues to provide technical assistance and periodic fidelity assessments.

One result of these statewide assessments was the realization that programs across the state did not include many peer-led mutual support groups. Mutual support and mutual aid groups are identified as one (1) of the ten (10) guiding principles of recovery from SAMHSA. The DBHDID leveraged funds from the TTI grant and later from the block grant, for purposes of hiring an individual in recovery from co-occurring disorders to consult with DBHDID staff, regional staff and

peers, and assist in the development of co-occurring mutual support groups in many regions across the state. Specifically, this individual in recovery assisted with development of Double Trouble in Recovery (DTR) mutual support groups across the state. DTR is an evidence-based model for peer-led group support for individuals with co-occurring mental health and substance use disorders. It is a twelve-step self-help peer group. At present, the Veteran's Administration and at least nine (9) regions provide DTR as a support for individuals and more groups are continuing to be developed. DBHDID continues to offer technical assistance and materials to assist with the development of this support across the state.

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

In working to establish and support ACT teams across the state it became apparent that a large number of individuals with SMI being served had co-occurring substance use disorders. The DBHDID contracted with Case Western Reserve University to provide a series of trainings in IDDT, an evidence-based practice that has been renamed Integrated Treatment for Co-Occurring Disorders by SAMHSA. All ACT teams across the state have had access to training in IDDT and continue to receive support and technical assistance through collaboration between the DBHDID and Case Western Reserve University.

Kentucky has been training peer support specialists since 2006. However, initially the only peers trained were in recovery from mental health or co-occurring disorders. For several years now peers in recovery from substance use disorders have been certified as peer support specialists as well. When the 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 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.

EMERGENCY SERVICES

Since 1995, the DBHDID has made a concerted effort to develop a statewide network of Crisis Stabilization Programs and include crisis stabilization units, mobile crisis teams, and emergency walk-in crisis intervention appointments. These programs, which primarily serve individuals with SMI, are a major factor in Kentucky's effort of decreasing inpatient utilization. Department staff supports the ongoing development and enhancement of the network by facilitating quarterly meetings of Emergency Service and crisis stabilization program directors and training events. The Department supports a full range of crisis services, including:

- 24-hour emergency hotlines;
- Warm lines;
- Walk-in crisis services;
- Mobile crisis services;
- Suicide hotlines;
- Residential crisis stabilization units;
- Crisis intervention services
- Overnight crisis beds;
- 23-hour observation beds in hospitals; and
- After hours face to face crisis evaluations.

Regional Boards have flexibility in how they choose to provide emergency services based upon the unique needs and population within their region. As such, the ideal array is not available in every region. For example, ten (10) of the fourteen (14) regions offer resident Crisis Stabilization Units or overnight beds. The flexibility does enable the regions to expand crisis services to meet their unique needs and two (2) regions have set aside at least one (1) bed in their facility to serve the crisis needs of adults with Developmental and Intellectual Disabilities. This has become a specific need in other regions and the Adult Crisis Directors group shares information and specific protocols for various populations, when an individual is admitted to a Crisis Stabilization Unit (CSU).

See the Crisis Services Environmental Factor for more detailed information about Crisis Services.

REHABILITATION SERVICES (Includes Educational and Employment Services)

The Psychiatric Rehabilitation Association (www.psychrehabassociation.org) defines psychiatric rehabilitation as services that help individuals with mental illness develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning and social environments of their choice. Psychiatric rehabilitation services are services that are collaborative, person directed, individualized and based in evidence.

The DBHDID promotes the use of psychiatric rehabilitation technology by regional programs. The Psychiatric Rehabilitation model developed by the Center for Psychiatric Rehabilitation at Boston University was selected as the exemplary model as it has been extensively documented, validated, and replicated in hundreds of different settings for over two (2) decades. This model also addresses the major components of Community Support Services identified by KDBHDID with a focus on improving the lives of persons with psychiatric disabilities by enhancing their use of skills and/or environmental supports to live, learn, work and socialize in the community and role of their choice.

The DBHDID also promotes the use of SAMHSA's working definition of recovery, including the dimensions of health, home, purpose and community, as well as the ten (10) guiding priniciples of behavioral health recovery.

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

opportunities.
Currently, the DBHDID, Kentucky Medicaid, the Regional Boards, and other providers have not adopted a specific model of practice. Some programs have independently adopted a specific model but have had difficulty implementing and maintaining a commitment to training and outcome measurement. The Psychiatric Rehabilitation model offers a method that would specifically address improvement in skills, functioning, social environment, and role attainment with a proven process, intervention and technology base.
The DBHDID supports the provision of these key psychiatric rehabilitative services at the regional level:
• Therapeutic rehabilitation programs;
• Supported employment;
• Supported education;
• Illness, management and recovery;
• Peer support services;
• Comprehensive community supports; and
• Assertive community treatment.
While each rely on psychiatric rehabilitation foundations, each are supported in very different ways.
KDBHDID supports psychiatric rehabilitation services through the Regional Boards in a variety of ways:
• The DBH designates a statewide Community Support Program (CSP) coordinator;
• Contracts with Regional Boards require designation of a regional Community Support Director and attendance at quarterly meetings;
• Technical assistance and training is provided for CSP Directors who coordinate services for the state's therapeutic rehabilitation programs (TRP). TRPs are goal-directed services aimed at improving skills in living, working and socializing in communities of one's choice. Technical assistance is provide to regional programs in how to incorporate psychiatric rehabilitation technology into daily programming. In SFY 2021, twelve (12) regions provide therapeutic services for individuals with SMI;
• The DBHD designates a statewide Individual Placement and Support (IPS) Supported Employment coordinator;
• Collaboration between the DBH and several agencies (Office of Vocational Rehabilitation, Human Development Institute of the University of Kentucky, and others) have established implementation support for IPS Supported Employment for adults with SMI across the state. IPS in Kentucky began through a Johnson and Johnson grant through Dartmouth in 2010. IPS is currently provided in sixty-three (63) counties across Kentucky, and available in an additional twenty-one (21) counties through a regional or out-of-county program. There are also an additional five (5) counties with a program in development. DBHDID, in collaboration with the other involved agencies, participates in an International IPS Supported Employment learning collaborative and coordinates with Westat consultants for technical assistance on a quarterly basis;
• The DBH, in collaboration with the Office of Vocational Rehabilitation, hosts an annual IPS conference, inviting IPS supported employment specialists and their supervisors, vocational rehabilitation counselors, and others from across the state to participate in learning opportunities and to discuss barriers and strategies to address the barriers;
• Contracts with the Regional Boards require all regions to provide access to ACT, IPS Supported Employment, and Peer support services for adults with SMI. As of SFY 2018, all regions across the state have developed ACT teams and are providing ACT services to adults with SMI. Thirteen (13) of the fourteen (14) Regional Boards provides IPS Supported Employment to adults with SMI. In addition, all regions across the state have hired at least one (1) peer support specialist (most regions have hired several peer specialists) and are providing peer support as a service to adults with SMI;
• Ten (10) regions are providing access to Illness, Management and Recovery (IMR) services, an evidence-based practice for adults with SMI;
• Twelve (12) regions are providing Comprehensive Community Supports to individuals with SMI, a relatively new service designed to provide skill building services in community settings to assist with independent living, and;
• Two (2) regions provide access to educational services to adults with SMI. According to the Kentucky Adult Literacy Survey, over 340,000 people lack the literacy skills to compete in the workforce. Lack of literacy skills act as a hindrance to the personal advancement of another 656,000 Kentuckians. The lack of available educational services can seriously hinder persons with SMI in accessing and maintaining employment and can negatively impact their quality of life. Providing access to educational support services should remain a priority. In addition, young adults experiencing first episode psychosis require supported education programming to navigate school successfully and/or explore higher education opportunities with good outcomes.
Although adult rehabilitation services are available, access to services is often inconsistent and often inadequate to meet the need. Only a fraction of adults with SMI in the state participate in rehabilitation programs offered through the Regional Boards.
The delivery of quality, timely rehabilitation services has been enhanced since approval of the Medicaid state plan amendment in January 2014, and since Kentucky's adoption of Medicaid Expansion under the Affordable Care Act. Many of the rehabilitation services are now billable through Medicaid, and all services are available off-site, often in community settings. However, quality, timely delivery remains challenged by a number of factors including:
• Kentucky Medicaid reimbursement rates for TRP, ACT, and peer support are quite low and significantly below the reimbursement rate for outpatient treatment services;
• Funding sources other than Medicaid do not reimburse for TRP, ACT or peer support services, or else have challenging processes of reimbursement, so individuals without Medicaid have difficulty accessing this service;
• Some rehabilitation services are inconsistent and do not have a specific model of practice with stated values, principles, practice guidelines, and expected outcomes of service;
• Supported employment is not reimbursed by Medicaid and there is limited funding for the long term employment

supports needed by adults with SMI;
• The advent of Managed Care, and Kentucky's contracts with six (6) separate Managed Care Organizations, has led to numerous difficulties with authorization for TRP, ACT and other rehabilitation services;
• Supported education is not reimbursed by Medicaid and is actually interpreted by some providers as being discouraged due to the possible appearance of duplicity of services; and
• Difficulties with transportation, especially for individuals who do not qualify for Medicaid benefits.

CHILDREN WITH SED

Specific to children and youth, there are a wide variety of initiatives that address the need for coordinated services.

Integration with Physical Health

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

Regional Boards are required to conduct a physical health screening of all clients served. Department staff continue to assist contracted providers in improving tools used to assess physical health concerns and to encourage further assessment and integration of physical and behavioral healthcare.

Kentucky Strengthening Families

Kentucky Strengthening Families (KYSF) represents a multi-disciplinary partnership of over twenty (2) national, state and local, and public and private organizations dedicated to embedding six (6) research-based Protective Factors into services and supports for children and their families. Supporting families is key strategy for promoting school readiness and preventing child abuse and neglect. All families experience times of stress, and research demonstrates that children grow and learn best in families who have the supports and skills to deal with those times. By supporting families and building their skills to cope with stressors, we can increase school readiness and reduce the likelihood abuse will occur in families. KYSF is using a nationally recognized strategy –Strengthening Families: A Protective Factors Framework---which is coordinated nationally by the Center for the Study of Public Policy. KYSF is supported by the Governor's Office for Early Childhood, the Kentucky Department for Public Health, and other state agencies. KDBHDID staff serve on the KYSF Leadership Team, subcommittees, and training cadre. Additionally, KYSF protective factors have been embedded into CMHC contracts and Trauma Informed Care training.

Mental Health and Rehabilitation Services

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

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

• All regions offer off-site therapy services at the home of the child and throughout the community;
• The CMHCs employ 186 Service Coordinators to provide targeted case management to children and adolescents with SED and another 28 Service Coordinators are trained and serve as High Fidelity Wraparound Facilitators;
• Ten (10) of the fourteen (14) regions offer specialized summer programs;
• All of the regions employ at least one (1) designated Early Childhood Mental Health Specialist and at least one (1) Early Childhood Consultant who provides therapeutic services for children birth to five (5) years of age and their families. They also provide education and consultation to others working with this population. In addition, the regions reports employing 104 additional staff who have experience serving this population;
• All of the regions employ clinicians who are trained to and routinely serve transition aged Youth, with a total of 437 staff trained;
• Eleven (11) regions employ Youth Peer Support Specialists (YPSS) with a total of 123 YPSS employed; and
• Twelve (12) regions employ Family Peer Support Specialists (FPSS) with a total of 150 FPSS employed.

Kentucky's Medicaid State Plan includes the Rehabilitation Option for behavioral health, including statewide coverage for therapeutic rehabilitation and targeted case management for children with SED. Five (5) of the Regional Boards operate partial hospitalization programs. There are additional Day Treatment programs across the state that are operated by school districts and the Department for Juvenile Justice (DJJ), and several private hospitals operate partial programs.

The Regional Boards rely heavily on their Kentucky IMPACT programs that offer traditional targeted case management services that adhere to the values of wraparound, as well as the more intensive approach of High Fidelity Wraparound, to ensure that children with SED and their families receive needed services and supports. Over $5 million is state general funds is allocated to support the Kentucky IMPACT programs. These funds are used to support program operation, including employment of Local Resource Coordinators that serve as staff to the eighteen (18) Regional Interagency Councils (RIACs), High Fidelity Wraparound activities, and flexible funds to meet the needs of youth and families. Most of the Kentucky IMPACT programs offer comprehensive community support services in which a child works with a community support associate who serves as a mentor and skills-building coach. Many of the children who receive IMPACT services work to improve organizational, impulse control, social and coping skills. Services may occur on or off site to allow for "real life" learning experiences. The majority of IMPACT services occur in the home, school or community. Some IMPACT programs also offer after-school and/or extended summer programs at which children may receive individual and group

therapeutic services, as well as mentoring and other supports.
A list of community services for children, youth, and families is provided below. This grid is updated annually based on required Plan and Budget submissions from the fourteen (14) Regional Boards. This grid is based on SFY 2022 submissions.

Children and Transition-age Youth Services Array
Services Region
1 2 3 4 5 6 7 8 10 11 12 13 14 15
Screening X X X X X X X X X X X X X X
Assessment X X X X X X X X X X X X X X
Psychological Testing X X X X X X X X X X
Outpatient Clinical: Individual X X X X X X X X X X X X X X
Outpatient Clinical: Collateral X X X X X X X X X X X X X X
Outpatient Clinical: Group X X X X X X X X X X X X
Outpatient Clinical: Family X X X X X X X X X X X X X X
Medication Management Services X X X X X X X X X X X X X X
School-Based Services X X X X X X X X X X X X
Intensive In-Home Services X X X X
Intensive Outpatient Program (IOP) X X X
After School Program X X X X
Day Treatment Program X X X X X X
Partial Hospitalization X X
Mental Health/Substance Use Integrated Clinical Services X X X X X X X X X X X X X X
Specialized Summer Program X X X X X X X
Comprehensive Community Support Services X X X X X X X X X
Youth Peer Support-individual X X X X X X X X x X
Youth Peer Support-group X X X X X X X x
Parent/Family Peer Support-individual X X X X X X X X X X
Parent/Family Peer Support-group X X X X X X X
Respite Care X
Service Planning X X X X X X X X X X X X X
Targeted Case Management X X X X X X X X X X X X X
High Fidelity Wraparound X X X X X X X X X X X
Therapeutic Foster Care X X
If Foster Care services are provided, enter the number of homes X X
Recovery Supports X X X X X X X X
Supported Employment (IPS) X X X X X X X X X X X X
Drop-in Center for Transition-age Youth X X X X X X
Early Childhood Consultation X X X X X X X X X X X X X X
Coordinated Specialty Care programs for Early Psychosis (iHOPE) X X X X X X X X

Employment
Supported Employment services are a needed service for transition age youth and are being addressed through several targeted initiatives, including the SAMHSA Healthy Transitions Grant (TAYLRD) the 10% block grant set aside for early serious mental illness (iHOPE), the Kentucky Partners for Youth Transitions, and collaboration with IPS supported employment training and coaching for the adult population. Most recently, Kentucky was chosen to be part of a new grant through the National Institute of Disability, Independent Living and Rehabilitation Research (NIDILRR) Field Initiated Research to evaluate the effectiveness of IPS Supported Employment for 150 young adults aged 16-24 with behavioral health issues in five (5) different states. Two (2) CMHCs from Kentucky are involved in the study. Each CMHC is expected to enroll at least fifteen (15) young adults through the three (3) year project (9/30/19 – 9/29/22).
The Kentucky Partners for Youth Transition (KPYT), an interagency group focusing on youth and young adults between 14-25 years old who have behavioral health issues, began meeting in 2008 out of a need to address the gaps in services for these individuals. Over fifteen (15) different child and adult serving agencies as well as a youth and family member continue to meet on an ongoing basis. In 2009, this committee was formally recognized by the State Interagency Council for Services to Children with an Emotional Disability (SIAC) as a standing committee and advisory group to SIAC. SIAC is a legislated committee with required members who are state leaders in child serving agencies as well as a youth and family member. Their purpose is to reduce the gaps to services for children and youth with behavioral health issues and their families. Using the backdrop of the Transition to Independence Process, the KPYT's central focus areas include employment and career, education, living situation and skills management. The goal is that youth and young adults with serious behavioral health will have earlier, faster and easier access to the developmentally appropriate care that they need. The KPYT presently provides state level oversight over the Health Transitions and Clinical High Risk for Psychosis grants

through SAMHSA.

Housing

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

The DBHDID does not assume custody of children within the state, nor does it operate a children's psychiatric hospital or any other residential program for children. The Regional Boards, under contract with the Department, do offer a limited amount of residential care. Therapeutic foster care is offered in three (3) of the fourteen (14) regions.

DCBS, within the Cabinet for Health and Family Services, is responsible for investigating child dependency, abuse and neglect, and making recommendations to the courts. When deemed necessary, DJJ, within the Justice Cabinet, also may assume custody of children. The DBHDID collaborates with these two (2) state agencies to ensure that the behavioral health needs of children are appropriately identified and addressed. DCBS and DJJ contract with Regional Boards and private providers to meet the residential needs of children in their custody.

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

DBHDID staff collaborate extensively with state and local educational agencies in support of IDEA and other initiatives focused on simplifying access to and coordinating services for children and youth with behavioral health needs. Currently, there are numerous school-based mental health initiatives across the state. Various models for school-based and off-site service provision continue to be studied and assessed for feasibility and effectiveness. The DBHDID has sponsored several training seminars featuring national presenters to educate personnel of the Regional Boards and school districts. These have been well attended and partnerships between school districts and Regional Boards continue to grow statewide.

The Kentucky Educational Collaborative for State Agency Children (KECSAC) was established through legislation in 1992. KECSAC is a statewide collaborative that works with state agencies, school districts and local programs to ensure that state agency children receive a quality education comparable to all Kentucky students. State Agency Children (SAC) are those children in the custody or supervision of the Commonwealth and who are being served in programs funded and/or operated by DJJ, DCBS, or DBHDID in the state of Kentucky. KECSAC Advisory Group members include representatives from the following six (6) agencies:

• Kentucky Department of Education
• Department for Juvenile Justice
• Department for Community Based Services
• Department for Behavioral Health, Developmental and Intellectual Disabilities
• Eastern Kentucky University and the College of Education
• Local Education Agencies
• The State Agency Children School Administrator Association (SACSAA)

KECSAC is the responsible entity for assuring that the benefits of the Kentucky Education Reform Act are extended to children in the custody of state agencies, in day treatment programs, and schools on the campuses of residential programs. KECSAC is a true partnership that links the schools, family and children's services, community mental health, juvenile justice, private providers, and institutions of higher learning. To accomplish the mission, all members of this statewide partnership must exemplify and publicly promote collaborative relationships with its partners and other associates.

In 2019, Kentucky's Department of Education (KDE) was awarded a federal grant to address violence prevention and behavioral health promotion. The resulting program, Project AWARE (Advancing Wellness and Resilience in Education), was designed to train school staff to identify students' behavioral health needs and to increase effective communication between school staff and behavioral health providers, and is being piloted in three (3) of the state's largest school districts. However, collaborative efforts are not limited to those three (3) districts. Kentucky's program includes emphasis on Trauma-Informed Care, Resilience Building, and educating school staff regarding Secondary Traumatic Stress, promoting these via learning collaboratives. In addition, KDBHDID collaborated with KDE to expand student access to TARGET (Trauma Affect Regulation Guide for Education and Therapy) statewide. The management team includes members from several different agencies including KDBHDID and also includes young adults and family members with lived experience.

In 1998, the Kentucky General Assembly authorized the establishment of the Center for School Safety (KCSS). This center's mission is to serve as the central point for data analysis, research, dissemination of information about successful school safety programs, research results, and new programs, and in collaboration with the KDE and others, to provide technical assistance for safe schools. The KDBHDID partners with KCSS to provide Safe School Assessments for participating districts. The KDBHDID also provides information and resources to support the work of KCSS.

Chaired by the Division of Exceptional Children within KDE, the Kentucky Interagency Transition Council for Persons with Disabilities is made up of over twenty-two (22) state agencies, including DBHDID. Their mission is to facilitate the work of state, regional and local agencies as they assist young persons with disabilities (all types) in moving from school to community living and employment. The DBHDID's participation on the Council has offered a valuable forum for sharing of program information and resources as well as data to better address the needs of young people served by the various agencies. Prior to the COVID-19 pandemic, this Council had transitioned to a hybrid Zoom and in person meeting combination, which allowed more participation from a much broader audience. Therefore, this Council was easily able to transition to a fully Zoom meeting while in-person restrictions took place this year.

Substance Abuse Treatment and Prevention Overview

Substance use among youth and their caregivers is often identified by Regional Board clinicians as a contributing factor to the poor mental health and overall wellbeing of clients they serve. Funding for substance use treatment for youth has improved in recent years and the use and abuse of nicotine, alcohol, inhalants, prescription and illegal drugs are addressed in the treatment provided. Outpatient clinicians and case managers collaborate with other agencies such as schools, courts, justice, child welfare, and other providers to identify, screen, refer and treat youth with substance use disorders and co-occurring mental health and substance use disorders. Additionally, each CMHC includes a Regional Prevention Center that providers community-based prevention and promotion supports and works in collaboration with CMHC treatment staff to ensure a continuum of evidence-based prevention, treatment and recovery supports is available.
Services are provided primarily through contracts with community-based services providers (CMHCs) and their subcontractors, local governmental agencies and other community-based organizations. Services include:
• Prevention programming in communities offered through fourteen (14) Regional Prevention Centers;
• Juvenile diversion programs, DUI assessment and education programs;
• Consultation with businesses on the development of a drug-free workplace and employee assistance programs;
• Social setting detoxification centers, residential treatment centers, outpatient treatment services;
• Specialized treatment services for pregnant women, adolescents and intravenous drug users; and
• Opiate replacement therapy to opiate dependent persons who are high-risk for HIV diseases due to their intravenous drug use.
The DBH provides alcohol and other drug abuse prevention and treatment services pursuant to KRS Chapter 222 (Alcohol and Drug Education, Treatment and Rehabilitation). The provision of alcohol intoxication fees is pursuant to KRS 431.100. Other statutes affecting the DBH services include: KRS 189A (DUI assessment, education and treatment) and KRS 218A.410 (drug forfeiture).
Effective prevention and treatment of alcohol and other drug use will have a major impact on the health and wellbeing of every Kentuckian. From peer pressure of youth to use alcohol and drugs to the risks of being involved in a drunk driving accident, all Kentuckians are at risk for alcohol and other drug related problems. The DBH has the statewide responsibility for providing leadership and program direction for the implementation of primary prevention, early identification (intervention) and treatment for children, youth, and adults, with or at risk of developing substance use disorders.
Medical, Dental and Vision Care
Medical Care
Regional Boards are required to complete physical health screenings for all new clients and to update this information at least annually. Data is now being collected through IMPACT Outcomes Management System on health concerns among children with SED, served by Kentucky IMPACT (a targeted case management for children with SED), and the most commonly reported concerns include allergies and asthma. The prevalence of and risk for obesity and diabetes are also high among Kentucky's youth.
According to the Centers for Disease Control (CDC), 35% of low-income children between two (2) and five (5) years of age in Kentucky are overweight or at risk for becoming overweight. According to the Youth Risk Behavior Survey (YRBS 2009), 61% of public high school students did not participate in sufficient moderate physical activity. Over 33% are overweight or obese (at or above the 85th percentile for body mass index). Almost 15% of high school students are seriously overweight, and an additional 15% are heavy enough to be considered "at risk" of becoming overweight adults. Obesity among Kentuckians is epidemic and Kentucky's children are among the most obese in the nation. A statewide plan to address this epidemic is a public/private partnership, called The Partnership for a Fit Kentucky, which supports the Kentucky Department for Public Health's CDC Obesity Prevention Grant. The focus is on promoting nutrition and physically active communities. This website is a clearinghouse of the Partnership for a Fit Kentucky's initiatives, and is an intent to link resources, network programs, provide tools that work, and strengthen partnerships in order to develop cutting-edge initiatives. www.fitky.org
There are School-Based Health Centers in a handful of schools (nine (9) of 174 school districts) across the state, the Kentucky School-Based Health Center Collaborative is advocating for legislation and funding to sustain such Centers. Schools and community health organizations across the country have concluded that providing medical services in the school building is one of the most effective approaches to reducing health problems and healthcare costs.
Oral Health
Kentucky Department for Medicaid has contracted with managed care organizations to provide dental care to Medicaid members. Kentucky has one of the worst oral health profiles for children of any U.S. state; the state lacks dental providers in poor and rural areas, and many of its providers historically have not accepted Medicaid. A 2005 report produced by the nonprofit group Kentucky Youth Advocates revealed that half of the state's children between ages two (2) and four (4) had cavities and that only a third of those children covered by Medicaid had used dental services in the past year.
The Kentucky Oral Health Coalition is a statewide group of dental providers, public health professionals, advocates, educators, and others working together to improve the oral health of all people in Kentucky. The coalition began in March 2012 and is staffed by Kentucky Youth Advocates. This coalition is currently working to increase oral health literacy, increase school based oral health care,, and increase the number of dentists accepting Medicaid. Learn more about the Kentucky Oral Health Coalition at www.kyoralhealthcoaliton.org . Kentucky Youth Advocates report that poor oral health stems from multiple factors including lack of access to care, lack of importance placed on oral health, lack of oral health knowledge, lack of money to pay for care, and many others.
The Kentucky Department for Public Health's Oral Health Program believes that children learn best when they are healthy and dental health is a key component of overall health. The Oral Health Program provides the following initiatives to help children maintain good dental care: a fluoride varnish program, a sealant program, a community water fluoridation program, a rural school fluoridation program, a fluoride supplement program, oral health education and Healthy Smiles

Kentucky.
The University of Kentucky College of Dentistry in coordination with other agencies provides a myriad of dental services for children:
• Inpatient and outpatient specialized dental services for children at the University of Kentucky Children's Hospital and the UK Medical Center. This includes the provision of services for dental patients with special needs (physical, medical and other special needs);
• Primary dental services at an indigent care clinic serving north Lexington and a clinic in south Lexington;
• Seal Kentucky, a mobile dental sealant program providing on-site dental screening and preventive dental sealant services at eastern Kentucky elementary schools;
• East Kentucky Mobile Dental Program, that provides dental prevention and treatment services on-site at elementary schools in central and eastern Kentucky;
• Western Kentucky Mobile Dental Program, that provides dental prevention and treatment services on-site at nine (9) elementary schools in three (3) western Kentucky counties;
• Ronald McDonald Mobile Dental Program, in partnership with Ronald McDonald Foundation provides on-site services at underserved preschools and elementary schools in Fayette and surrounding counties; and
• School-Based Dental Clinics in rural Kentucky.
The pediatric dentistry program at the University of Louisville School of Dentistry provides services to patients between six (6) months and fourteen (14) years of age. Special needs patients of any age are accepted. The program focuses on prevention dentistry such as cleanings, x-rays and fluoride treatments in addition to fillings, stainless steel crowns and extraction. Emergencies or outpatient treatment is provided at Kosair's Children's Hospital for very young children with excessive decay or special needs of any age.
Several faith-based organizations have provided the financial support needed to start these services and to keep them operating. In addition, some Christian groups have opened free clinics in church buildings, which are staffed by volunteer dentists who come to the region from all over the state for weeklong mission trips. And yet others hold dental events in Walmart parking lots, handing out free samples of toothpaste, dental floss and toothbrushes to anyone who wants them. Still, case managers and clinicians that have knowledge of local resources and well-developed relationships with local providers tend to lead to better access to dental services. There are, in many communities, those dentists who will serve children in need who have no ability to pay for dental care. However, overall access is generally considered poor.
In 2008, the General Assembly passed HB 185 which requires a dental screening for the first year that a three (3), four (4), five (5), or six (6) year old child is enrolled in a public school, public preschool or Head Start program. The law took effect for the 2010-2011 school year. Supporters hope this law will decrease the number of school days that Kentucky's students miss due to pain associated with dental problems and will establish a dental home for children from early in life, so that more children receive routine dental care and become less reliant on costly and sometimes invasive emergency care in childhood and later life.
Vision Care
Kentucky Medicaid provides coverage for members of all ages for most examinations and certain diagnostic procedures performed by ophthalmologists and optometrists. Professional dispensing services, lenses, frames and repairs are covered for persons under age 21.
All Kentucky children are required to have an eye exam by a board certified Optometrist or Ophthalmologist before they enter school. This is in addition to the requirement for immunizations and dental and hearing screenings. For children with vision problems, the Kentucky Lions Eye Foundation (KLEF) is a great resource for assistance with screenings, exams, and eyeglasses. Though located in Louisville, KLEF serves citizens across the state by operating the Vision Van, Eye Clinics across the state, and providing thousands of photo screenings at the Kentucky State Fair. KLEF includes specialty services for children at their Pediatric Clinic.
Visually Impaired Preschool Services (VIPS) is a Kentucky non-profit agency that provides assessments, early intervention services, childcare consultation and play groups/classes for infants, toddlers, and preschooler who are blind or visually impaired. For parents and caregivers, VIPS provides various opportunities for education and support. While their main offices are located in Lexington and Louisville (metropolitan areas of the state), there is also an Outreach Program that served rural areas of the state.
Support Services
All fourteen (14) Regional Boards offer to their communities, consultation and education services regarding behavioral health care and services. There are a number of ancillary support services that are offered in the children's array of services, including, but not limited to:
• Respite services;
• Intensive in-home services;
• After school programs;
• Family peer support;
• Youth peer support;
• Specialized summer programs;
• Comprehensive community support services;
• Transition planning for transition age youth; and
• Youth and Family Engagement and Leadership support.
Across all regions of Kentucky, parents' voices are most consistently heard through their membership on Local and Regional Interagency Councils (LIACs and RIACs). These Councils are responsible for the identification of children with SED and for coordination of the services they receive. These representatives also make up the State Family Advisory Council

(SFAC), which serves in an advisory capacity to the State Interagency Council to Children with an Emotional Disability (SIAC).

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

The DBHDID tries to model the importance of the voices of youth, parents and caregivers in shaping not only individual treatment decisions, but also program development and policy determinations at the local, regional, and state levels. This principle is strengthened by the advocacy efforts of parents and youth at various points in the system of care.

The Kentucky Partnership for Families and Children (KPFC) is a statewide family organization working to ensure "that all families raising youth and children affected by behavioral health challenges will achieve their fullest potential." KPFCs mission is to empower families affected by behavioral health challenges to initiate personal and systems change. The board of directors consists of twenty-one (21) to thirty-one (31) members: twelve (12) parent representatives from various community mental health center regions, two (2) transition-age youth representatives, seven (7) child-family serving agency representatives, and ten (10) flexible positions to assist with identified needs. As a family organization, over 51% of KPFCs board of directors must be parent/primary caregivers raising children with behavioral health disabilities and more than 50% of staff are also parents/primary caregivers that have raised, or are raising, children with behavioral health disabilities.

KPFCs programs and/or activities include:

• Dissemination of a quarterly newsletter via hard-copy or e-newsletter to over 3,000 members;

• Participation on number committees with various child-family serving agencies to represent parent and youth voices and perspectives;

• Operation of a website (www.kypartnership.org) and a toll-free phone number (800-369-0533) for parents to access information about KPFC and resource information statewide;

• Provision of an infrastructure for Kentucky Youth MOVE which is comprised of 14-26 year olds who have a behavioral health challenge;

• Provision of the Kentucky Family Leadership Academy and the Kentucky Family Peer Support Specialist Core Competency Training;

• Partnerships with regional community mental health boards to establish Regional Youth Councils and to assist in the identification of youth leaders that will help facilitate the meeting;

• Distribution of resource information and learning opportunities for families raising young children from birth to five (5) that have an emotional-social delay;

• Opportunities for teens (13-26 year olds) with behavioral health challenges and their parents to learn, connect and network as part of the youth and parent movement; and

• Strengthening of Kentucky's family-driven and youth-guided system of care.

Early Childhood Mental Health

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

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

• To provide program and child level consultation to early care and education (childcare) programs regarding social, emotional, and behavioral issues;

• To provide training for child-serving agencies and individuals on working with young children with social, emotional, and behavioral needs and their families; and

• To provide evaluation, assessment, and therapeutic services for children from birth through the age of five (5) and their families.

ECMH funds the equivalent of fourteen (14) ECMH Specialists, resulting in one (1) Specialist per CMHC region. The Specialists' time is devoted solely to their regional ECMH programs, and to building the capacity of regional providers to better meet the social, emotional and behavioral needs of children up to age five (5) and their families. Through the Kentucky Opioid Responses Effort (KORE) grant (SAMHSA State Opioid Response grant), Kentucky has been able to add Early Childhood Consultants (ECCs) to each CMHC. These ECCs work with infants, young children, and families impacted by opioid and other substance use disorders. ECCs provide training to families, child welfare, healthcare providers, treatment facility staff, and others, provide collaboration with community partners on the impact of substance use on infants, early childhood development, healthy attachment, and building resilience in families affected by SUD.

The ECMH Specialists provide the following services annually:

• Over 2,000 children receive clinical (outpatient) services;

• Over 1,000 training opportunities to childcare providers and mental health professionals; and

• Over 3,000 consultations to child care centers and other entities.

Services for Youth with Co-occurring Mental Health and Substance Use Disorders

Services for youth with co-occurring mental health and substance use disorders are coordinated within the Children's Behavioral Health and Recovery Services Branch which has a full-time position for a 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. Beginning in SFY 2022, DBHDID is supporting a full-time Youth Substance Use Treatment Coordinator staff position within each of the CMHCs. The coordinator will be located within the

CMHCs children's services division and shall serve as the regional subject matter expert in youth substance use and co-occurring substance use and mental health disorder treatment. The coordinator will collaborate and coordinate with other CMHC programs that have contact with individuals (children, adolescents, and adults) with or at-risk of developing SUD, and with youth and families. This position was created in response to information from CMHCs that they were not receiving referrals for youth with substance use issues and that there was a general lack of knowledge in communities regarding how to identify, screen for, and refer youth with substance use issues as well as a lack of awareness of what services and supports are available for these young people. The coordinator is charged with providing community education and outreach. During SFY 22, they will conduct a needs assessment related to youth substance use services and use it to create a training and outreach plan. The coordinator will also keep an inventory of clinicians within their agency that are trained to serve youth with substance use disorders. Results from a recent survey of CMHC children's directors and substance use directors show that across all CMHCs, there is a total of 541 clinicians who are trained to and routinely serve youth with substance use disorders, thus provider capacity in serving the population is not an issue. This further supports the need for community education and engagement around identifying, screening and appropriately referring youth with substance use issues.

The SIAC serves as the governing body for Kentucky's system of care for children and youth with or at-risk of developing behavioral health (inclusive of mental health, substance use, and co-occurring mental health and substance use) challenges. In this role, the SIAC has also served as the governing body for all past and present SAMHSA SOC and adolescent CSAT grants, as well as other federal grants and state-level initiatives focused on these populations and their families. The SIAC was created statutorily in 1990 and is comprised on representatives from state child- and transition age youth-serving agencies, youth with lived experience with behavioral health challenges, parents of children with lived experience with behavioral health challenges, and a family-run organization. It was created and continues to serve as a structure for coordinated policy development, comprehensive planning, and collaborative budgeting for services and supports to children and transition age youth with or at risk of developing behavioral health needs and their families. The SIAC currently operates four (4) standing committees that support the work of the SIAC. The standing committees are: Social and Emotional Health and Wellbeing; Racial and Ethnic Disparities; Disability; and Outreach and Promotion. Eighteen (18) Regional Interagency Councils (RIACS) with similar membership serve as regional loci of accountability for the system of care.

Children's Crisis Services

CMHC crisis services are an important part of the state's behavioral health safety net for children and families. Crisis services facilitate ongoing community care and reduce psychiatric hospitalization, psychiatric boarding in hospital emergency departments, and disrupted placements. A variety of funds are blended to support Kentucky's 24/7 call center and intervention services (e.g. state general funds, Medicaid, Medicare, commercial insurance, and private pay).

CMHCs are preparing for 988 in July 2022, eleven (11) CMHCs are members of the National Suicide Prevention Lifeline (NSPL) and two (2) additional CMHCs are in the onboarding process. CMHCs respond to regional crisis calls in addition to NSPL calls. In addition to increasing 988 call center service capacity, CMHCs are also working to increase their mobile crisis services capacity. Current challenges include the state's rural landscape, workforce shortages, funding deficiencies and technology limitations such as lack of cellular and broadband access. Other models of community-based crisis stabilization are in place across the state in addition to mobile crisis services, including the following:

• Residential Crisis Stabilization Units;
• Intensive In-Home Services;
• Walk-In Crisis Services;
• Intensive Outpatient Services;
• Crisis Case Management;
• Call Center Services, including Warm Lines; and
• Crisis Respite

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.

3. Describe your state's case management services

Targeted Case Management (TCM) for adults with SMI or children with SED is a covered service in Kentucky's Medicaid state plan. TCM for individuals with SUD is also a covered service. DBHDID also provides funding to cover this service for those without insurance or who have another payor source. TCM for individuals with either SMI or SED (or SUD) and a co-occurring "chronic physical health condition" is also a covered service, with defined client eligibility and provider credentialing requirements. The DBHDID is responsible for credentialing all Targeted Case Managers in Kentucky, regardless of who employs them (if they are billing Medicaid or DBHDID) or which population they are serving. The majority of the credentialing activity occurs through an on-line portal. This website contains an overview for processes for all curricula. https://dbhdid.ky.gov/dbh/cap.aspx. Both Kentucky Medicaid and DBHDID have promulgated regulations for TCM that dictate credentialing and service provision. These regulations are as follows:

• DBHDID regulation for TCM: Eligibility and Training Requirements https://apps.legislature.ky.gov/law/kar/908/002/260.
• Medicaid regulation for TCM: Coverage provisions and requirements regarding TCM for individuals with SMI and children with SED. https://apps/legislature.ky.gov/law/kar/907/015/060.pdf.
• Reimbursement provisions and requirements regarding TCM for individuals with SMI and children with SED. https://apps.legislature.ky.gov/law/kar/907/015/065.pdf.
• Coverage provisions and requirements regarding TCM for individuals with SUD. https://apps.legislature.ky.gov/law/kar/907/015/040.pdf.

• Reimbursement provisions and requirements regarding TCM for individuals with SUD. https://apps.legislature.ky.gov/law/kar/907/015/045.pdf.
• Coverage provisions and requirements regarding TCM for individuals with a co-occurring SMI or SED or SUD and a Chronic Physical Health Condition. https://apps.legislature.ky.gov/law/kar/907/015/050.pdf.
• Reimbursement provisions and requirements regarding TCM for individuals with a co-occurring SMI or SED or SUD and a Chronic Physical Health Condition. https://apps.legislature.ky.gov/law/kar/907/015/055.pdf.

As explained in Criterion 2, Kentucky's statutory definitions for SMI and SED are more stringent than the federal definitions and thus the prevalence rates are lower than most used nationally. Based on an estimated prevalence rate of 2.6% of the adult population in Kentucky, the CMHCs served approximately 50% (43,410 of 86.216) of the estimate number of individuals with SMI and 6.9% (5,950) of those individuals receiving TCM services, in SFY 2020. Based on an estimated prevalence rate of 5% of the child (under age 18) population in Kentucky, the CMHCs served approximately 47% (24,094 of 51,169) of the estimated number of those individuals with SED and 11% received TCM (5,722) services, in SFY 2020 (unduplicated counts). DBHDID has created guidance documents for determining TCM eligibility, which includes SMI, SED and SUD designation. https://dbhdid.ky.gov/dbh/documents/tcm/faq.pdf.

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

Continuity of Care

DBHDID 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.

DBHDID addresses continuity of care for adults with SMI through several avenues. Through contracts with fourteen (14) CMHCs, DBHDID requires the regions to provide an outpatient appointment for adults with SMI within fourteen (14) calendar days of discharge from a state psychiatric facility. DBHDID also requires the assignment of a targeted case manager and provision of targeted case management services to adults with SMI who are discharged from a state psychiatric facility within fourteen (14) calendar days. Since SFY 2013, contact language has also included a requirement that individuals within the Department for Corrections' Psychiatric Treatment Unit (CPTU), an all-male unit within Kentucky State Reformatory, and individuals within the Psychiatric Care Unit (PCU), an all-female unit within 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 CMHCs and the state operated/contracted psychiatric hospitals must work closely together to assure continuity of care. Contracts with all parties address continuity of care 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 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 CMHCs. 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 CMHC in each of the four (4) state psychiatric Catchment areas. These flexible funds are designated for necessary goods and services for identified individuals that meet the following Olmstead criteria:
o Have resided in the hospital over 90 days;
o Have had repeat admissions to the hospital over the course of one (1) year and need flexible funding to remain in the community;
o Treatment professions determine that community placement is appropriate;
o Community treatment is chosen via fully informed awareness; and
o Placement can be reasonably 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, Kentucky Long Term Care Ombudsman, Managed Care Organizations, and other community stakeholders for that Catchment area. The purpose for these meetings is to discuss and plan for transitioning individuals that fit the Settlement Agreement criteria:
o Adults with SMI who are transitioning from personal care homes or at risk of being admitted to a personal care home;
o 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 CMHCs to assist with the development of a Memorandum of Agreement (MOA) between the two (2) entities. In order to assure a seamless system of care, the need was identified to strengthen the relationships between the hospitals and the CMHCs. The MOAs include the contractual responsibilities each entity has to the DBHDID, but also defines and clarifies roles and responsibilities for the hospital and CMHC, to assure continuity of care for individuals 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 individuals, as well as opportunities for community partners to discuss pertinent strategies for creating "warm hand-offs".

CMHCs, through contracts with DBHDID, have been recreating the system of care for adults with SMI by strengthening newer billable services such as ACT, peer support and comprehensive community supports, as well as building better infrastructure for

outpatient and residential crisis services for all individuals, including those with substance use disorders. CMHCs have also being adjusting to multiple Managed Care Organizations. Continuity of care is a major priority for the DBHDID. Challenges include:

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

In July of 2020, DBHDID was awarded an Assisted Outpatient Treatment (AOT) grant from SAMHSA. This program is being implemented in two (2) initial pilot sites, through two (2) CMHCs. For the next year, the program will be expanding to two (2) additional CMHC sites. This program is being designed to assist some adults with SMI who have not responded to traditional outpatient behavioral health treatment and have been hospitalized in psychiatric hospitals two (2) times or more in a two (2) year period, and are in need of court-ordered AOT as the least restrictive mode of treatment presently available and appropriate. The goal is to assist these individuals with SMI through community-level treatment, but with more support from the court system to enhance treatment adherence. AOT requires regular written updates to the court and individuals who do not adhere to treatment may be hospitalized, as needed, on a 72-hour emergency admission pursuant to KRS 202A.031. The program is designed to enhance outcomes and reduce inpatient psychiatric hospital utilization. As of July 2021, 20 individuals have been served through the AOT program.

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 M/SUD 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	86,216	43,000
2.Children with SED	51,169	24,000

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.

Estimate of Prevalence – Adult Mental Health

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 served by the Regional Boards during SFY 2020.

Regional Boards Adult Census 2010 Estimated Prevalence (2.6% of the Adult Census) Kentucky Adults with SMI Served in SFY 2020 Penetration Rate - SMI Served
Four Rivers 161,545 4,200 4,311 84%
Pennyroyal 158,100 4,111 2,690 65%
RiverValley 161,977 4,211 2,280 54%
LifeSkills 217,231 5,648 1,297 23%
Communicare 200,640 5,217 3,959 76%
Seven Counties 730,843 19,002 7,125 38%
NorthKey 326,235 8,482 3,426 38%
Comprehend 42,757 1,112 526 47%
Pathways 170,601 4,436 4,013 90%
Mountain 119,756 3,114 5,121 164%
Kentucky River 89,550 2,328 906 39%
Cumberland River 181,110 4,709 2,151 46%
Adanta 160,202 4,165 2,545 61%
New Vista 595,449 15,482 3,060 20%
TOTAL 3,315,996 86,216 43,410 50%

*Note: The data for SFY 2021 is not certified until October 2021 thus SFY 2020 data is used.

Estimate of Prevalence – Children's Mental Health

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 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 SED Children Served SFY 2017 – 26,043 or 51% (of the 5% SED population)
Kentucky SED Children Served SFY 2018 – 25,956 or 51% (of the 5% SED population)
Kentucky SED Children Served SFY 2019 – 25,883 or 51% (of the 5% SED population)
Kentucky SED Children Served SFY 2020 – 24,094 or 47% (of the 5% SED population)

Regional Boards Child Census 2010 Estimated Prevalence (5% of the Child Census) Kentucky Children with SED Served in SFY 2019 Penetration Rate of Children with SED Served in SFY 2019 Kentucky Children with SED served in SFY 2020 Penetration Rate of Children with SED Served in SFY 2020
Four Rivers 44,367 2,218 1,836 83% 1.548 70%
Pennyroyal 51,686 2,584 987 38% 1,010 39%
RiverValley 51,495 2,575 1,181 46% 911 35%
LifeSkills 66,964 3,348 1,056 32% 880 26%
Communicare 68,477 3,424 2,561 75% 2,246 66%
Seven Counties 228,248 11,412 5,370 47% 4,754 42%
NorthKey 112,412 5,621 2,255 40% 2,661 47%
Comprehend 13,721 686 610 89% 582 85%
Pathways 48,935 2,447 2,053 84% 2,041 83%
Mountain 34,337 1,717 2,494 145% 2,396 140%
Kentucky River 25,212 1,261 784 62% 688 55%
Cumberland River 55,508 2,775 2,252 81% 2,152 78%
Adanta 47,054 2,353 954 41% 890 38%
New Vista 174,955 8,748 1,490 17% 1,335 15%
TOTAL 1,023,371 51,169 25,883 51% 24,094 47%
*Note: The data for SFY 2021 is not certified until October 2021 thus SFY 2020 data is used.

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.

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs.

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. 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

a. Describe your state's targeted services to rural population.

Rural Outreach

Using the Rural-Urban Continuum Codes and the 2010 Census information, Kentucky has 35 (29%) counties considered metropolitan, 49 nonmetropolitan urban (41%), and 36 nonmetropolitan completely rural (30%). See table below:

Rural-Urban Continuum Codes Description of Rural-Urban Continuum Codes # of KY Counties
1 Metro - Counties in metro areas of 1 million population or more 14
2 Metro - Counties in metro areas of 250,000 to 1 million population 11
3 Metro - Counties in metro areas of fewer than 250,000 population 10
4 Nonmetro - Urban population of 20,000 or more, adjacent to a metro area 2
5 Nonmetro - Urban population of 20,000 or more, not adjacent to a metro area 4
6 Nonmetro - Urban population of 2,500 to 19,999, adjacent to a metro area 19
7 Nonmetro - Urban population of 2,500 to 19,999, not adjacent to a metro area 24
8 Nonmetro - Completely rural or less than 2,500 urban population, adjacent to a metro area 11
9 Nonmetro - Completely rural or less than 2,500 urban population, not adjacent to a metro area 25
Data Source: USDA, Economic Research Service, May 2013

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. Seven Counties 730,843 699,976 30,867
7. NorthKey 326,235 282,835 43,400
8. Comprehend 42,757 13,225 29,532
9/10. Pathways 170,601 87,533 83,068
11. Mountain 119,756 0 119.756
12. Kentucky River 89,550 0 89,550
13. Cumberland River 181,110 0 181,110
14. Adanta 160,202 19,047 141,155
15. New Vista 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 2020 are listed in the table below:

Region Rural SMI Pop Rural SMI Served Percent Rural SMI Served
1. Four Rivers 2,085 1,703 82%
2. Pennyroyal 1,799 1,051 58%
3. River Valley 1,392 657 47%
4. Lifeskills 3,024 820 27%
5. Communicare 3,185 2,402 75%
6. Seven Counties 803 313 39%
7. NorthKey 1,128 561 50%
8. Comprehend 768 443 58%
9/10. Pathways 2,160 2,046 95%
11. Mountain 3,114 3,338 107%
12. Kentucky River 2,328 1,503 65%
13. Cumberland River 4,709 2,125 45%
14. Adanta 3,670 1,665 45%
15. New Vista 2,300 858 37%
Total 32,465 19,485 60%
*Based on SFY 2020 data

Kentucky children with SED who live in rural areas (based on 2010 US Census Data) and were served by CMHC regions for SFY 2020 are listed in the table below:

Region Rural SED Pop Rural SED Served % Rural SED Served
1. Four Rivers 1,147 539 47%
2. Pennyroyal 986 540 55%
3. River Valley 851 310 36%
4. Lifeskills 1,839 624 34%
5. Communicare 2,053 1,392 68%
6. Seven Counties 521 273 52%
7. NorthKey 778 485 62%
8. Comprehend 473 406 86%
9/10. Pathways 1,176 1,274 108%
11. Mountain 1,717 1,188 69%
12. Kentucky River 1,261 833 66%
13.Cumberland River 2,775 2,152 78%
14. Adanta 2,079 608 29%
15. New Vista 1,390 392 28%
Total 19,046 11,016 58%
*Based on SFY 2020 data

The three (3) 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 (1) 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 provide non-emergency, non-ambulance medical transportation services to eligible Medicaid, Vocational Rehabilitation, and Department of the Blind recipients. Twelve (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. Eleven (11) of fourteen (14) Regional Boards report engaging in initiatives to better coordinate transportation services for adults with SMI/children with SED 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 behavioral health services. It is important for rural behavioral 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. Access to these services has been greatly expanded across the state due to the pandemic, and all Regional Boards now report delivering or accessing services from the telehealth network. Examples of how the regions utilize telehealth equipment for providing services are 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 Memorandum of Agreements (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. Since COVID-19, outpatient therapy services are being offered/delivered via telehealth or telephonic platforms. Involuntary psychiatric hospitalization petition (202A) evaluations are also being conducted in conjunction with regional hospitals via telehealth.
• Lifeskills utilizes the telehealth network to increase access of psychiatric services and offers telehealth services in all ten (10) counties to increase access to providers with therapy services, med management, case management, and peer support. They use a dedicated HIPAA compliant zoom connection for these appointments to ensure higher level of security for private health information.
• Communicare uses telehealth for psychiatry services and therapy services in all eight (8) rural counties in their region.
• Seven Counties Services sites all have a telehealth room for clients who walk in and can be seen by providers at other sites.
• NorthKey utilizes telehealth for all clinincal services currently via zoom telehealth due to COVID-19. Clients are contacted by phone and asked if they would like to be seen via telehealth.
• Comprehend provides the majority of previous direct services via telehealth, including outpatient therapy clinical services, medication management, adult and children case management services.
• Pathways provides Intake and Assessment, Medication Evaluation and Follow-up, and Individual Therapy via telehealth for someone who is referred to a prescriber or a specialty provider out of their geographic area.
• 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. During the COVID-19 Crisis, they are providing telehealth services to as many clients as possible for all of their services.
• 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 has telehealth available in each outpatient clinic across their region and offers telehealth between sites. All services can be accessed through telehealth. Telehealth crisis services are also provided to local law enforcement, hospitals, and other community partners. They recently established an Accomplished Teaching Learning and Schools (ATLAS) site at the Whitley County Health Department for individuals to be able to access telehealth mental health and substance use treatment with their clinics.
• Adanta provides telehealth psychiatry services to rural counties in their region and provides telehealth psychiatry services via contract with the University of Louisville as well. They are utilizing the telehealth network to provide psychiatric and therapy services to counties within the agency who do not have onsite prescribers or medicare billable behavioral health providers.

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 and Medicaid began providing 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 consulations, evaluations, individual and group therapy, pharmacological management and diagnostic examinations to eligible individuals through real-time telecommunications as part of a medically necessary service, under telehealth.

Due to the pandemic, CMS greatly expanded access to telehealth services and the Regional Boards expanded these reimbursable services into their array. It is hoped that this will continue and that more rural consumers will have better access to services and better continuity of care between providers. The work Kentucky had done previously regarding enhancing regulations regarding telehealth was helpful in allowing rapid adaptation for telehealth services during the pandemic.

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.

b. Describe your state's targeted services to the homeless population.

Adults with SMI
KDBHDID recognizes the importance of system coordination among the numerous agencies and programs involved with services to Kentucky's homeless population. At the state level, KDBHDID participates in the Kentucky Interagency Council on Homelessness (KICH), a group of state and local providers, consumers and government officials, established to develop statewide systems and policies that forge partnerships among state agencies that allow communities to achieve local solutions to homelessness, in addition to establishing targets for permanent supported housing production.
The Council's 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 people, 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.
KDBHDID, KICH and Kentucky Housing Corporation (KHC) continue to collaborate on the SSI/SSDI Outreach, Access, and Recovery (SOAR) Initiative, developed a Case Management Manual for homeless service providers and a Homelessness Rights Manual (both available on the KICH website), and promote education and training for discharge planning in public institutions. Efforts are also underway to increase access and availability of housing options for homeless individuals through the promotion of the "Housing First" model.
Most Community Mental Health Centers 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 Community Mental Health Centers in Kentucky:
• All regions give a service priority to homeless individuals;
• 10 regions do consultation with local shelters;
• 10 regions have staff dedicated to homeless individuals;
• 10 regions regularly visit local homeless shelters;
• 4 regions have a walk-in clinic; and
• 3 regions do street outreach.
KDBHDID has continued PATH Grant funding to the Community Mental Health Centers that received contracts in the prior year. The six PATH regions are:
• New Vista, subcontracts and works with the HOPE Center, a private non-profit shelter and homeless service provider, to provide outreach, screening and diagnostic services, case management, mental health treatment, rehabilitation and staff training in the Lexington / Fayette County area.
• LifeSkills, Inc., which provides outreach, case management and training in the Bowling Green / Warren County area.
• NorthKey Community Care, which utilizes a multidisciplinary outreach team employed by the CMHC to provide screening, treatment, and case management, and subcontracts with Welcome House of Northern Kentucky, a private non-profit shelter and homeless service provider, for case management and payee services. The program serves the northern region of Kentucky, just south of Cincinnati, Ohio. The majority of clients served in the PATH program come from Boone, Campbell, and Kenton counties, which are the urban areas.
• Seven Counties Services, who 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 (the largest urban county in the Commonwealth).
• Cumberland River Regions BH Board, which provides outreach, case management and housing support services in Laurel County.
• Kentucky River Community Care, which provides outreach, case management, housing support services, and support for six (6) emergency apartments for homeless persons with a mental illness located in Hazard / Perry County, but which also draws from Breathitt, Knott, Lee, Leslie, Letcher, Owsley, and Wolfe Counties in southeast Kentucky.

By combining PATH and other McKinney funds (that support specialized services) with state and federal funds (that support Community Support Services), DBHDID and the Regional Boards attempt to provide a statewide system of outreach, community support, and mental health services for persons with serious mental illness who are homeless. The role of the State PATH Contact (SPC) is central to supporting local PATH providers throughout Kentucky. The SPC prepares the annual PATH application in collaboration with local providers, insures that annual data collection requirements are met, and insures that fund allocation and contracts are in place. Support is also provided through notification of relevant training, updates on homeless issues, and on-site technical assistance as needed. The Department is also involved with other homeless initiatives including:
• 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, Seven Counties Services, the Department of Corrections, the Department for Community Based Services, and the Louisville Coalition for the Homeless. 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 KHC in the operation of local homeless planning boards ("Continuum of Care Committees") in Kentucky's area development districts (which correspond to the fourteen mental health regions). Regional Boards are encouraged to participate in this process for the benefit of individuals with serious mental illness who are homeless or may become homeless in their regions.
• Funding an Outreach Worker with the St. Johns' Day Center in Louisville to provide on-site assessment and link individuals with services at Seven Counties Services.
• A Rural Homeless Outreach program in the Mountain Regional Board area, covered by CMHS Block Grant funds. The goal of this program is the identification of individuals with serious mental illness who are homeless and linkage with mainstream mental health services. Consultation and training to homeless service providers is also provided under this initiative.

Children with SED
The Kentucky Housing Corporation conducts a Point-In-Time Count of the Homeless every year to best monitor the homeless situation in Kentucky. The U.S. Department of Housing and Urban Development (HUD) requires such a count every other year, but KHC believes it best serves the people of Kentucky to conduct this count yearly. According to the Kentucky Department of Education (KDE), which provides the most accurate number of homeless children, there were 21,648 homeless children statewide in all grades during the 2019-2020 school year.

To determine if a child is homeless, Kentucky Department of Education uses the Department of Education/McKinney-Vento Education for Homeless Children and Youth definition of homelessness, which is broader than the HUD definition. The HUD definition of homelessness excludes those living in substandard housing conditions, doubled-up with family or friends, or expecting eviction within seven days who have a community support network to assist them. According to HUD, these individuals are precariously housed, not homeless. The Department of Education/McKinney-Vento Education for Homeless Children and Youth definition states that homeless students/people are those who lack a fixed, regular and adequate nighttime residence. This includes children and youth, ages three through 21 who are:
• Sharing housing due to loss of housing or economic hardship;
• Living in motels, hotels, dilapidated trailers or camping ground due to lack of alternative adequate housing;
• Living in emergency or transitional housing;
• Abandoned in hospitals;
• Awaiting foster care;
• Having a primary nighttime residence that is a public or private place not designed for, or ordinarily used as regular sleeping accommodations;
• Living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations; or
• Migratory students who live in housing described above.

c. Describe your state's targeted services to the older adult population.

According to the United States Census (2016 American Community Survey 5-year estimates) Kentucky's population for 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: 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.

Due to the COVID-19 pandemic, there is a delay in the release and analyzing of data results from the 2016-2020 American Community Survey 5 year estimates and 2020 Census data (e.g. age, sex, race, and ethnicity). The data presented represents the most current data available at the time of this application.

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. Based on the 2010 Census population numbers, and utilizing the 2.6% federal formula, there are 21,558 Kentuckians over the age of 60 with SMI. When 2020 Census numbers become widely available this number is expected to be higher. In SFY 2020, Kentucky's community mental health centers served approximately 6,472 individuals over the age of sixty (60) with a serious mental illness (SMI), accounting for 30.02% of the state's total SMI population of individuals over age sixty (60).

The diagnosis and treatment of serious mental illness can be more complex with older adults due to the presence of other health diagnoses. The 2016 Behavioral Risk Factor Surveillance System (BRFSS) survey through the Centers for Disease Control (CDC) states the following:

? "Prevalence of arthritis increased significantly with age. The highest prevalence was among adults aged 65 years or older (58.0%).
? Prevalence of COPD increased significantly with age; adults 65 years or older had the highest prevalence of COPD (18.3%).
? Prevalence of coronary heart disease increased significantly with age: adults aged 65 years or older had the highest prevalence (17.4%) compared to other age groups.
? The prevalence of diabetes increased significantly with age; adults aged 65 years or older had the highest prevalence of diabetes (25.5%).
? Fair or poor general health ratings increased significantly with age. The highest prevalence was among adults aged 65 years or older (34.4%).
? The prevalence of heart attack significantly increased with age. The highest prevalence was among adults aged 65 years or older

(17.4%).
? Prevalence of stroke significantly increased with age. The highest prevalence of stroke was among adults aged 65 years or older (10.7%)."

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 regarding 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. Older adults in Kentucky with mental health disorders are at risk.

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 required for older adults.

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 for Aging and Independent Living (DAIL), a sister agency to DBHDID. Over the year, DBHDID and DAIL have collaborated on several initiatives including educational campaigns and conferences, the Interim Settlement Agreement and subsequent settlement agreements, and grant proposals related to aging.

In 1999, DBH received a SAMHSA grant that eventually led to the development of a state-level Mental Health and Aging Coalition that was created through partnerships with DAIL, the University of Kentucky Sanders Brown Center on Aging, Kentucky Counseling Association, the Department for Community Based Services, older adults with lived experience in behavioral health issues, and other stakeholders. This Coalition assisted with the development of regional mental health and aging coalitions with support from each community mental health center across the state. DBH provided mini-grants for these regional coalitions to provide educational events regarding mental health and aging as well as funding provider manuals, infographics and training materials for local coalitions, suicide prevention projects, and training local coalition members in Mental Health First Aid for Older Adults.

The COVID-19 pandemic negatively impacted the state-level Mental Health and Aging Coalition through staff turnover, decreased meeting participation and decreased statewide program activities. Kentucky DBH is committed to addressing the behavioral health and wellness needs of older adults with serious mental illness. The state Coalition will strive to meet the following goals by the end of SFY 2023:

1. Rebuild the state Mental Health and Aging Coalition with representatives from state and local government agencies, institutes of higher education, medical and behavioral health organizations, caregivers, and persons with lived experience, faith based community members, and other stakeholders;
2. Develop a five (5) year strategic plan;
3. Utilize federal and state data reports and other relevant data to better inform, understand, and guide state and local coalition work on behalf of the behavioral health and wellness needs of older adults;
4. Sponsor/Host live virtual and/or live in-person trainings, series, forums, etc. (e.g. Mental Health First Aid for Older Adults, QPR Suicide Prevention, Whole Health Action Management, Behavioral Health Equity, Cultural Humility, Trauma Informed Care and Resiliency, Wellness Recovery Action Plan, and the ABCs of Working with Older Adults and Caregivers);
5. Increase the social media presence of the state coalition and produce film/video content;
6. Develop Kentucky specific behavioral health educational materials for statewide distribution; and
7. Provide technical assistance, training, educational resources, and mini-grants for current and prospective local Mental Health and Aging Coalitions.

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.

This criterion addresses three (3) critical components of the overall management of the systems of care that serves adults with SMI and children with SED. These components include Financial, Staffing and Training. Kentucky has historically struggled to maintain and improve provider performance with serious financial constraints and workforce shortage issues. Weathering the pandemic has made both of those issues more challenging for Kentucky. DBHDID will continue thoughtful and collaborative planning with funding sources, government leaders, stakeholders and others, to continue to move the systems forward in the face of such challenges. Offered below is discussion about the status of the three (3) key management components for Kentucky.

Component 1: Financial

Kentucky fully embraced the Affordable Care Act (ACA) during SFY 2014 and developed a State Health Benefit Exchange, where individuals could enroll in various insurance options. Kentucky also opted for Medicaid Expansion and over 300,000 individuals, who were not previously insured or who were underinsured, have enrolled in Medicaid. In addition, a Medicaid State Plan Amendment was approved by CMS in January 2014 that impacted Kentucky's behavioral health system by opening the network of available providers in the state, adding additional services to the Medicaid reimbursement list, and making all services available in the community due to the Rehabilitation Option. Substance use disorder services, an array of crisis services, and many additional evidence-based practice options became Medicaid reimbursable. During SFY 2015 and 2016, due to more services being Medicaid reimbursable and more individuals qualifying for Medicaid, traditional state funding for behavioral health saw $51 Million in savings.

Due to these changes, DBHDID evaluated purchasing options, redesigned CMHC contracts and implemented performance based contracting. In addition, the CHFS continued to contract with Managed Care Organizations (MCOs) to coordinate behavioral health services for individuals with Medicaid across the state. As of SFY 2021, there are six (6) MCOs coordinating these services. CMHCs must negotiate services and reimbursement rates and provide authorization requirements for each service with each separate MCO. Some regions are more successful at this process than others. During the pandemic, some authorization requirements from MCOs were relaxed temporarily to make services more readily available for those in need.

As described earlier in this grant application, CMHCs are required by statute and contract to provide a core array of services and are held accountable to selected performance indicators, but are given some autonomy in how funds are distributed based on regional priorities. Detailed mental health block grant planned expenditures are provided as an attachment to this section of the block grant application.

DBHDID is awarded state general funds for community mental health services as a result of an annual allocation from the state General Assembly. The funding amounts are a result of a biennium budget proposed and ultimately passed by the General Assembly in the form of a budget bill. DBHDID also enters into contracts with other state agencies to provide specific behavioral health services. DBHDID also applies for and receives other federal grant funds to support the systems of care for adults with SMI and children with SED.

Per Section 1911 of the Title XIX Block Grants, the state will expend the block grant funds only for the following purposes:

• Carrying out the plan submitted for the fiscal year;
• Evaluating programs and services carried out under the plan; and
• Planning, administration 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 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 data collection and analysis and the operation of the Kentucky Behavioral Health Planning and Advisory Council. The attached table with planned expenditures of mental health block grant funds outlines exactly how the funds are allocated for SFY 2022. SFY 2023 allocations will be determined at a later date.

Component 2: Staffing

DBHDID contracts directly with each Regional Board to provide direct services and each Board employs staff who deliver the services at the local level. Thus, DBHDID involvement in human resource development activities for the Regional Boards and their staff have traditionally been indirect, focusing on staff training, technical assistance and the establishment of minimum qualifications and core training requirements for providers. The Medicaid State Plan included new staff requirements for various services. Most Medicaid billable services now require an independently licensed professional or an individual under supervision to obtain their license. A billing supervisor must now manage all non-licensed providers.

Component 3a: Training for Mental Health Services Providers

DBHDID strives to provide access to on-going training and technical support for all Central Office staff as well as partner agencies and providers statewide. The Department seeks to utilize available technology to provide educational/training and consultation opportunities. One example is the AdobeConnect system of webinar technology. Several DBHDID staff were trained in the AdobeConnect technology and hosting of webinars. When the pandemic shut down offices, DBHDID staff quickly adapted to Zoom technology and several Zoom licenses were purchased for various DBHDID staff. For over a year and a half, most meetings and staff trainings have occurred utilizing the Zoom network. In addition, DBHDID began utilizing Microsoft Teams as well and

much teamwork has become “Teams” work.
DBHDID provides or sponsors and participates in a variety of training initiatives. This includes many opportunities for central office staff, as well as contracted and private behavioral health service providers, to increase their knowledge and skill level in various best practices. Many offerings include sessions necessary for continuing education requirements for professional board certification or licensure. During the pandemic all training efforts became virtual. Providers from all over the state could, and did participate from their local venues.
During SFY 2015, DBHDID created the Program Integrity Division to assist with contract monitoring, technology support, legislative support and training support. This Division included a Program Support Branch that works to streamline procedures that assist all DBHDID staff in providing training events. A Central Help Desk was created through Program Support Branch, where information can be uploaded to assist with continuing education approval for various offerings. The Program Support Branch also manages the database for ALL certified Targeted Case Managers, Peer Support Specialists, and Comprehensive Community Support Providers across the state, as well as tracking required continuing education for those para-professionals.
The Department makes a wide variety of trainings, technical assistance, and coaching available, free of charge, to CMHC staff and other contracted providers. The DBHDID also provides scholarships (as funding allows) for individuals with lived experience, parents/family members, and Regional Board staff, to attend training events. Funds are also used to provide Certified Psychiatric Rehabilitation Practitioner (CPRP) examinations from the Psychiatric Rehabilitation Association (PRA) for Regional Board staff, as well as to support technical assistance for the development and maintenance of adult and children’s programming. (e.g. Targeted Case Management, Therapeutic Foster Care). The table below details available DBHDID training events.
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
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
Community Support Program (CSP) Directors
Technical Assistance Meetings CSP Directors Approximately 25 Quarterly
3 hours
Direct Intervention: Vital Early Responsive Treatment System (DIVERTS) Training Series In Reach Coordinators, ACT team staff, Regional Transition Coordinators, DBH, others as appropriate Unlimited Monthly
IPS Supervisor Meeting Coaching and feedback IPS supervisors and IPS state coaches Approximately 20 Quarterly 2 hours
IPS Supported Employment Trainings IPS employment specialist, supervisors and Office of Vocational Rehabilitation (OVR) Approximately 45 2 -6 hours
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 4 hour training, repeated across the state
Peers in the Know Training Series Adult, Family, and Youth Peer Support Specialists Up to 500 Monthly
1-2 hours
Settlement Agreement Meetings In Reach Coordinators, ACT team staff, Regional Transition Coordinators, DBH, others as appropriate Unlimited Biannual
1 Day
BOLD Denotes that Continuing Education Units (CEUs) may be offered for these training sessions.
The following offers additional detail about the training events listed above.

Description of Trainings Relevant to Adult Services

ACT Team Leader Technical Assistance Meetings
DBHDID program administrator for ACT meets quarterly with ACT team leaders. Peer group meetings 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.

Community Support Program (CSP) Directors Technical Assistance 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.

DIVERTS Training Series
A monthly training series for provider staff working to assist persons with SMI to transition from institutionalization to community living. The series covers topics such as trauma and resilience, financial assistance, housing assistance, advocacy organizations, co-occurring disorders, and recovery.

IPS Supervisor Meeting Coaching and Feedback
These meeting are held quarterly and are open to IPS supervisors and state coaches across the state, serving adults with SMI.

IPS Supported Employment Trainings
These trainings are open to IPS employment specialists, supervisors and the Office for Vocational Rehabilitation (OVR) staff, and cover a variety of topics including documentation, career profiling, substance use disorders, recovery, and self-care.

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

Peers In The Know Training Series
Monthly live virtual training series designed to build peer knowledge and capacity.

Settlement Agreement Meetings
Statewide meetings led by DBH staff to discuss issues related to the 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.

Trainings Relevant to Children's Services
Type of Training Intended Audience # of Participants
Anticipated Frequency/
Length of conference

Advancing Wraparound Practice

For High Fidelity Wraparound Facilitators 30 2 Days

Behavior Institute, co-sponsor Educators, administrators, agency service providers, and families Approximately 1200 Biennially; 2.5 days. Held virtually in SFY 2021.
Child and Adolescent Needs and Strengths (CANS) CMHC staff and other Child Clinicians who will be administering the CANS Differs by Need 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

Engagement in the Wraparound Process High Fidelity Wraparound Facilitators, High Fidelity Wraparound Supervisors and directors as well as community partners that may participate in a child and family team process 45 2 Days
Offered As Needed

Family Learning Vacation
(co-sponsor)
Parents, Grandparents, and Other Caregivers of Children with Behavioral Health Challenges who are Deaf or Hard of Hearing 30 Families 2-3 Day Weekend
As Needed

Introduction to Wraparound High Fidelity Wraparound (HFW) Facilitators, HFW Supervisors and directors as well as community partners that may participate in the child and family team process 45 3 Days

Offered As Needed
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, 2 Sessions per Year

Parent Cafes Parents or Caregivers of Children with behavioral health challenges and who are Deaf, Hard of Hearing, or Deafblind 3-20 per session 2-3 hour block

Regional Interagency Council (RIAC) Learning Series
Regional Interagency Council members and system of care partners across the state 25-50 1.5 hours
1st Friday of each month

Regional Interagency Council (RIAC) Overview Workshop RIAC Leaders, RIAC Members, and system of care partners across the state 100-150 1-4 hours
As Needed
Resources for Serving Children with SED who are Deaf or Hard of Hearing and Their Family Members IMPACT Service Coordinators 20-30 per session 3 hour session
As Requested
School-Based Suicide Prevention School Administrator, Educators, Staff 40 As requested

System of Care Framework Any Community Agency Staff that serves children and youth who are at risk of or have behavioral health challenges, families, parents, and youth. 100 1-4 Hours
As Needed
Trauma Informed Care Considerations for Children who have behavioral health challenges and 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
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

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.

Behavior Institute
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, and Kentucky's System to Enhance Early Development through the Kentucky Division of Behavioral Health, Kentucky Autism Training Center and the Central Kentucky Special Education Cooperative.

Child and Adolescent Needs and Strengths (CANS)
Functional assessment used for children entering out-of-home care through Department for Community Based Services (DCBS). It is also the outcomes management tool that for High Fidelity Wraparound.

CASII
Tool required in determining medical necessity for the Managed Care Organizations (MCOs). It is also used as part of the eligibility determination process for High Fidelity Wraparound.

ECSII
Tool required in determining medical necessity for the MCOs. It is also used as part of the eligibility determination process for High Fidelity Wraparound.

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.

Family Learning Vacation
A weekend-long event co-sponsored by DBHDID. Families attend a series of workshops related to raising a child with behavioral health challenges who is Deaf or Hard of Hearing. Parent Support Groups were added 3-4 years ago. For many families, this is the only time each year that they meet others with a Deaf-member.

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.

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

Parent Cafes
Based on Kentucky's Strengthening Families, the Parent Cafes are offered by DBHDID and often in partnership with Kentucky Hands and Voices and/or the Kentucky School for the Deaf Outreach Team. Cafes focus on the Protective Factors and have been adapted to include questions and resources specific to families with children with behavioral health challenges and who are Deaf, Hard of Hearing, or Deafblind. Youth cafes are in the development process for this population.

Regional Interagency Council (RIAC) Learning Series
The learning series supports regional system of care efforts. Topics are RIAC-driven. The series is free and open to all RIAC members and system of care partners.

Regional Interagency Council (RIAC) Overview Workshop
Provides an overview of the RIAC Policies and Procedures; System of Care Core Values and Guiding Principles; RIAC Duties; Expectations, and Member Responsibilities; Using Data to Drive the Work of the RIACs; Successful Community Collaboration; and additional needs as identified by DBH and RIAC members.

Resources for Serving Children with SED who are Deaf or Hard of Hearing and Their Family Members
Starting with scenarios derived from regions' real experiences, targeted case managers learn about the developmental, social, and emotional implications for children who have SED and are Deaf or Hard of Hearing. ADA rights and provider obligations are covered and resources are shared.

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.

System of Care Framework
Provides an overview of the history and development of the System of Care framework at the national level as well as Kentucky's implementation.

Trauma Informed Care Considerations for Children who have behavioral health challenges and 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.

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
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
Behavioral Health Training for Law Enforcement All new police recruits through the police academy 350 total target Monthly
3 Days
24 hours total
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 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
Cognitive Behaior Therapy for Psychosis (CBTp) Supervision Training Regional Board staff and other providers of psychiatric services who had been identified as supervisors/coaches Approximately 20 1 Day
As Needed
Come Learn Presentations DBHDID staff Unlimited Quarterly
1 hour
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)
Crisis Intervention Team Training Refresher Law Enforcement Officers Approximately 180 Total Varies
3 Days (24 hours)
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
Early Interventions for First Episode Psychosis Any community providers 50 3 hours
As needed
Evidenced Based Care for the Client At-Risk for Suicide Behavioral health clinicians Target-80 As requested
One Day
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 ½ Hour Monthly
Hearing Voices that are Distressing Behavioral health providers and administrators and family members Maximum of 40 As requested
3 hours
Individual Placement and Support (IPS) Supported Employment Conference IPS Supported Employment staff from Regional Boards, other contracted entities, DBH staff, OVR. Approximately 50 2 Days
Annually
Integrated Dual Diagnosis Treatment (IDDT) Training ACT team members
Other providers Approximately 40 3 Days
Repeated in 3 locations across the state
Kentucky Behavioral Health Planning and Advisory Council (BHPAC) Member Orientation New and current members 15 Annually
KDBHDID Orientation Newly Hired Central Office Staff Average 4-8 Quarterly and as needed
1 Day
Kentucky Registry of Interpreters for the Deaf (RID) DHHS Interpreters from across the state 17-40 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
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 Response to Individuals with Special Needs (Mental Health 101) Police Officers, Deputies, School Resource Officers 25 Biannually
5 Days
40 Hours
Let's Talk Safety for Families: Access to Lethal Means General Audience New offering for suicide prevention As requested
1.5 Hours
Let's Talk Safety: Clinical Issues Associated with Access to Lethal Means Behavioral Health Clinicians New offering for suicide prevention As requested
1.5 Hours
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
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
Multifamily Group Therapy Regional Board staff, DBH staff, other providers of psychiatric services for youth and young adults Approximately 30 2 Days
As needed
Plan of Safe Care Behavioral Health service coordinators, clinicians, prevention specialists 1000 Offered Regionally and Annually
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 Clinical Interview for DSM 5 (SCID) CMHC Clinicians, iHOPE Clinicians, Other Agency Clinical staff 20-30 2 Day Biannually
Structured Interview for Psychosis Risk Syndromes (SIPS) Required for persons who will be administering the SIPS tool to young people. Approximately 25 3 Days
Biannually and as needed
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
Therapists' Retreat for those Serving Individuals with Behavioral Health Challenges with Hearing Loss Behavioral health service providers, state operated or contracted facilities, consumers, local interest groups and KDBHDID central office staff Ranges from 4-25 4 per year
Transition 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
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.

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.

Behavioral Health Training for Law Enforcement
Training instituted in June of 2017 for all new police recruits at the police academy. This training consists of two (2) days of training by CIT instructors, regarding ways to respond to incidents involving individuals with behavioral health issues, and one (1) day of an overview of behavioral health information.

Cognitive Behavioral Therapy (CBT) for Consumers who are Deaf with Language and Learning Challenges
Training in specific adaptations for CBT in use with individuals who are Deaf and who may have learning challenges.

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.

CBTp Supervision Training
Follow-up training and coaching for identified supervisors/coaches from across the state. The focus is 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, as well as all peer support specialists, comprehensive community support staff 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 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.

Crisis Intervention Team (CIT) Refresher Training (CIT 2)
A training course targeting Law Enforcement officers who have already been trained in CIT. Is designed as a CIT refresher, but also addresses current trends in law enforcement identified through local CIT Advisory Boards. For SFY 2022, CIT 2 training will focus on autism, methamphetamine induced psychosis, and trauma informed care, in addition to the recurring behavioral health pieces, involuntary commitment and developmental and intellectual disabilities.

Deaf and Hard of Hearing Services Providers’ Symposia
Offered quarterly, these trainings bring together Deaf and Hard of Hearing services specialists as well as other CMHC staff who serve individuals with behavioral health challenges with hearing loss. Due to the lack of training in contiguous states, participants from Ohio and Indiana attend training as well.

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

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

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

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 Technical Assistance 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.

Hearing Voices that are Distressing
Based on curricula developed by Patricia E. Deegan, Ph.D., consists of activities designed to simulate auditory hallucinations. The goal is to foster understanding and empathy in behavioral health providers.

Individual Placement and Support (IPS) Supported Employment Conference
DBH Adult Mental Health and Recovery Services Branch, in collaboration with the Office for Vocational Rehabilitation, hosts an annual 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.

Integrated Dual Diagnosis Treatment Training (IDDT)
Training regarding IDDT, an evidence-based practice for individuals with co-occurring mental health and substance use disorders. ACT teams are targeted for this training due to the high incidence of co-occurring disorders of individuals served by ACT.

Kentucky Behavioral Health Planning and Advisory Council Member Orientation
A 4-hour orientation 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.

KDBHDID Orientation
Provided to all new staff. Enhances staff knowledge of the mission and vision of the agency, programs and services administered by the Department, and staff who lead those initiatives.

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

Kentucky School of Alcohol and Other Drug Studies
The Kentucky School of Alcohol and Other Drug Studies (KSAODS) is an annual weeklong 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.

Kentucky School of Alcohol and Other Drugs Studies – Adolescent Treatment and Recovery Track
As of 2015, the School began offering a specific 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 Response to Individuals with Special Needs (Mental Health 101)
40-hour training offered biannually to interested 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.

Motivational Interviewing (MI)
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.

Motivational Interviewing (Basic/Booster/Advanced/Supervisor)
Trainings 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 individuals and their families. The course includes experiential "real plays", brief lectures and videos.

Motivational Interviewing Supervisor Training
Training for Motivational Interviewing Supervisors who will be providing onsite coaching and skill building to agency staff who have completed MI Basics, Booster Session and Advanced Training.

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

Plan of Safe Care
Training offered regionally and annually for behavioral health case managers, clinicians, and prevention specialists, focusing on plans of care with the goal of reducing the cycle of abuse/substance abuse that leads to subsequent prenatal exposure to substances. Identifies services and supports needed across agencies to support infant, caregiver/family.

Question, Persuade and Refer (QPR) Community Suicide Prevention Presentation.
Basic community-oriented presentation designed to create greater awareness, recognition of warning signs and knowledge of what to do if someone 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 Clinical Interview for Diagnostic and Statistical Manual 5 (SCID-5)
Assessment tool used to more accurately diagnose behavioral health conditions as categorized in the DSM-5. Standard of practice for iHOPE teams serving young people with early psychosis, but also utilized by other clinical staff.

Structured Interview for Psychosis Risk Syndromes (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. Dr. 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.

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

Therapists' Retreat for those Serving Individuals with Behavioral Health Challenges with Hearing Loss
Networking and support opportunity that occurs four (4) times per year.

Transition Aged Youth Launching Realized Dreams (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
Provides an overview of trauma and the necessary components that support the provision of care that recognizes 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.

Workshops for the Deaf Community
Most states focus on existing consumers; these workshops focus on identifying individuals who are in need of services, as well as existing consumers, and 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 Vocational Rehabilitation counselors in their regions ("Taking Care of Yourself in Tough Economic Times").

Trainings Related to Prevention
Type of Training Intended Audience # of Participants
Anticipated Frequency/
Length of conference
Applied Suicide Intervention Skills Training
(ASIST) ASIST is widely used by healthcare providers, but there are no formal training required to attend the workshop. ASIST can be taught to and used by anyone. From 15 – 40 2 days
As Needed

Assessing and Managing Suicide Risk (AMSR) Health and Behavioral Health professionals working in outpatient settings with a master's degree or above. Approximately 40 1 Day
6.5 hours
As Needed
Kentucky Prevention Network Conference (KPN) Regional Prevention Center staff, Prevention professionals. Approximately 50 at each session Annual 2 day training
Mental Health First Aid Designed for laypersons, including support staff at an agency serving adults with mental health issues, community members, family members, etc. Maximum of 30 per session. 1 day

As Needed
Prevention Academy Individuals seeking Prevention Specialist Certification. Varied 4 days
Annually/ More frequently if needed
Question, Persuade, and Refer (QPR) Training For Trainers (T4T) QPR is designed and recommended for everyone regardless of background or occupation. From 20 – 40 8 hours
As Needed
Sources of Strength Middle and High School aged youth and Adult Advisors. 35-50 Youth
5-8 Adults 4-5 hours for adults
6 hour for youth peer leaders
Substance Abuse Prevention Skills Training Individuals who are interested in the basics of prevention. RPC Staff, etc.. Maximum of 30 4 days
2-3 times per year
Suicide to Help (s2H) Designed for clinicians and other professional caregivers who work with former at risk persons. Varied 6.5 hours
As Needed
Too Good for Drugs
Implementer Training Majority grade school educators, or former educators. Regional Prevention Center Staff. Maximum of 30 per training.
2 days
Quarterly

Too Good for Drugs
Training of Trainers Only those that have completed the implementer trainings can attend and be certified. Maximum of 10 per training. 2 days
3 Times Per Year

Youth Mental Health First Aid Adults who regularly interact with adolescents. Maximum of 30 per session. 1 day
As Needed

Description of Trainings Relevant to the Prevention Branch

Applied Suicide Intervention Skills Training (ASIST)
Two-day interactive workshop in suicide first aid. ASIST teaches participants to recognize when someone may be at risk of suicide and work with them to create a plan that will support their immediate safety.

Assessing and Managing Suicide Risk (AMSR)
Designed to increased knowledge in the following core competencies: Maintaining an effective attitude and approach, collecting accurate assessment information, formulation risk, developing a treatment and services plan, and managing care.

Kentucky Prevention Network Conference (KPN)
Promotes collaboration and quality substance abuse prevention efforts, through training, education and networking.

Mental Health First Aid
This training provides participants skills to help an individual who is developing a mental health issue or experiencing a mental health crisis. Does not have to be a mental health professional.

Prevention Academy
This training provides individuals an opportunity to increase their knowledge about the field of prevention. Participants learn about substance use, building community capacity to address substance related issues, the Regional Prevention System in Kentucky, and other related topics.

Question, Persuade, and Refer (QPR) Training for Trainers (T4T)
This certification course trains instructors to teach QPR for suicide prevention to their community. Participants will learn about the nature of suicidal communications, what form these communications take and how they may be used as the stimulus for QPR intervention.

Sources of Strength
Sources of Strength is an evidence-based, peer-led mental health wellness model that taps into the power of young people to use social networking to change unhealthy norms and cultures. For this model, leaders from all identified school/organization groups (sports, academics, ethnicity, religion, etc..) work together to deliver messages to the school population at large to promote help-seeking, school connectedness, adult connectedness, mental and emotional strength building, and more through a series of self-designed strategic message campaigns.

Substance Abuse Prevention Skills Training (SAPST)
SAPST is for entry-level prevention practitioners and is appropriate for professionals working in related fields, e.g. treatment,

mental health etc. The SAPST training is grounded in current research and SAMHSA's Strategic Prevention Framework.

Suicide to Help (s2H)
This training is intended to highlight how to improve health and well-being leading to a self-directed and fuller life or, in other words, growth. Hoping to end the cycle of relapse followed by another round of coping, s3H aims for goals of more lasting significance.

Too Good for Drugs Implementer Training
Implementation Competency is essential for any instructor delivering an evidence-based prevention program like Too Good for Drugs. The fidelity model for Too Good for Drugs includes completion of a Curriculum Training session as part of its built-in quality assurance mechanism. To implement the Too Good programs with confidence, results, and fidelity to the implementation model, participation in a Too Good Curriculum Training is the first step.

Too Good for Drugs Training of Trainers
This training is specifically for implementers of the Too Good program and is intended to increase the capacity surrounding the program. Each of the trainees will go through a two-day training and at completion, they will be able to take their knowledge and experiences to train others interested in the curriculum.

Youth Mental Health First Aid
This training provides participants skills to help an adolescent who is developing a mental health issue or experiencing a mental health crisis. Does not have to be a mental health participant.

Component 3b: Training for Emergency Services Providers
The Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), serves as a support agency for the Kentucky 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 (CHFS). The ESF group assist 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 falls 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 and 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 response lies elsewhere.
DBHDID requires the fourteen (14) CMHCs via contract, to maintain a community-level behavioral health disaster plan (COOP plan) regarding emergency preparedness that outlines expected regional response in the case of a crisis of 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 and/or retired 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 2019, KCCRB reported ten (10) Psychological First Aid online trainings held. Psychological First Aid is now a six (6) hour online training event.
Mental Health First Aid (MHFA) training is another way 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 that targets any member of the community that helps with identification, understanding and responses to signs of mental illness and substance use disorders. It is managed by national entities and has rigorous requirements, including a weeklong training session, in order to be certified as a MHFA instructor. At the state level, each MHFA training is eight (8) hours and includes education on an action plan consisting of five (5) steps, 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 MHFA instructors in Kentucky has grown over the last few years. DBH contracts with the National Alliance on Mental Illness (NAMI) Lexington affiliate to provide Adult MHFA trainings across the state, and to track both the numbers of persons approved to provide the training as well as the number of actual trainings occurring across the state. The audience has included first responders and emergency dispatchers, state guardians, police officers, and others. DBH also provides Youth Mental Health First Aid training through a partnership with Kentucky Partnerships for Families and Children (KPFC), an advocacy organization for children with behavioral health issues and their families. In addition, DBH has provided funding over the years, through the Mental Health Aging Coalition, to train instructors in Mental Health First Aid for Older Adults.
Effective June 16, 2021, the Community Behavioral Health Training Program was established through DBHDID. This program was created through legislation (908 KAR 2:270) in response to increased numbers of substance overdose deaths and suicides in Kentucky. DBHDID continually seeks to increase access to appropriate behavioral health services, and this requires the assistance of all Kentucky citizens to aid in identifying individuals and families who may be struggling and help them find adequate care.

Through this program, DBH staff coordinates additional MHFA trainings as well as Question, Persuade and Refer (QPR) training and Applied Suicide Intervention Skills Training (ASIST).

DBHDID also participates in Department of Corrections Criminal Justice Training (DOCJT), which provides a weeklong training event annually, to new state police cadets and other Kentucky state troopers and law enforcement agents, commonly known as Mental Health 101. This training includes a comprehensive list of components including involuntary hospitalization law, behavioral health basics, and an auditory hallucination simulation exercise. This training has instructors who are peer support specialists and individuals in recovery.

Through a partnership with a retired police lieutenant, DBHDID provides Crisis Intervention Team (CIT) training across the state. This training is based on the Memphis Model and Kentucky trains law enforcement officers in behavioral health specifics, as well as assists local communities in the creation of CIT Advisory Boards. The Advisory Boards assist with gathering local leaders from pertinent stakeholders to build relationships and work to problem-solve local issues related to law enforcement and behavioral health. In addition, DBHDID provides planning and implementation assistance for an annual statewide CIT conference. A new training offering is CIT 2, which is like refresher training for law enforcement officers who have already received the CIT training that includes current trends for law enforcement and other training needs identified through regional Advisory Boards. During SFY 2021, despite the pandemic closing classes from April to July 2020, thirteen (13) CIT trainings occurred across the state, and one (1) CIT 2 class. In addition, an addendum to DOCJT Mental Health 101 training began, which includes two (2) days of CIT instruction and one (1) day of behavioral health overview training. For SFY 2022, the CIT 2 training will focus on autism, methamphetamine induced psychosis and trauma-informed care.

Footnotes:

Criterion 3 Narrative

Kentucky's State Interagency Council for Services and Supports to Children and Transition Age Youth

The State Interagency Council (SIAC) is comprised of representatives from state child-serving agencies, a parent of a child with an emotional disability, and a youth with lived experience receiving services related to an emotional disability. This Council serves as the governing body for Kentucky's system of care for children, youth, and young adults with or at risk of developing a behavioral health need. Enacted by 2018 legislation, representation on the SIAC expanded to include agencies that work with or on behalf of transition-age youth (i.e., Council on Postsecondary Education, Kentucky Housing Corporation, & Office of Vocational Rehabilitation) as well as a nonprofit family organization representing consumers of services and supports within the system of care whose membership, leadership, and governance include parents, primary caregivers, or children or transition-age youth with serious emotional, behavioral, or mental health needs and representation of the Juvenile Justice Advisory Board's Subcommittee on Equity and Justice for All Youth (SEJAY) to support efforts to reduce health disparities and promote health equity. In August 2020, the SIAC engaged in a strategic planning process resulting in action plans for the four (4) SIAC Standing Committees: Social & Emotional Health & Wellbeing; Outreach & Promotion; Disabilities; and Racial & Ethnic Disparities. These Standing Committees are responsible for reporting to the SIAC on the progress of their respective action plan activities.

Regional system of care modernization efforts continue via targeted technical assistance to the Regional Interagency Councils (RIACs) as they continue to shift their role and functions from gatekeeping/individual child plan reviews toward one of serving as the locus of accountability for the system of care. Several years ago, RIAC functions were re-conceptualized to a second-generation model that includes activities aimed at: Planning and Operations; System-level Continuous Quality Improvement; System of Care Expansion, and Promoting System of Care Awareness, and collaborate with Family Accountability, Intervention & Response (FAIR) Teams, as appropriate, to improve and/or promote the system of care. The RIACs are each operating from a regionalized system of care action plan. RIACs are using regional data to inform their function-based activities. For example, some RIACs are focusing on youth and gun violence prevention, developing online resource directories, for transition-age youth transitioning out of foster care, promoting suicide prevention in schools and communities, and hosting trainings in evidence-based practices. Monthly reports of RIAC activities are provided to the SIAC.
In 2018, legislation was enacted to update statutory language within the law governing SIAC and RIACs to align with the modernization efforts and to issue voting rights to the new members of the SIAC as well as add new required members to the RIACs.

Membership of State and Regional Interagency Councils

SIAC Representative Domain RIAC Representative

Parent of a child or transition-age youth with a behavioral health need, who is a consumer of services and supports within the system of care Family Members Parent of a child who received services related to behavioral health challenges

Commissioner, Department for Behavioral Health, Developmental & Intellectual Disabilities Behavioral Health Director of Children's Services, Community Mental Health Center

Commissioner, Department for Community Based Services Child Welfare Representative,
Department for Community Based Services

Commissioner, Department for Public Health Public Health Representative, Local Health Department

Commissioner, Department for Medicaid Services Medicaid Regional Representative,
Department for Community Based Services

Commissioner, Department of Juvenile Justice Juvenile Justice Regional Program Manager, Department of Juvenile Justice

Executive Officer of the Department of Family and Juvenile Services , Administrative Office of the Courts Courts Court Designated Worker, selected by district judge

Commissioner,
Department of Education Education Special Education Coordinator,
Local Education Authority

Director, Division of Family Resource and Youth Services Centers Prevention and Early Intervention Not currently required but may be added at the discretion of the RIAC

Executive Director, Commission for Children with Special Health Care Needs Children with Special Health Care Needs Not currently required but may be added at the discretion of the RIAC

Youth between the ages of sixteen (16) and twenty-five (25), who has a behavioral health disorder and who is receiving or has received services to address mental health, substance use, or co-occurring mental health and substance use disorder

Transition-age Youth

25 who has a behavioral health disorder and who is receiving or has received a service to address mental health, substance use, or co-occurring mental

Executive Director, Office of Vocational Rehabilitation Vocational Rehabilitation Representative, Kentucky Office of Vocational Rehabilitation

Chair, Subcommittee for Equity and Justice for All Youth of the Juvenile Justice Advisory Board Racial & health equity Not required

Executive Director, Kentucky Housing Corporation Housing Not required

President, Council on Postsecondary Education Postsecondary Education Not required

Non-profit statewide family organization Parents and/or primary caregivers of children and transition-age youth with serious emotional, behavioral, or mental health needs Not required

Required RIAC membership has expanded, although RIACs can add membership at any time based upon regional need.

The collaborative nature of the state, regional, and local councils allows members to identify barriers from their agency perspective and discuss solutions within a multidisciplinary context. The RIACs have moved to a focus on system of care expansion and implementation. A CMHC employee, the Local Resource Coordinator (LRC), staffs RIACs and LIACs.

Social Services

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

• Designating clinical staff whose primary function is to provide mental health and substance; abuse services to children, youth, and adults referred by DCBS ;
• Providing therapy services in the local DCBS offices in counties that do not have a CMHC clinic;
• Providing therapeutic foster care services;
• Prioritizing scheduling for DCBS referrals;
• Providing clinical staff on-site at DCBS weekly to provide consumer assessments, staff consultations, and to involve consumers and their families in the process of treatment;
• Participating in team meetings to review high priority/intensive cases and discuss treatment goals and coordinate joint outcomes;
• Utilizing a standardized referral form from DCBS to guide DCBS referrals into their intake system and allowing the Center to contact those families directly upon receiving the DCBS referral to schedule an assessment;
• Meeting regularly with DCBS regional staff (usually monthly or quarterly) to discuss new services, changes in service array, possible grant collaborations, and other issues that may arise;
• Collaborating to implement currently-funded SAMHSA System of Care Expansion and Sustainability grant that focuses on improving behavioral health outcomes in children and youth who have child welfare involvement and are not placed in out-of-home care, and
• Providing a standardized functional assessment (the KY Child and Adolescent Needs and Strengths) to all children and youth referred by DCBS.

Kentucky's currently funded SAMHSA System of Care Expansion grant, awarded to the DBHDID in 2019, was intentionally written to align with the state's implementation of the Family First Prevention Services Act. The System of Care FIVE (Families – Involved! Valued! Empowered!) Grant aims to improve behavioral health outcomes for children and youth (birth to age 21) who meet criteria for having a serious emotional disability (SED) and their families and who have child welfare involvement. For this project, child welfare involvement means that a family has had a substantiated instance of child abuse and/or neglect or a finding that services are needed, and for whom child welfare does not have custody. DCBS, the child welfare agency, partnered with DBHDID in development of the grant application and is actively involved in the State Grant Management and Implementation Team. The SOC FIVE grant is building upon the foundation of previous behavioral health and child welfare innovations including previously funded SAMHSA and Children's Bureau grants.

Educational Services, Including Services Provided Under the Individuals with Disabilities Education Act

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

Project AWARE (Advancing Wellness and Resilience in Education)

In 2019, Kentucky's Department of Education (KDE) was awarded its second SAMHSA Project AWARE grant to address violence prevention and behavioral health promotion. The resulting program, designed to train school staff to identify students' behavioral health needs and to increase effective communication between school staff and behavioral health providers, is being piloted in three (3) of the state's largest school districts. However, collaborative efforts are not limited to those three (3) districts. Kentucky's program includes emphases on Trauma-Informed Care, Resilience Building, and educating school staff regarding Secondary Traumatic Stress, promoting these via learning collaboratives. In addition, KDBHDID collaborated with KDE to expand student access to TARGET (Trauma Affect Regulation Guide for Education and Therapy) statewide. The management team includes members from several different agencies including KDBHDID and includes young adults and family members with lived experience.

Kentucky Educational Collaborative for State Agency Children

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

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

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

Regional and Local Voices

Across the fourteen (14) CMHCs, Children's Services Directors report having over 430 staff who are trained to and routinely serve transition-age youth (age 16-25). Staff provide evidence-based and developmentally appropriate services and supports to this age group, including connections to educational and/or vocational services and. Examples of the services and supports include the following:
? IPS Supported employment services;
? Active coordination between Child and Adult Targeted Case Management 24 months prior to transition;
? Ongoing interface with supported employment and Vocational Rehabilitation services twelve (12) months prior to transition;
? Shared information about transitioning, training opportunities, Job Corps, community supports, and higher education; and
? Transition to adulthood skills, services and supports incorporated into Service
Coordination.

Juvenile Justice Services

Kentucky's juvenile justice system has undergone significant reform in recent years as a result of Senate Bill 200, passed in 2014.

An overarching aim of the legislation was to reduce the incarceration of children younger than 18 charged with noncriminal "status" offenses, such as skipping school or running away from home, by steering more young offenders into community based assessment and treatment, while also discouraging recidivism rates and a path toward adult incarceration. Under the new law, before cases are referred to the county attorney, court designated workers must use evidence-based tools to screen and assess youth and make referrals for appropriate services.

SB 200 also required new and amended law and policy for a number of child serving agencies including the Administrative Office of the Courts (AOC), the Department of Juvenile Justice (DJJ), the Justice and Public Safety Cabinet, the Cabinet for Health and Family Services (CHFS), and the Kentucky Department for Education (KDE).
As part of the legislation requires, the Administrative Office of the Courts (AOC) continues to implement the Family Accountability, Intervention and Response (FAIR) teams. These teams function much like an enhanced case management team to assist families and youth by connecting them with community supports to prevent youth from ending up in the justice system. AOC is working diligently to make sure that FAIR teams are established in all judicial districts. The FAIR teams are working collaboratively with Regional Interagency Councils to ensure needs of the youth and families are met most appropriately and efficiently.
The Kentucky Department for Juvenile Justice (DJJ) is a recipient of a Second Chance Act "Ensuring Public Safety and Improving Outcomes for Youth in Confinement and while Under Community Supervision" grant through the Office of Juvenile Justice Delinquency Prevention (OJJDP). The focus of this federal grant is on treatment and successful reentry of youth into the community with co-occurring substance abuse issues and mental health needs. With the support of this grant, the DJJ will is seeking to implement evidenced-based practices for staff training and support for substance abuse disorder services across the continuum in addition to identifying internal and external stakeholders to support successful reentry to the community for youth with co-occurring substance use and mental health challenges. DBHDID staff is on the steering committee for this grant and is providing information and resources to support planning, implementation, and evaluation.
DJJ is also working collaboratively with the Department for Medicaid Services and DBHDID to develop an 1115 Waiver application that would allow substance use treatment provided to youth who are in DJJ facilities to Medicaid billable. The application is being modeled after Kentucky's current 1115 Waiver for substance use treatment provided to adults in correctional facilities.

Environmental Factors and Plan

10. 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) Services for special populations:

Targeted services for veterans?	(•) Yes ( ) No
Adolescents?	(•) Yes ( ) No
Other Adults?	(•) Yes ( ) No
Medication-Assisted Treatment (MAT)?	(•) Yes ( ) No

Criterion 2: Improving Access and Addressing Primary Prevention -See Narrative 8. 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. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? (●) 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 Has your state identified a need for 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, and custody issues? (●) 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.

Pregnant Women and Women with Dependent Children (PWWDC)

Kentucky's behavioral health system of care has incorporated multiple programs to address the needs of pregnant and parenting individuals. These programs address substance use disorder by developing a continuum of care that includes screening, assessment, outpatient, intensive outpatient, and residential treatment services, along with recovery supports including transitional housing, case management, peer support and other community-based recovery supports. DBHDID includes the Program Integrity branch that functions to monitor provider compliance with program contract deliverables and performance indicators. Funding for contracted providers is contingent upon satisfactory completion of contract deliverables and performance indicators. The Program Integrity branch reviews contract deliverables with pertinent DBH program staff and prepares monitoring reports during the third quarter for Commissioner-level staff to discuss with contracted entities. Plans of correction are developed and monitored through Program Integrity branch staff.

Kentucky continues to expand its Plan of Safe Care (POSC) initiative with pilot sites at seven (7) of the fourteen (14) CMHCs, with plans for further expansion as funding allows. This initiative aims to improve access to evidence-based, quality services for PWWDC and to develop a coordinated and collaborative community-based system of care that supports the needs of families served.

Senate Bill 192 provides funding for the Kentucky Justice and Public Safety Cabinet to combat heroin and substance use disorder in the Commonwealth. The Office of Drug Control Policy within that cabinet works in tandem with the Kentucky DBHDID to assist with the selection of provider agencies to receive funds for programs focusing on Neonatal Abstinence Syndrome (NAS). Qualified providers receive funding to develop or expand comprehensive, evidence-based residential treatment services, increase access to transitional housing, and other recovery supports to pregnant and parenting individuals and their families. From SFY 2016 to SFY 2021, it is estimated that more than 3,000 individuals and their children/families have received treatment and utilized services from twenty-one (21) selected providers across the state supported by these funds.

As part of the KIDS NOW Early Childhood Development Initiative, the Kentucky Division of Behavioral Health, Adult Substance Use Treatment & Recovery Services branch is implementing a statewide effort to improve the health of all babies in Kentucky by decreasing the use of alcohol, tobacco, and other substances during pregnancy and postpartum periods through the KY-Moms Maternal Assistance Towards Recovery (MATR) program. This program is currently operating in all fourteen (14) CMHCs across Kentucky where collaborative outreach services seek to identify and engage pregnant and postpartum individuals who are at risk for substance use and/or present with a substance use disorder. KY-Moms services are focused on providing universal, selective,

and indicated prevention services that are designed to provide prevention education services to an at-risk population of pregnant and postpartum individuals. Pregnant and post-partum individuals that are diagnosed with a substance use disorder can receive case management services during their pregnancy and up to sixty (60) days after delivery. Prevention and case management services are designed to reduce harms to Kentucky children from maternal substance use during and after pregnancy.

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, if applicable	(•) Yes ( ) No
e)	Monitoring requirements as outlined in the authorizing statute and implementing regulation	(•) Yes ( ) No

2. Has your state identified a need for 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 (e.g., 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 services for individuals identified at risk for diseases associated with intravenous drug use. Each CMHC is required to have written policies for screening individuals and referring them for appropriate treatment services. The DBHDID includes the Program Integrity Branch that functions to monitor provider compliance with program contract deliverables and performance indicators. The Program Integrity branch reviews contract deliverables with pertinent DBH program staff and prepares monitoring reports during the third quarter for Commissioner-level staff to discuss with contracted entities. Plans of correction are developed and monitored through Program Integrity branch staff. Funding is contingent upon satisfactory 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. Has your state identified a need for 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.

Contractual requirements include guidelines for providing education and referral services for individuals identified at risk for diseases associated with tuberculosis. Each CMHC is required to have written policies for screening individuals and referring them for appropriate treatment services. The DBHDID includes the Program Integrity Branch that functions to monitor provider compliance with program contract deliverables and performance indicators. The Program Integrity branch reviews contract deliverables with pertinent DBH program staff and prepares monitoring reports during the third quarter for Commissioner-level staff to discuss with contracted entities. Plans of correction are developed and monitored through Program Integrity branch staff. Funding is contingent upon satisfactory completion of performance indicators.

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

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

2. Has your state identified a need for 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 syringe services programs (SSPs) across the state. There are currently seventy-four (74) SSPs in sixty-three (63) counties in Kentucky. Many of these programs provide outreach services, including harm reduction information/education, peer support and access to treatment. SABG funds are not used to support Syringe Services Programs.

Criterion 8,9&10

Service 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. Has your state identified a need for 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 services 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. Has your state identified a need for 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, such as 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. Does your state provide any of the following:

- **a)** Notice to Program Beneficiaries — (•) Yes ( ) No
- **b)** An organized referral system to identify alternative providers? — (•) Yes ( ) No
- **c)** 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. Has your state identified a need for 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. Has your state identified a need for 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 including 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.

The Department contracts with independent reviewers (including peers) to review three (3) CMHCs per year.

3. Has your state identified a need for 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) Development of 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, such as the 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)

Accreditation is not required for block grant sub-recipients, but all of the funded service providers are accredited by one or more of the organizations. Of the fourteen (14) CMHCs, six (6) are accredited by The Joint Commission and eight (8) are accredited by CARF.

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. Has your state identified a need for 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 opportunity 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) Performance-based accountability: (●) Yes ( ) No

d) Data collection and reporting requirements (●) Yes ( ) No

2. Has your state identified a need for 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

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?

a) Prevention TTC? (●) Yes ( ) No

b) Mental Health TTC? ( ) Yes (●) No

c) Addiction TTC? (●) Yes ( ) No

d) State Targeted Response TTC? (●) 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 that govern the Mental Health and Substance Use Disorder Programs.

There are many statutes and regulations in place that govern behavioral health programs in Kentucky.

https://apps.legislature.ky.gov/law/statutes/chapter.aspx?id=38158

Kentucky Administrative Regulations DBHDID

Kentucky Administrative Regulations Medicaid

Office of the Inspector General/Division of Audits and Investigations is responsible for investigating and auditing for possible fraud, waste or abuse of the programs administered by the Cabinet as mandated by KRS 194A.030. The Division is responsible for enforcing the Kentucky Controlled Substances Act as outlined in KRS 218A.

Footnotes:

Kentucky's behavioral health system of care includes fourteen (14) Community Mental Health Centers (CMHCs) as well as multiple licensed and credentialed private providers as specified on the Department for Behavioral Health, Developmental, and Intellectual Disabilities (DBHDID) provider directory. These programs provide access within the state to a full continuum of services, including education, screening, brief intervention, assessment, outpatient, intensive outpatient, residential, withdrawal management, and recovery supports. Kentucky is continuously identifying specific populations of need and works to provide targeted services to those populations. Those populations include Service Members Veterans and their Families (SMVF), adolescents, pregnant and parenting persons, individuals experiencing homelessness, older individuals, individuals with co-occurring substance use and mental health disorders and others as identified. Kentucky promotes the use of Medication for Opioid Use Disorder (MOUD) as an invaluable treatment tool through twenty-eight (28), state-certified Narcotic Treatment Programs that dispense methadone or other FDA-approved forms of MOUD in tandem with treatment services. Kentucky also maintains comprehensive legislative regulations to support access to buprenorphine formularies. For example, Kentucky has removed prior authorizations for buprenorphine formularies including the long-acting injectable formulation, Sublocade. Additionally, Kentucky has established an online treatment locator platform called FindHelpNow.org that is a real-time substance use disorder treatment availability locator and information center. The locator lists treatment openings and providers including CMHCs; private, non-profit, and faith-based treatment providers; and providers of Medication for Opioid Use Disorder (MOUD). Providers are encouraged to update their treatment availability and facility information daily. FindHelpNow.org also contains a multidisciplinary information center to help answer questions about substance use, treatment, and recovery resources. FindHelpNow.org was created by the Kentucky Injury Prevention and Research Center (KIPRC) as a bona fide agent for the Kentucky Department for Public Health in partnership with the Kentucky Office of Drug Control Policy, the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities, and Operation UNITE.

In SFY 2017, DBHDID, collaborated with two (2) national consultants, Diane Grieder, M.Ed.; and Janis Tondora, Psy.D., to work with providers regarding person-centered recovery planning. A person-centered planning kick-off occurred in the fall of 2016, and subsequent work with a pilot program consisting of six (6) CMHCs followed. DBH identified program administrators to work as person-centered planning liaisons for each of the regions. Implementation efforts included monthly case consultation calls for each region, monthly supervision technical assistance calls for all regions, and bi-monthly state workgroup calls with regional and DBHDID leadership. This work continued into SFY 2018 and included additional providers across the state, targeted work with prescribers and peer support specialists.

Managed Care Organizations in Kentucky require the use of American Society of Addiction Medicine (ASAM) Criteria for determining level of care for Medicaid billable services. The DBHDID contracts with CMHCs require the use of ASAM Criteria for level of care determination for SUD treatment services.

In other efforts to build workforce capacity, training on ASAM's Multidimensional Assessment was offered statewide and included ASAM Criteria Overview, ASAM Criteria Skill Building, Individualized Service Planning, and Motivational Interviewing. Between 2019 and 2020, 247 clinicians received this training.

Additionally, DBHDID is supporting ongoing training efforts including Screening, Brief Intervention, and Referral to Treatment (SBIRT), Trauma-informed Care, Comprehensive Opioid Response paired with 12-steps (COR 12), Motivational Interviewing, Targeted Case Management, and Peer Support.

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, the evidence-based Oxford House model was chosen to establish new recovery homes utilizing that loan fund. Beginning in January 2016, DBH contracted directly with Oxford House, Inc. to expand the recovery home network in the Commonwealth. Since that time, Kentucky's network has grown from four (4) houses in Northern Kentucky providing thirty-two (32) recovery beds, to ninety-two (92) houses with over 650 beds across the state. Due to the recent increase in houses, we have increased the total revolving loan fund to sustain rapid expansion of our recovery home network. Our contract with Oxford House, Inc. provides our state with Oxford House outreach workers who identify, open, and sustain community-based recovery housing, as well as establish relationships with service providers to ensure linkage with the extant continuum of care.

Kentucky Division of Behavioral Health (DBH) became the state affiliate of the National Alliance for Recovery Residences (NARR) on April 1, 2020. Since then, DBH has operated the Kentucky Recovery Housing Network (KRHN), a voluntary certification program for recovery housing. To date, KRHN has certified twenty (20) recovery residences with one hundred ninety-seven (197) recovery beds. KRHN has established a monthly open call to promote quality recovery housing and to grow and strengthen the recovery housing community in Kentucky.

DBHDID provides and sponsors a variety of trainings and technical assistance throughout the year including Kentucky School of Alcohol and Other Drug Studies, Operation Immersion, Gambling Association Conference, and Case Management and Peer Support Specialist Conference. Although some trainings were not completed due to the COVID-19 pandemic, it is anticipated that they will resume in SFY 22. Other events and trainings were conducted virtually, including the Prevention Academy and the System of Care Academy. The Division of Behavioral Health within DBHDID has also established the Community Behavioral Health Training Program which offers Mental Health First Aid (MHFA) trainings virtually. During SFY 21, this program provided ten (10) adult and youth MHFA trainings with 115 participants.

Through the State Targeted Response (STR) and State Opioid Response (SOR) grants, the Kentucky Opioid Response Effort (KORE) has supported the provision of numerous trainings designed to build workforce capacity. In partnership with the Hazelden Betty Ford Foundation, KORE developed a "Recovery Champions" curriculum tailored to Kentucky, which includes core competencies necessary for

working with individuals with Opioid Use Disorders (OUD) and their families. Nine (9) modules were developed including: 1) SUD, 2) Opioids, 3) Treatment, 4) MOUD, 5) Return to Use, 6) Harm Reduction, 7) Stigma, 8) Trauma, and 9) Recovery-Oriented Systems of Care. Since 2019, this curriculum has been used to support the professional development of over 9,300 staff, including judges and other court personnel, child and adult protective services, and family support workers. As part of the Responsive Education to Support Treatment in Opioid Recovery Efforts (RESTORE) program, the Administrative Office of the Courts implemented fourteen (14) Opioid Summits (Summer and Fall 2019), which adapted the Recovery Champions curriculum, for judges and court staff where 1,291 court staff were trained, including 132 judges/justices. In 2020, across five (5) virtual sessions, 1,122 judges and other court staff were trained. The Department for Community Based Services (DCBS) adapted the Recovery Champions curriculum to better equip DCBS staff to guide individuals and families within the child welfare system to evidence-based OUD prevention, treatment, and recovery supports. Across nine (9) regional trainings 1,394 child welfare employees and 51 foster parents were trained.

Environmental Factors and Plan

11. 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 2020-FFY 2021? ○ Yes ◉ No

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

Our state would appreciate opportunities to learn and share with other state behavioral health authorities about their Quality Improvement Planning process. Our state has organized a collaborative among three (3) 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 our state's ability to improve.

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Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma [57] 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 M/SUD 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 M/SUD services. 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 M/SUD 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 M/SUD 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[58] paper.

57 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.*
58 *Ibid*

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for M/SUD 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 M/SUD providers? (●) Yes ( ) No

3. Does the state have a plan to build the capacity of M/SUD 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 (DBH) has been facilitating trainings on Trauma-Informed Care and Seeking Safety, a manualized treatment for co-occurring substance use disorders and posttraumatic stress disorder. To date, over 150 individual providers across the state have been trained on Trauma-Informed Care (TIC) so they can train their agencies and other community partners on a general overview of trauma, trauma-informed care, and secondary traumatic stress. Technical assistance calls are offered quarterly to trauma-informed care trainers to discuss implementation needs/strengths, best practices, and additional resources. All fourteen (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.

In 2018, the Cabinet for Health and Family Services (CHFS), under the leadership of DBHDID, organized a Cabinet-level trauma-informed care roundtable. The TIC roundtable provides supports to the Departments and Offices within CHFS to implement trauma-informed, resilience-oriented, policies, practices and procedures. Several CHFS Departments, as well as the Cabinet Secretary's Office are represented on the workgroup. The TIC roundtable hopes to assist all programs with adopting a trauma-informed approach.

In 2019, Kentucky's Department of Education (KDE) was awarded its second SAMHSA Project AWARE grant to address violence prevention and behavioral health promotion. The resulting program, designed to train school staff to identify students' behavioral health needs and to increase effective communication between school staff and behavioral health providers, is being piloted in three (3) of the state's largest school districts. However, collaborative efforts are not limited to those three (3) districts. Kentucky's program includes emphases on Trauma-Informed Care, Resilience Building, and educating school staff regarding Secondary Traumatic Stress, promoting these via learning collaboratives. In addition, KDBHDID collaborated with KDE to expand student access to TARGET (Trauma Affect Regulation Guide for Education and Therapy) statewide. The management team includes members from several different agencies including KDBHDID and includes young adults and family members with lived experience.

In 2020, the DBHDID created the Trauma and Resilience Team. Members of this team consist of representatives from each Division and Branch across the Department. The primary goal of this team is to guide and support the implementation of trauma-informed and resilience-building policies and practices across the workforce and programming. During SFY 2021, DBHDID hired a Commissioner-level advisor for TIC, through Project AWARE (Advancing Wellness and Resilience in Education). This advisor participates in the learning collaboratives and has organized education and awareness campaigns for internal staff, including "Food for the Soul", a virtual sharing and learning forum regarding trauma-informed principles. DBHDID also provides psychosocial support for healthcare and behavioral health providers through a partnership with the University of Kentucky Center on Trauma and Children (CTAC), made possible through a grant from SAMHSA regarding the impacts of the pandemic. Through CTAC, healthcare and behavioral health providers across the state have access to "Well at Work" podcasts, resource links and other supports to promote health and wellness for organizational staff and members. CTAC provides additional targeted assistance to organizations that have experienced significant outbreaks, pandemic related deaths, and other pandemic related impacts.

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

N/A

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Footnotes:

Environmental Factors and Plan

13. 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.[59]

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.[60]
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 the Health Insurance 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.

[59] 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 Ren?e L. Binder. **OJJDP Model Programs Guide**
[60] **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 M/SUD 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, M/SUD 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 M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD 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 M/SUD 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 utilizes the "Sequential Intercept Model', (Munetz and Griffin 2006) as a framework for statewide systems integration to accomplish this task.

Developed nearly twenty (20) years ago, the Sequential Intercept Model (SIM) was designed for communities to use "when considering the interface between criminal justice system and mental health systems as they address concerns about the criminalization of people with mental illness" (Munetz and Griffin 2006, 544). Over the past two (2) decades, the model has gained prominence as an effective framework for systematically assessing available community resources, determining critical service gaps, identifying opportunities to safely divert people from needless involvement in the criminal justice system, and implementing reforms at criminal justice decision points, or "intercepts."

Intercept 0: Community Services is considered a gatekeeper to formal interaction with the criminal justice system. It encompasses the early intervention points for people with mental health issues before they are arrested and involves entities outside the criminal justice. Examples of this in Kentucky include a rich crisis stabilization infrastructure and an array of crisis service elements including crisis hotlines and community dispatchers coordinating with law enforcement; a continuum of crisis care options ranging from 23-hour stabilization or observation beds to short-term crisis residential stabilization services, mobile crisis services, peer crisis services, and specialized protocols for collaboration between law enforcement and behavioral health service providers are also common approaches.
Intercept 1: Law Enforcement recognizes that law enforcement officers and/or emergency services are the first responders for people experiencing a mental health crisis or emergency, which can be an intervention point to avoid formal entry to the criminal justice system. Intercept 1 includes all pre-arrest diversion options and concludes when someone is arrested. Crisis intervention team (CIT) training, mobile crisis outreach teams staffed by law enforcement agencies and mental health providers, training 911 dispatchers to identify a mental health crisis, and crisis stabilization are all examples of projects designed to accomplish this in Kentucky. 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 5,058 Kentucky law enforcement officers (including sheriff's departments, local police departments, state police officers, KY Fish and Wildlife Conservation Officers etc.) have been trained as members of Crisis Intervention Teams since the program's implementation. In SFY 2020, 240 Kentucky Police Officers received the 40-hour CIT certification and there were 10,330 statewide law enforcement responses to persons with either mental illness, substance use disorders, intellectual disabilities, or co-occurring disorders. There have also been over 57 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 (5) years. Starting in 2021, Bowling Green, Hopkinsville and Owensboro will also begin providing the CIT training to every officer. Twelve (12) of fourteen (14) 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 (2) CMHC regions that do not currently have them. In June 2021, KDBHDID will begin a pilot CIT 2 training. This new training consists of 24 hours of instruction over three (3) days and will be offered to law enforcement officers who have taken the original (40 hours) CIT training. CIT 2 was approved by the Kentucky Law Enforcement Counsel (KLEC) in March 2021. The new CIT 2 training will be flexible and will be based on training needs identified by local CIT Advisory Committees. The training needs identified for focus in 2021 were Autism, methamphetamine induced psychosis, and trauma-informed care.

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 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 instructors in this training.

KDBHDID, in partnership wit 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 ninety-one (91) 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 2021, 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 individuals in jails statewide. In SFY 2020, the program served 20,812 clients in the jails.

Intercept 2: Initial Detention/Initial Court Hearings encompasses post-arrest diversion options, including diversion to treatment instead of incarceration or prosecution. It aims to avoid the costly collateral consequences of incarceration and connect people to services. Strategies include use of validated screening to detect mental health issues, substance use disorders, and co-occurring disorders; pretrial diversion for low-level offenses with treatment as a condition of probation; and, data-matching between systems to link people to services.
Intercept 3: Jails/Courts focuses on people being held in pretrial detention and awaiting the disposition of their criminal cases. Intercept 3 concludes when someone is sentenced to incarceration (intercept 4) or community supervision (intercept 5). Specialty treatment courts (mental health court, drug court, veterans court, etc.) offer an alternative to both prosecution and incarceration.

Kentucky began implementing mental health courts to divert individuals into treatment and aftercare rather than long-term incarceration over fifteen (15) years ago. Currently seven (7) 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), Daviess County (Owensboro) 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.

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.

Intercept 4: Reentry addresses the continuity of care between correctional facilities and community behavioral health providers as people return to their communities. It concludes when someone is released from jail or prison and starts community supervision (intercept 5). Transition planning, such as the, assess, plan, identify and coordinate (APIC) care model, to assist with transitioning from incarceration to the community is one (1) approach that may be used at this intercept. In-reach by behavioral health providers to people in the correctional facility before release is another option.
KDBHDID has also collaborated with the CMHC in the Louisville area (Seven Counties) 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 (2) 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 Seven Counties Services 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, peer support, 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 integrated itself into Seven Counties' two (2) ACT programs due to the high number of clients with histories of criminal behavior. The ACT teams identify clients that require additional supports from the forensic therapists and forensic case managers. These forensic specialists often work with DOC, county detention centers, and circuit/district courts to ensure a smooth transition into treatment and community supports after completing short stints in the criminal justice system.

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.

Kentucky is also involved with a re-entry pilot program involving individuals diagnosed with Opioid Use Disorder (OUD) who are incarcerated. The program is in early stages and was developed in collaboration with DBHDID and the Department for Corrections. In this program, in-reach case managers assist clients with OUD, who are serving out their sentences, with treatment and service planning, submitting applications for Medicaid, SSI, or Medicare enrollment as applicable, and linkages to services critical to the reintegration process. Due to the pandemic, access to prison facilities stopped in March 2020. At that time, the in-reach case managers were enlisted to provide assistance to individuals who were released pursuant to the Governor's Emergency Covid Prisoner Release Program. Implementation of the re-entry pilot program resumed in August 2020 and engagement with clients is gradually increasing. As of May 2021, 362 justice-involved individuals with OUD were served by this program.

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 statewide pre-court program to ensure that diverted youth receive due process and equitable outcomes. They are available 24/7 in every Kentucky county. The Kentucky Department of Juvenile Justice (DJJ) is responsible for statewide detention services, residential placement/treatment services, probation, community aftercare/reintegration programs and youth awaiting adult placement or court.

FAIR Teams
Family Accountability, Intervention, and Response Teams (FAIR Teams) work in conjunction with court designated work to keep juveniles out of the formal court system by providing great access to treatment services and diversion programs. FAIR Team members review diversion agreements and service referrals to ensure young people are receiving effective, community-based interventions to reduce their risk factors and address their needs. FAIR Teams operate in all 60 judicial districts and were created as a result of Senate Bill 200, which reformed the state's juvenile code in 2014.

Juvenile Justice Advisory Board
The Juvenile Justice Advisory Board (JJAB) is Kentucky's federally mandated State Advisory Group (SAG) for juvenile justice issues. JJAB is composed of sixteen (16) members who represent juvenile justice, education, behavioral health, courts, youth advocates, and public advocacy. JJAB provides recommendations to the Governor, policy makers and the public to improve the quality of life and reduce recidivism for youth in or at risk of being involved with the juvenile justice system.

Juvenile Justice Oversight Council
The Juvenile Justice Oversight Council (JJOC) provides an independent review of Kentucky's juvenile justice system and provides recommendations to the General Assembly. The council is to actively engage in the implementation of 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.

Other Activities
Kentucky staff from Medicaid, Juvenile Justice and Behavioral Health are in the process of drafting a Medicaid waiver to provide substance use disorder treatment services to adolescents in juvenile justice custody. This waiver is being modeled after a similar waiver for incarcerated adults that Kentucky has submitted for CMS review.

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

N/A

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Footnotes:

Environmental Factors and Plan

14. Medication Assisted Treatment - Requested (SABG only)

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], 49 [4], and 63[5].

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.

TIP 40 - https://www.ncbi.nlm.nih.gov/books/NBK64245/ [ncbi.nlm.nih.gov]

TIP 43 - https://www.ncbi.nlm.nih.gov/books/NBK64164/ [ncbi.nlm.nih.gov]

TIP 45 - https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4131.pdf [store.samhsa.gov]

TIP 49 - https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4380.pdf [store.samhsa.gov]

TIP 63 - https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-006_508.pdf [store.samhsa.gov]

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)** [x] Methadone
- **b)** [x] Buprenophine, Buprenorphine/naloxone
- **c)** [ ] Disulfiram
- **d)** [ ] Acamprosate
- **e)** [x] Naltrexone (oral, IM)
- **f)** [x] 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?

Kentucky maintains comprehensive legislative regulations to support the implementation and continued quality assurance of methadone treatment delivered by Narcotic Treatment Programs (NTPs). To achieve this, the Division of Behavioral Health (DBH) employees the State Opioid Treatment Authority (SOTA) with the responsibility of ensuring regulatory compliance. Compliance is monitored by the SOTA, in part, through a methadone central registry. The central registry maintains a daily record of enrollment, discharges, take-homes, and client demographics as well as NTP staffing ratios.

Kentucky also maintains comprehensive legislative regulations to support access to buprenorphine formularies. For example, Kentucky has removed prior authorizations for buprenorphine formularies as well as the long-acting injectable, Sublocade.

Additionally, 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 classes are provided on MOUD and other Opioid Use and Substance Use Disorder evidence based treatment. MOUD education is also delivered through the Recovery Champions curriculum developed in partnership with the Hazelden Betty Ford Foundation for non-clinical staff in Kentucky.

Community Mental Health Centers (CMHC) are required by DBH contract to provide MOUD to individuals receiving treatment services through their agency. Those services can be provided directly by the CMHC or through partnerships with other community providers. Additionally, in partnership with the Office of Drug Control Policy, DBH has provided funding opportunities to expand access to MOUD services at the CMHC's.

DBH also supports specialized medication services for pregnant and parenting women with an opioid or alcohol use disorder. These additional supports include:
• Utilizing funds through Kentucky's Office of Drug Control Policy (ODCP) and SAMHSA State Opioid Response (SOR) grant, 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;
• 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;
• Funding services at two publicly funded Narcotic Treatment Programs to target services to pregnant women as a priority population and operates a methadone access program using SOR funding to serve as a payor of last resort for uninsured individuals; and
• Funding teams to support implementation of plans of safe care that includes the use of MOUD.

DBH utilizes the SOR grant to increase utilization of MOUD in a wide variety of treatment settings including:
• Hospital bridge clinics
• Federally-qualified health clinics and rural health clinics
• State prisons and county jails
• Drug courts
• Community pharmacies
• Mobile treatment

DBH also utilizes the SOR grant to increase the number of recovery support services that welcome individuals taking MOUD as part of their treatment and recovery plan. This includes:
• Recovery housing that accepts persons taking MOUD
• Mutual aid groups that support persons taking MOUD such as SMART Recovery

**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.*

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Footnotes:

Environmental Factors and Plan

15. Crisis Services - Required for MHBG

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 M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.[61] 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 M/SUD conditions and their families. According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[62],

"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 M/SUD 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.

[61] **http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848**

[62] Practice Guidelines: Core Elements for Responding to Mental Health Crises. 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 check those that are used in your state:

1. Crisis Prevention and Early Intervention

- **a)** ☑ Wellness Recovery Action Plan (WRAP) Crisis Planning
- **b)** ☑ Psychiatric Advance Directives
- **c)** ☑ Family Engagement
- **d)** ☑ Safety Planning
- **e)** ☑ Peer-Operated Warm Lines
- **f)** ☐ Peer-Run Crisis Respite Programs
- **g)** ☑ Suicide Prevention

2. Crisis Intervention/Stabilization

- **a)** ☑ Assessment/Triage (Living Room Model)
- **b)** ☐ Open Dialogue
- **c)** ☑ Crisis Residential/Respite
- **d)** ☑ Crisis Intervention Team/Law Enforcement
- **e)** ☑ Mobile Crisis Outreach
- **f)** ☑ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- **a)** ☑ Peer Support/Peer Bridgers
- **b)** ☑ Follow-up Outreach and Support
- **c)** ☑ Family-to-Family Engagement
- **d)** ☑ Connection to care coordination and follow-up clinical care for individuals in crisis
- **e)** ☑ Follow-up crisis engagement with families and involved community members

f) ☑ Recovery community coaches/peer recovery coaches

g) ☑ Recovery community organization

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

DBHDID would like to highlight the following CMHC initiatives to enhance crisis system capacity:
• Expansion of National Suicide Prevention Lifeline (NSPL) member call centers. CMHCs are rapidly preparing for implementation of 988 in July 2022. Kentucky was awarded 988 Capacity and Planning Grants and has seen NSPL in-state response rates increase significantly. In the last two (2) years, four (4) additional CMHCs have become National Suicide Prevention Lifeline (NSPL) member call centers; a total of eleven (11) CMHCs are members of the NSPL network and two (2) are in the onboarding process. All fourteen (14) CMHCs are members of Kentucky's new 988 Planning Coalition that meets monthly. Several CMHCs have upgraded their telephone systems to cloud-based platforms that allow staff to work from home and many are learning how to increase text and chat capabilities. At least half of the CMHCs operate regional warm lines and many anticipate greater utilization of the service when 988 is implemented.
• Strong Commitment to Providing Crisis Services during the COVID-19 Pandemic. While many services were disrupted by the pandemic, the CMHC crisis programs maintained a commitment to continuing care. Crisis stabilization unit staff quickly implemented CDC guidelines so that they could keep their doors open. This required quickly accessing PPE, implementing enhanced disinfecting protocols, accessing testing services for staff and clients, reducing bed capacity, and tailoring clinical treatment to allow social distancing. CSUs were able to remain open most of the time despite staff occasionally needing to quarantine due to COVID-19 exposure or illness.
• Expansion of Quick Response Teams. Quick Response Teams (QRTs) provide compassionate, assertive outreach to adult and adolescent overdose survivors to facilitate treatment and harm reduction services. Teams may be composed of peer specialists, treatment providers and first responders. CMHCs provided QRT services in sixteen (16) counties in SFY 2021 and in thirty (30) counties in SFY 2022.
• Expansion of telehealth delivered crisis assessments and interventions. The COVID-19 pandemic required rapid expansion of telehealth capacity. CMHCs purchased necessary technology such as software, iPads, and laptops, trained staff and collaborated with clients, families and community partners. A new law that took effect in 2019 allows patients to access telehealth from home (instead of a clinical setting) and with a greater diversity of providers, and state lawmakers are considering making permanent many of the emergency telehealth provisions allowed due to COVID. Crisis program directors report that local hospital emergency department and law enforcement staff like the faster access to behavioral health crisis services that telehealth access allows. Some CMHCs have provided community partners with iPads and laptops so that they can immediately engage crisis providers.
• Integration and expansion of services for individuals experiencing substance use disorder crises. CMHCs continue to increase crisis assessment and intervention for individuals with substance use and co-occurring mental health and substance use disorders. Three (3) CMHCs report working toward the American Society of Addiction Medicine (ASAM) certification of their crisis stabilization units. Others are increasing capacity by training staff in evidence-based practices, reconfiguring their crisis stabilization units to serve individuals with SUD or co-occurring disorders, including SUD specialists on ACT teams, training staff on the administration of Narcan, embedding ASAM into their electronic health records, and providing rapid engagement with SUD treatment services.
• Enhanced organizational capacity to ensure client safety and provide suicide-specific care. CMHCs are engaging in various activities to support a Zero Suicide culture. Such as: preparing for 988 implementation; maintaining Zero Suicide committees; conducting workforce surveys; providing training opportunities for staff and community partners; enhancing in-house training capacity; embedding prompts, alerts and safety planning into electronic health record platforms; utilizing evidence-based suicide screening, assessment and treatment practices; enhancing organizational policies; providing follow-up calls, caring letters and outreach to clients at-risk and for clients who miss an appointment; and conducting safety audits of facilities.
• Crisis services improvements. Some CMHCs are utilizing Certified Community Behavioral Health Clinic (CCBHC) and other federal grants to enhance mobile crisis services and in-home services, expanding services to individuals who do not have stable housing, and expanding on-site crisis services during nights and weekends instead of utilizing on-call services.
• Enhanced community partnerships and relationships. CMHCs quickly increased telehealth crisis assessment and intervention services in response to the pandemic. Crisis directors report that most community partners have responded favorably to telehealth services because transportation and wait times decreased. CMHCs also engage in cross-system crisis plans for individuals who are high utilizers of community services and have enhanced regional Crisis Intervention Team advisory groups.

Crisis Narrative
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 (14) 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
(See previous Block Grant applications for earlier entries on the timeline.)
2017: Kentucky convened its first Kentucky Zero Suicide Academy. Teams of senior leaders from fifteen (15) behavioral health care organizations participated in this two (2) day academy learning how to incorporate best and promising practicing into their organizations and processes to improve safety and care for individuals at risk of suicide.
2017-2018: The Substance Abuse and Mental Health Services Administration awarded technical assistance to KDBHDID to enhance the behavioral health crisis system of care, for individuals experiencing a substance use-related crisis. The following needs were

identified in the August 2018 report: consistency statewide, culture change, financing structure, and integration of substance use disorder, intellectual, and developmental disabilities services into crisis delivery at all levels.
2019-2021: National Suicide Prevention Lifeline Grant: A two (2) year grant was awarded to Kentucky to increase to at least 70% the number of calls to NSPL originating in the state that are answered by trained Kentucky counselors. DBHDID contracts with Pennyroyal Center, RiverValley Behavioral Health and Seven Counties Services to accept calls originating in the state but outside their regions.
2020-2021: COVID-19 Emergency Response for Suicide Prevention Grant: Kentucky was awarded this 16-month grant to reduce suicide deaths and attempts among individuals in Jefferson County who are experiencing increased risk of suicide, substance use, domestic violence, and homelessness because of increased psychological distress occurring across the state as a result of COVID-19.

2020-2021: Kentucky Rural Suicide Prevention Project: Kentucky was awarded funds from Kentucky Tobacco Settlement Funds to focus on reducing suicides among rural residents, especially farmers and their families. KDBHDID increased awareness of resources, created and disseminated farmer cultural humility trainings for behavioral health providers, increased the numbers able to recognize suicide risk by providing gatekeeper trainings and increased surveillance to identify high-risk geographic areas based on self-harm emergency department data.

2021: In March 2021, the Kentucky Law Enforcement Council approved CIT 2, a new 24-hour training for interested law enforcement officers who have taken the original (40 hours) CIT training. The new CIT 2 training will serve as a refresher and be flexible, with training topics based on needs identified by local CIT Advisory Councils.

2021: Vibrant 988 Suicide Prevention Lifeline Grant: Kentucky was awarded this nine (9) month grant by Vibrant Emotional Health to assist the state in planning for the implementation of 988, a new, national, three-digit number for mental health crisis and suicide response (9-8-8). Kentucky conducted a landscape analysis of the current service array, developed the Kentucky 988 Planning Coalition, and will develop a two (2) year strategic plan.
Kentucky's Crisis System of Care Guiding Principles
• Embraces Recovery
In a recovery-oriented approach to crisis care, the risks of harm to self or others are recognized; however, crises are viewed as challenges that present opportunities for growth and empowerment.
1.1 Preferred Practice: A recovery-oriented crisis system carefully engages the experiences, capabilities, and compassion of people who have experienced behavioral health crises.
• Zero Suicide/Suicide Safer Care
The Zero Suicide framework is a system-wide, organizational commitment to safe suicide care in health and behavioral health care systems, a call to relentlessly pursue a reduction in suicide and improve the care for those who seek help.
1.1 Preferred Practice: Lead a system-wide culture change committed to reducing suicides.
1.2 Preferred Practice: Train a competent, confident, and caring workforce.
1.3 Preferred Practice: Identify individuals with suicide risk via comprehensive screening and assessment
1.4 Preferred Practice: Engage all individuals at-risk of suicide using a suicide care management plan.
1.5 Preferred Practice: Treat suicidal thoughts and behavioral using evidence-based treatments.
1.6 Preferred Practice: Transition individuals through care with warm hand-offs and supportive contacts.
1.7 Preferred Practice: Improve policies and procedures through continuous quality improvement.
• 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.
1.1 Preferred Practice: Each system considers the strengths and resources of the person in crisis, the person's family and the community.
1.2 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.
2.1 Preferred Practice: Each system will be flexible to account for regional differences.
2.2 Preferred Practice: Each system will have a method to determine needs for crisis interventions, including mobile crisis, a crisis stabilization unit, and crisis intervention.
2.3 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, location in the region or agency of origin.
3.1 Preferred Practice: Each region is served by a hotline that operates 24/7/365.
3.2 Preferred Practice: Each CMHC has at least one (1) designated place where an evaluation can be completed, including law enforcement initiated cases.
3.3 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.
3.4 Preferred Practice: Transportation resources are available within the region to permit rapid access to acute care services.
• Timeliness
Quick response times are a critical feature of an effective behavioral health emergency system.
4.1 Preferred Practice: A reasonable response time for a face-to-face interaction with a clinician is 30 minutes for a walk-in crisis assessment.
4.2 Preferred Practice: On a crisis call, the individual or family member will be able to speak to a clinician within 15 minutes.
• Inclusion
Every person has the right to receive a timely, effective crisis response from their CMHC.
5.1 Preferred Practice: Each CMHC will have the capacity to respond to individuals in crisis with mental health disorders, development and intellectual disabilities, substance use disorders, 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.
6.1 Preferred Practice: Each region has a secure, safe environment that is non-stigmatizing to conduct crisis evaluations and interventions.
6.2 Preferred Practice: When possible, each region makes use of natural community supports, crisis prevention plans, support groups, and peer–run centers.
• Accountability
The emergency service system is accountable to individuals, their caregivers, families, communities and funding sources.
7.1 Preferred Practice: The emergency services system will reduce the use of higher levels of care. The CMHC will be able to demonstrate a relationship between crisis intervention activities and the reduction of hospital admission/utilization rates.
7.2 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.
7.3 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.
8.1 Preferred Practice: Clients and family members are included in the annual process for designing and improving the crisis services system.
8.2 Preferred Practice: Memoranda of Understanding or other formal mechanisms exist with key stakeholders in the community to outline roles and responsibilities.
• Data Informed
Decision making at the individual and systems level is guided by data.
9.1 Preferred Practice: So that information is available for decision making, all CMHCs will report crisis services data faithfully and consistently using the DBHDID data system.
9.2 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 evidence-based and best practices.
10.1 Preferred Practice: Trauma informed care is a guiding practice in all crisis services.
10.2 Preferred Practice: Standardized tools
are used for determining the level of care needed.
10.3 Preferred Practice: All services need to be co-occurring capable as measured by the Dual Diagnosis Capability in Addiction Treatment (DDCAT) or Dual Diagnosis Capability in Mental Health Treatment (DDMHT).
• Cultural Competence
Crisis services shall be provided by staff who are culturally and linguistically competent.
11.1 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.
12.1 Preferred Practice: The toll-free crisis hotline number, a description of the available crisis services, and how to access those services should have prominent placement on the agency website and other community outreach materials.
12.2 Preferred Practice: Law enforcement, first responders and other community partners should receive training on how to access crisis services.
Sources of Funding for Crisis Services
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.

Federal and Local Funds
CMHCs allocate mental health and substance abuse prevention and treatment block grant funds for crisis services for individuals

with SED, SMI and SUD. 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 (3) crisis services were approved for payment by the Centers for Medicaid and Medicare Services:
• Crisis Intervention: clinic-based crisis services
• Mobile Crisis: face-to-face crisis stabilization provided in the community
• Residential Crisis Stabilization: residential crisis stabilization in a crisis stabilization unit

Commercial Health Insurance
Crisis program also submit claims for crisis services to commercial health insurance providers. Below is a table that notes the three (3) Medicaid billable services (crisis intervention, mobile crisis and residential crisis stabilization) and the percent of individuals served with commercial insurance as the intended payment source. Mobile crisis services had the largest increase in commercial insurance payments since SFY 2019, with a 200% increase for clients age 0-17 and a 350% increase for clients over 18.

Percent of Crisis Clients for Whom Commercial Insurance is the Intended Payer
SFY 2015* SFY 2019 SFY 2021**
Crisis Intervention for Clients Age 0-17 9%*** 11% 10%
Crisis Intervention for Clients Age 18 and Over 3% 6% 8%
Mobile Crisis for Clients Age 0-17 11% 6% 12%
Mobile Crisis for Clients Age 18 and Over 3% 4% 14%
Residential Crisis Stabilization for Clients Age 0-17 9% 12% 7%
Residential Crisis Stabilization for Clients Age 18 and Over 4% 7% 5%
* The data in this table reflects the percent of clients for whom commercial health insurance is the intended payer (i.e., a claim was submitted for payment), not the percent of crisis clients with commercial insurance paid claims.
** State fiscal year 2021 data reflects year-to-date data. This is not a complete year of data and this data has not been certified.
***Percent of Individuals Served with Commercial Insurance is obtained by combining the totals for the following CMHC data field "Payer" responses: F (Commercial Insurance Company), I (HMO) and P (Blue Cross).
Data from the following reports: Crisis Intervention Response Client Count by Payer Source, Age 17 and Under/Age 18 and Over, Non-Residential Crisis Response Client Count by Payer Source, Age 17 and Under/Age 18 and Over, Residential Crisis Stabilization Client Count by Payer Source, Age 17 and Under/Age 18 and Over

Medicare
Medicare covers a range of outpatient services such as individual, group and family psychotherapy, psychiatric evaluation, medication management, partial hospitalization and prescription medications and is the primary health insurance provider for individuals age 65 and older. Community mental health centers submit claims to Medicare for individuals who are experiencing behavioral health crises. The table below depicts the percent of CMHC clients who received a crisis service and had Medicare as the intended payer for state fiscal years 2015, 2019 and 2021. The table shows that there have been dramatic decreases in Medicare payments for SFY 2021, perhaps due to older adults and other high-risk individuals sheltering in place in their homes and not seeking in-person services due to COVID-19.

Percent of Crisis Clients for Whom Medicare is the Intended Payer
SFY 2015* SFY 2019 SFY 2021**
Crisis Intervention for Clients Age 18 and Over 3% 4% 2%
Mobile Crisis for Clients Age 18 and Over 1% 0% 1%
Residential Crisis Stabilization for Clients Age 18 and Over 0% 4% 2%
* The data in this table reflects the percent of clients for whom Medicare is the intended payer (i.e., a claim was submitted for payment), not the percent of crisis clients with Medicare paid claims.
** State fiscal year 2021 data reflects year-to-date data. This is not a complete year of data and this data has not been certified.
Data from the following reports: Crisis Intervention Response Client Count by Payer Source, Age 17 and Under/Age 18 and Over, Non-Residential Crisis Response Client Count by Payer Source, Age 17 and Under/Age 18 and Over, Residential Crisis Stabilization Client Count by Payer Source, Age 17 and Under/Age 18 and Over

TRICARE
Some CMHCs are behavioral health providers in the TRICARE network and provide crisis services to Service Members and their families; however, crisis services claims submitted to TRICARE tend to be fewer than ten (10) clients per year statewide.

Self-Pay
All fourteen (14) CMHCs assist, directly or through referral, clients and families with insurance enrollment. For clients and families who refuse to participate in the insurance enrollment process, a sliding fee scale is available. Clients who present with a behavioral health crisis are not charged for crisis services if they are unable to pay and their services are billed to DBHDID (state general funds) or other state, local or grant funds.

Percent of Crisis Clients for Whom Self Pay is the Intended Payer

SFY 2015* SFY 2019 SFY 2021**
Crisis Intervention for Clients Age 0-17 2% 2% 2%
Crisis Intervention for Clients Age 18 and Over 2% 1% 1%
Mobile Crisis for Clients Age 0-17 1% 1% 0%
Mobile Crisis for Clients Age 18 and Over 1% 0% 1%
Residential Crisis Stabilization for Clients Age 0-17 3% 1% 4%
Residential Crisis Stabilization for Clients Age 18 and Over 3% 2% 4%
* The data in this table reflects the percent of clients for whom Self Pay is the intended payer (i.e., a claim was submitted for payment), not the percent of crisis clients with Self Pay paid claims.
** State fiscal year 2021 data reflects year-to-date data. This is not a complete year of data and this data has not been certified. Data from the following reports: Crisis Intervention Response Client Count by Payer Source, Age 17 and Under/Age 18 and Over, Non-Residential Crisis Response Client Count by Payer Source, Age 17 and Under/Age 18 and Over, Residential Crisis Stabilization Client Count by Payer Source, Age 17 and Under/Age 18 and Over

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 (24) 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 each individualized plan of care:
• Assessment and Screening
• Psychiatric Evaluation
• Medication Management and Medication
• Crisis Intervention (clinic based)
• Residential Crisis Stabilization
• Mobile Crisis (face-to-face services provided in the community)
• Access to Withdrawal Management 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. 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 2022 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 fourteen (14) community mental health centers and the number of agencies that provide the service to individuals in their catchment areas:

Crisis Service or Component Adults' Crisis Services Children's Crisis Services
Adult Peer Support 14 *
Criminal Justice Drop-Off Sites 7 6
Crisis Assessment via Telehealth 14 14
Crisis Case Management 11 11
Psychiatric Eval. and/or Medication
Management within 24 Hours or
Next Business Day 14 14
Crisis Respite 3 4
Crisis Transportation Services 8 8
Family Peer Support 10 10
Intensive In-Home Services * 7

Intensive Outpatient Crisis Counseling 11 10
Mobile Crisis 14 14
Quick Response Teams 7 6
Residential Crisis Stabilization 9 7
Safety Planning for Suicide Risk 14 14
Crisis Transportation Services 8 8
Virtual Crisis Support - Chat 4 3
Virtual Crisis Support - Text 4 5
Walk-in Crisis Intervention After
Business Hours 12 12
Walk-In Crisis Intervention During
Business Hours 14 14
Warm Line 8 8
Withdrawal Management 7 0
Youth Peer Support 7 10
24/7 Crisis Hotline 14 14
* Data is not collected for this service.
Data from SFY 2022 Form 132 Emergency Services Application

Kentucky's Adult and Child Crisis Stabilization Unit Sites that Receive State General Funds
Agency Adult Programs # of Adult Beds Child Programs # of Child Beds
Four Rivers Behavioral Health Mayfield 10
RiverValley Behavioral Health Owensboro 8
LifeSkills, Inc. Bowling Green 8 Bowling Green 12
Communicare, Inc. Elizabethtown 8 Elizabethtown 12
Seven Counties Services Louisville 12
Comprehend, Inc. Maysville 7
Pathways, Inc. Ashland 16 Morehead 6
Mountain Comprehensive
Care Center Prestonsburg 8 Prestonsburg 6
Kentucky River Community Care Hazard 7
Cumberland River Behavioral Health London 8 Corbin 10
The Adanta Group Jamestown 8
Wellspring Louisville 10
Wellspring Louisville 8
Number of Adult CSUs 12 Number of Children's CSUs 7
Number of Adult Beds 99 Numbers of Children's Beds 65
Statewide Total Number of Beds 164

Kentucky Behavioral Health Crisis Services
24-Hour Toll-Free Telephone Numbers

? Four Rivers Behavioral Health (800) 592-3980
Ballard, Calloway, Carlisle, Fulton, Graves, Hickman, Livingston,
McCracken, Marshall
? Pennyroyal Center (877) 473-7766
Caldwell, Christian, Crittenden, Hopkins, Lyon, Muhlenberg, Todd, Trigg
? RiverValley Behavioral Health (800) 433-7291
Daviess, Hancock, Henderson, McLean, Ohio, Union, Webster
? LifeSkills, Inc. (800) 223-8913
Allen, Barren, Butler, Edmonson, Hart, Logan, Metcalfe, Monroe, Simpson, Warren
? Communicare (800) 641-4673
Breckenridge, Grayson, Hardin, Larue, Marion, Meade, Nelson, Washington
? Seven Counties Services Adults (800) 221-0446
Bullitt, Henry, Jefferson, Oldham, Shelby, Children (800 432-4510
Spencer, Trimble
? NorthKey Community Care (877) 331-3292
Boone, Campbell, Carroll, Gallatin, Grant, Kenton, Owen, Pendleton
? Comprehend, Inc. (877) 852-1523

Bracken, Fleming, Lewis, Mason, Robertson
? Pathways, Inc. (800) 562-8909
Boyd, Carter, Elliott, Greenup, Lawrence, Bath, Menifee, Montgomery,
Morgan, Rowan
? Mountain Comprehensive Care Center (800) 422-1060
Floyd, Johnson, Magoffin, Martin, Pike
? Kentucky River Comprehensive Care (800) 262-7491
Breathitt, Knott, Lee, Leslie, Letcher, Owsley, Perry, Wolfe
? Cumberland River Behavioral Health (800) 273-8255
Bell, Clay, Harlan, Jackson, Knox, Laurel, Rockcastle, Whitley
? The Adanta Group (800) 633-5599
Adair, Casey, Clinton, Cumberland, Green, McCreary, Pulaski, Russell, Taylor, Wayne
? New Vista (800) 928-8000
Anderson, Bourbon, Boyle, Clark, Estill, Fayette, Franklin, Garrard, Harrison, Jessamine,
Lincoln, Madison, Mercer, Nicholas, Powell, Scott, Woodford

Diversion from the Justice System
CMHC crisis programs provide a range of services and supports to divert individuals from the justice system and higher 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.
Below is statewide data for SFY 2020. The statewide data reveals that CMHC staff provided 12,170 involuntary hospitalization evaluations for adults and 245 involuntary hospitalization evaluations for children, with 6,083 emergency transports 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 86 jails and many juvenile detention facilities and programs in Kentucky. In SFY 2020, CMHCs provided 22,917 consultation calls to these facilities, and 30 formally scheduled training events to 444 jail and juvenile detention center staff.

Diversion from the Justice System Objective – SFY 2020 Total
Number of involuntary psychiatric evaluations provided to adults. 12,170
Number of involuntary psychiatric evaluations provided to children. 245
Number of emergency transports provided to adults and children requiring reimbursement. 6,083
Number of calls for consultation provided to jails and juvenile detention centers. 22,917
Number of formally scheduled training events provided to jail and detention center staff. 30
Number of jail or detention center staff trained. 444
SFY 2020 Compilation of Plan and Budget Form 113D data.
Outcomes
DBHDID conducts an annual program performance and compliance review of the CMHC's program. Monitoring consists 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 is continuing performance-based contracts for SFY 2020 and will include two (2) crisis performance indicators in the CMHC contract. The indicators measure the rate of continuing care for clients who received a crisis service. The incentive for achieving the targets is 2% of the CMHC's total emergency services funding.

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 can stay abreast of performance. For Incentive Bond Year (IBY) 2021, these measures indicated that almost three (3) out of four (4) or (77%) adults and nine (9) out of ten (10) or (87%) children engaged in a service at a CMHC within thirty (30) days of receiving a crisis service.

Summary
Kentucky's Crisis Prevention and Response System has many exciting initiatives to rally around – an expanding behavioral health network of crisis services providers; an expansion of services and support for individuals experiencing a substance use crisis; excellence in suicide care and suicide prevention; enhanced community partnerships; and improvements to crisis call lines. 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 related to this section.

N/A

Footnotes:

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD 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 M/SUD 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 to the greatest extent possible, 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. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. 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 ( ) No

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 (TRP) 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 (PCRP) which includes a shared decision making component, Coordinated Specialty Care (CSC), with peer specialists embedded for young adults with SMI who are experiencing First Episode Psychosis, 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 operated/contracted 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 contracts with a local COSP to provide peer support specialists to assist with recovery mall work, group and individual peer support to individuals who are hospitalized as well as to work with families during visitation times. Self-help groups offered throughout the state include Double Trouble in Recovery (DTR), National Alliance on Mental Illness (NAMI) Connection groups across the state, which are recovery support groups led by individuals with lived experience in mental illness; NAMI family support groups across the state, which are family support groups led by family members with lived experience in having a family member with mental illness; and other recovery support groups for individuals with mental illness facilitated by people with lived experience, often peer support specialists.

In addition, CMHC contracts include a requirement to hire at least 2.0 Full Time Equivalent (FTE) peer support specialists 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.

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), Family and Youth 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 with peer specialists embedded for young people with SED who are experiencing First Episode Psychosis, Service Planning, Wellness Recovery Action Planning (WRAP), and a full array of Crisis services including Mobile Crisis. 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.

DBHDID also contracts with the Kentucky Partnership for Families and Children (KPFC) to provide education, advocacy, and leadership opportunities to children and youth with SED and their families. KPFC also provides a variety of cafes` using the world Café` model. These include Parent; Dad; Youth; Recovery; and Community Cafés.

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 for Opioid Use Disorder (MOUD). Kentucky's recovery support services aim to enhance effects and improve outcomes of existing treatment services in an 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 and receive continuing education. Self-help groups offered throughout the state include: Alcoholics Anonymous, Narcotics Anonymous, Al-Anon, Double Trouble in Recovery (DTR), and Celebrate Recovery. 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, in part, is established through the Commonwealth's Group Home Loan Program. Kentucky utilizes the Oxford House evidence-based practice model for recovery homes and contracts directly with the organization to provide outreach to our state. Most recently, Kentucky became the state affiliate of the National Alliance for Recovery Residences (NARR), operating a voluntary certification program and monthly open call, offering opportunities for networking, advocacy, and training.

Using regulatory compliance measures, the State Opioid Treatment Authority (SOTA) monitors provision of MOUD 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 families and friends, along with staff, programs, public, quasi-public, and private organizations and other entities that influence the recovery services within Kentucky.

Through the provision of the State Opioid Response (SOR) and the State Targeted Response (STR) grants, the Kentucky Opioid Response Effort (KORE) has supported the implementation of multiple recovery support programs aimed to help clients build recovery capital and maintain long-term recovery. Programs such as the Access to Recovery Program, links individuals to treatment and recovery support and provides a support for services that increase recovery capital and for which there is no payor source. Recovery support services can include basic needs, transportation, childcare, employment support, and recovery housing support. In addition, eleven (11) Recovery Community Centers (RCCs) have been established to provide centralized resources for community-based recovery supports. Each has developed various support groups previously unavailable in their communities, including medication-friendly mutual aid, peer support, recovery capital and career coaching, and childcare for parents attending support groups. One RCC has established two (2) mobile recovery outreach units. These mobile units provide engagement to recovery services, recovery coaching, mutual aid meetings, overdose response training and naloxone distribution, and assertive linkage to MOUD. For youth, ages 16-25, Transition Age Youth Launching Realized Dreams (TAYLRD) provides a network of community-based drop-in centers for youth who have, or are at-risk of developing, addiction challenges. Young People in Recovery (YPR) supports young people in or seeking recovery by empowering them to obtain stable employment, secure suitable housing, and explore continuing education. YPR has established and maintains eight (8) YPR chapters and five (5) 'My Recovery Is Epic' programs. In partnership with RCCs, mutual aid groups have been established across the state. This includes, SMART (Self-Management and Recovery Training), SMART Family and Friends, and Double Trouble in Recovery (DTR).

KORE funding was also utilized to develop a skill-building learning collaborative to enhance the knowledge and skills of state-certified peer support specialists who provide recovery support services to persons with OUD specifically, and SUD more broadly. The focus of the learning collaborative includes 1) Being Recovery-Oriented and Person-Centered, 2) SUD 101 and MOUD, 3) Ethics and Boundaries, 4) Telehealth and Virtual Service Provision, 5) Communication Skills, 6) Motivational Interviewing, 7) Person Centered Recovery Planning. In efforts to ensure the availability of peer support services among vulnerable populations, KORE has supported the following initiatives: 1) The Kentucky Coalition Against Domestic Violence, alongside regional CMHCs, has worked to co-locate peer support specialists in shelters; 2) Four (4) pilot sites at CMHCs were established to provide peer support services to Service Members and Veterans as well as prevention services for their families. Hired peer support specialists are Service Members or Veterans in recovery from a substance use disorder; 3) In collaboration with state partners overseeing Deaf and Hard of Hearing services, a taskforce was established to expand language accessibility in treatment and mutual-aid settings. To date, Kentucky has trained two (2) Deaf Certified Peer Support Specialists who provide group and individual peer support services as well as SUD-related education for both the Deaf community and Deaf providers.

For individuals with substance use disorders, the past year was of particular difficulty because the pandemic limited access to the supports necessary to establish and sustain recovery. Despite these challenges, Kentucky DBH continued to see success in assisting those in recovery. Although growth of the Oxford House network slowed during SFY 2021, fourteen (14) new community -based recovery homes were still established. Outreach staff focused on sustainability and ensuring residents' basic needs were met, and existing houses continued to operate and provide safe, supportive living environments. Recognizing that housing is not the only need for persons in recovery during this unprecedented time, the Access to Recovery (ATR) program was utilized, through which people in recovery from opioid use received additional supports and services not typically funded through third-party payor sources. (e.g. identification cards, clothing).

The Kentucky Recovery Housing Network (KRHN), the newly established state affiliate of the National Alliance for Recovery Residences (NARR), implemented a certification program for recovery residences. To date, KRHN has certified twenty (20) recovery residences and certified 197 recovery beds. KRHN has also established a monthly open call, offering training and presenters on a variety of topics, including the Social Model of Recovery and staff development.

Understanding the unique challenges related to treatment and recovery for those with substance use, DBHDID offered enhanced SUD Peer Support Training through KORE. This training equips certified peer support specialists with knowledge and skills specific to topics such as multiple pathways to recovery, motivational interviewing, and recovery planning.

During SFY 2021, DBHDID continued to support the CMHCs and providers of services for pregnant and parenting women (PPW) with additional funding from Kentucky's Office of Drug Control Policy (ODCP) to establish and expand recovery support services. Thirteen (13) providers received funding awards during SFY 2021. CMHC funding concentrated on crisis services, as well as recovery supports including recovery housing and transportation. There was also a strong emphasis on persons with co-occurring mental health and substance use disorders this year. PPW funds focused on recovery housing that met the needs of parents with children, including additional recovery support services and meeting basic needs.

KORE supported the establishment and expansion of twelve (12) Quick Response Teams (QRTs). These multi-disciplinary teams respond to individuals and families following an overdose event. While their primary purpose is to conduct outreach and promote engagement in treatment services, they also provide access to harm reduction and other recovery support services, such as peer support and case management.

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 of individuals with lived experience of behavioral health disorders 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 with lived experience of behavioral health disorders 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 with lived experience and family members to rewrite contracts to be awarded to statewide groups. 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 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 is designated for each of these contracts, as well as monitoring staff from the Program Support Branch.

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 with lived experience, 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 eight (8) of the fourteen (14) CMHC regions, with another one (1) in development.

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. Due to the pandemic, during SFY 2020 and 2021, KYSTARS hosted the conference in a virtual format. The Annual Peer Excellence Awards, a ceremony that occurs the night before the actual conference, continued and regional peer excellence awards were awarded. This award ceremony recognizes an outstanding individual with lived experience from designated geographical regions 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 six (6) 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 2021 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 training and technical assistance to support Participation Station in Lexington, Kentucky;
• Provide FACIT reviews to all DBH funded COSPs annually;
• Provide technical assistance to all DBH funded COSPs based on results of reviews;
• Provide an annual needs assessment regarding recovery oriented system of care;
• Sustain nine (9) Double Trouble in Recovery (DTR) groups in certain identified high-risk regions;
• Launch six (6) new Double Trouble in Recovery (DTR) groups in identified recovery community centers across the state; and
• Develop a Community Implementation Toolkit for Kentucky Communities interested in developing a Mental Health Court.

The Family- and 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;
• Self-advocacy;
• Family Leadership and Youth Leadership; and
• Integrating KY Strengthening Families protective factors into system change efforts.

KPFC also supports DBHDID in the implementation of several SAMHSA grants and supports KPFC, young people, and family members in participation on councils and attendance at state and national training (stipends, travel, childcare, etc.). KPFC employs two (2) of the state-level staff for Kentucky's SAMHSA Healthy Transitions grant, including the Project Director and Youth Coordinator. 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. In addition to employing Healthy Transitions grant staff, KPFC employs several of the staff for Kentucky's SAMHSA System of Care Expansion and Sustainability, including a full-time Family Leadership Coordinator, a full-time Youth Leadership Coordinator, and a half-time Training Coordinator. This staff works with DBHDID-hired grant staff as well as regional implementation teams and families to ensure that youth and family voice are embedded throughout the system. They provide training, outreach, engagement, and participate on the State Grant Management and Implementation Team. They partner with Regional Interagency Councils and Regional Grant Management and Implementation Teams to help identify, prepare, and support youth and family leaders to serve on committees and participate in the planning, implementation, and evaluation of grant activities.

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.

KPFC 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.

Beginning in SFY 2021, KPFC is charged with leading the development and implementation of a multi-year strategic plan that will support Kentucky's system of care for children and youth at risk of developing or with already identified behavioral health needs in becoming family and youth-driven. To that end, an interagency group consisting of state-level agency leaders from State Interagency Council (SIAC) member agencies, KPFC staff, and others formed a group to drive this work. The initiative is named Lived Experience Authentically Driven in Kentucky (LEAD KY) and is being facilitated by youth and parent leaders from the national organizations of Youth MOVE National and the Family-Run Executive Directors' Leadership Association. The work aligns with a goal identified by the SIAC during its 2021 strategic planning work to heighten youth and family engagement within SIAC member agencies and at all levels of the system of care.

DBHDID awarded the Recovery Oriented Training and Technical Assistance for Individuals with Substance Use Disorders contract to People Advocating Recovery (PAR), with the charge to establish and operate a recovery-oriented training and technical assistance center (the Center) to assist individuals and organizations with recovery efforts on behalf of the Department. DBHDID recognizes and supports recovery from substance use disorders as a lifelong process, and further recognizes that substance use disorders may co-occur with mental health disorders, and that increasing integrated services is an essential goal to promote

wellbeing. The PAR contract supports DBHDID efforts to reduce the stigma associated with substance use disorder as a means of enhancing recovery and the availability of services. The Center provides services to individuals in all stages of recovery, their family members and friends, along with staff, programs, public, quasi-public and private organizations and all other entities that influence recovery services within Kentucky. Training is based on nationally recognized recovery principles and best practices. The focus of technical assistance will be to incorporate recovery-oriented principles (and specific training topics) into existing programming and staff training within Kentucky. PAR also provides Food and Drug Administration (FDA) approved intranasal naloxone (Narcan) emergency kits in community settings throughout the state, targeting twenty-five (25) underserved counties in central and eastern Kentucky. The need to prevent opioid overdose in the Commonwealth of Kentucky is increasing, and this partnerships with PAR will allow those with a loved one with Opioid Use Disorder to act in an emergency to rescue someone from an opioid overdose.

Additionally, for approximately the last five (5) years, DBH has collaborated with Bridgehaven, a behavioral health services organization located in Louisville, Kentucky, to assist with supporting the infrastructure for peer support specialists who are working in the behavioral health workplace. This work includes:

• Maintaining a statewide 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) advocacy academy training, which targets individuals who have lived experience and want to learn leadership skills to contribute in their communities.

During SFY 2021, Kentucky hired both a parent who is dually certified as a Family Peer Support Specialist and as an Adult Peer Support Specialist (meaning she has lived experience as a parent of a young person with a behavioral health issue and also is a person in recovery herself) as well as a certified Youth Peer Support Specialist (meaning she has lived experience as having been a young person with a behavioral health issue) to work in the Children's Behavioral Health and Recovery Services Branch within the DBH. This is the first time in over a decade that DBH has intentionally hired a parent because of their lived experience and the first time ever for a young adult. While both positions were hired with SAMHSA discretionary grant funds (System of Care and Healthy Transitions, respectively), they work across the state toward operationalizing a true family- and youth-driven system of care. They achieve this by providing technical assistance and support to state, regional, and local programs and councils as they identify, engage, and support family and youth voice in their work. They also provide support and coaching to family and youth representatives who serve on various councils, including the parent and youth representatives on the State Interagency Council (SIAC) for Services and Supports to Children and Transition Age Youth. SIAC serves as the governing body for Kentucky's system of care for children, youth, and young adults with or at risk of developing behavioral health challenges, and their families.

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

N/A

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

Environmental Factors and Plan

17. 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 M/SUD 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 M/SUD 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.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

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

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

N/A

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Footnotes:

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 Medicaid State Plan Amendment, approved by CMS in January of 2014, made 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, an Amended Settlement Agreement (ASA) was signed by the Cabinet of Health and Family Services and Kentucky Protection and Advocacy. 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 had 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. https://apps.legislature.ky.gov/law/kar/908/002/065.pdf

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.

In October 2018, the Cabinet for Health and Family Services continued the Settlement Agreement with Kentucky Protection and Advocacy, agreeing to transition 1,275 adults with SMI living in personal care homes over the three Agreements. During two previous agreements, 926 individuals transitioned, leaving 350 adults with SMI to be transitioned from personal care homes into community-based living by October 2021.

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.

As a part of the Second Amended Settlement Agreement, DBHDID contracted with the Technical Assistance Collaborative (TAC) to provide consultation services to provide strategic recommendations to create and maximize permanent supportive housing options that comply with the Second Amended Settlement Agreement (SASA) population. This included performing a gap analysis, interviewing stakeholders, working with DBHDID's SASA committee and submitting a report of recommendations to the Department.

TAC is a national nonprofit organization that offers strategic planning; policy and systems design; financing and reimbursement strategies; program development and implementation; evaluation and quality improvement, and customized technical assistance and training.

KENTUCKY OLMSTEAD COMPLIANCE PLAN AND IMPLEMENTATION UPDATE

DECEMBER 2019

Cabinet for Health and Family Services
275 East Main Street
Frankfort, KY 40621
(502) 564-7903

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Kentucky Olmstead Compliance Plan

and Implementation Update

December 2019

EXECUTIVE SUMMARY

Kentucky's Olmstead Compliance Plan, originally released September 25, 2001, outlines state programs that currently support community-based efforts, makes recommendations, sets goals and strategies for each initiative, and lists challenges with Olmstead compliance. The plan is modified and updated as necessary to ensure that older adults and persons with disabilities are provided with appropriate choice and access to community-based services, long-term care options, and housing opportunities. In 2015, the Cabinet for Health and Family Services updated the Olmstead Compliance Plan to further its commitment to serving individuals with disabilities in the least restrictive and most appropriate setting possible for each individual. This document serves as an update on the implementation of those goals and establishes an updated Kentucky Olmstead Compliance Plan 2019.

Kentucky's first "Olmstead Compliance Plan" was established in 2002 within the former Cabinet for Health Services. An administrative order executed by the secretary of the then Cabinet for Health Services created the Kentucky Olmstead State Consumer Advisory Council, which consisted of 35 representatives of persons with specific disabilities, geographic regions and cultural groups along with many members of the original Olmstead planning group. To create the Olmstead Compliance Plan, public forums were conducted throughout the state wherein housing, access to services and transportation were identified as key issues. Stakeholders and consumers, in collaboration with members of the Advisory Council, then created recommendations to improve and expand community-based services to individuals with disabilities.

Kentucky's Olmstead Compliance Plan establishes a framework for the state to ensure that its statutes, regulations, and program initiatives are harmonious with the principles established in the landmark civil rights case *Olmstead v. L.C.*, 527 U.S. 581, 119 S. Ct. 2176, 144 L. Ed. 2d 540 (1999). The decision in this case established that keeping persons with disabilities in segregated settings when they are capable of and desire to reside in the community is unlawful, discriminatory and in violation of Title II of the Americans with Disabilities Act (ADA). The plan adopted in 2002 organized recommendations for future actions into thirteen components. The most recent plan update, released in 2015, combined these thirteen components into nine major goals:

Goal 1: To establish an environment which enables all individuals with disabilities to live meaningful, inclusive, and integrated lives within 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 appropriate.

Goal 2: To establish Education/Outreach programs for individuals with disabilities, and their families or support systems, in order to prevent facility placement, with input from his/her family and legal guardian, as appropriate.

Goal 3: To prevent persons with disabilities from being incarcerated for minor offenses that are a result of their disability, and to provide persons with disabilities who leave correctional institutions, or other institutions, access to needed community-based services, with family and legal guardian input, as appropriate.

Goal 4: To establish evidence-based programs which will facilitate the transition to adulthood for all transition age youth (14-25 years old), according to individual choice and need, with family and guardian input, as appropriate.

Goal 5: To increase available, accessible, quality, and affordable community housing.

Goal 6: To establish a process that will allow individuals with disabilities to safely and appropriately transition from an institution to a community setting.

Goal 7: To establish effective work programs that will allow Kentuckians with disabilities 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 appropriate.

Goal 8: To establish cost-effective, and accessible transportation choices for individuals with disabilities that support the essential elements of life such as employment, housing, education, and social connections.

Goal 9: To ensure allocation of quantifiable, measurable tasks in regard to the elements of the Olmstead plan, including regular updates in order to ensure that the Commonwealth progresses toward the vision of protecting the rights of persons with disabilities. In order to do this, the Commonwealth will update the Olmstead plan a minimum of every two years.

These goals remain essential to Kentucky's Olmstead Compliance Plan.

INTRODUCTION

This update, effective December 2019, organizes the previously established nine goals into four major categories based on current statutes, regulations, and program initiatives:

1. **State Commitment:** The Commonwealth of Kentucky is dedicated to providing community living as well as community-based services and supports for all who desire it and are appropriate for non-institutional care. To enhance these services, Kentucky will continue to administer state programs, services, and activities in the most integrated setting appropriate to a person's needs, and will collaborate with stakeholders to ensure ongoing and meaningful stakeholder relationships.
2. **Assessment and Transition:** The Commonwealth of Kentucky is committed to providing timely assessments for persons currently residing in, or at risk of entry into, institutions or other congregate living settings. Kentucky will continue to seek out and implement successful treatment programs in order to decrease the institutionalization of individuals with disabilities who are capable of and desire to receive all therapeutic and residential services in the most community-integrated setting appropriate for their individual needs.
3. **Diversion:** Kentucky's Olmstead Compliance Plan includes recommendations and goals designed to divert individuals at risk of institutionalization. As part of its commitment to providing individuals with disabilities community-integrated services to the fullest extent possible, Kentucky will continue to develop and implement diversion programs including, but not limited to, Peer Support Services, Crisis Service Systems, Person-Centered Recovery Planning, Assertive Community Treatment (ACT), Supportive Housing Assistance, and Supported Employment Services.
4. **Data and Research:** Kentucky's Olmstead Compliance Plan includes recommendations and goals designed to enhance the collection and analysis of data to support the implementation of this Plan. Kentucky is currently collecting and analyzing data related to individuals' experiences in avoiding long-term institutional placements. Once completed, the information collected will establish a database of home and community-based services and long-term care services data. The collected data will be analyzed and used to enhance ongoing treatment and support services as well as to create any new services that are determined necessary for the treatment, support, and success of individuals with disabilities.

IMPLEMENTATION

I. State Commitment

Financing Long-Term Services and Supports. The Kentucky Olmstead Compliance Plan includes policy and financing goals consistent with the *Olmstead* decision, including the use of Medicaid to fund long-term services and supports for individuals with disabilities. The Kentucky Medicaid Program is administered by the Cabinet for Health and Family Services (the "Cabinet"), Department for Medicaid Services (DMS). DMS is bound by both federal and state

statutes, and regulations governing the administration of the State Plan. The Kentucky Medicaid Program serves eligible recipients of all ages. The following is a brief highlight of Kentucky's Medicaid-supported programs which promote and strengthen home and community-based services for individuals with disabilities:

A. *Advisory Council*. The Kentucky Medicaid Program is guided in policy making decisions by the Advisory Council for Medical Assistance. This council is composed of eighteen members consisting of the Secretary of the Cabinet for Health and Family Services and seventeen others appointed by the Governor to four-year terms. Ten of these members represent various professional groups who provide services to Program recipients. The remaining seven are lay citizens.
B. *Policy*. The basic objective of the Kentucky Medicaid Program is to assure the availability and accessibility of quality medical care to eligible recipients. All participating providers agree to provide services in compliance with federal and state statutes regardless of sex, race, creed, religion, national origin, handicap, or age, and must comply with all amendments, rules, and regulations of the Americans with Disabilities Act. Program recipients are allowed to choose the participating provider from whom he or she wishes to receive medical care.
C. *Medicaid Participation*. In January 2013, pursuant to the terms set out in the Affordable Care Act (ACA), Kentucky implemented a traditional Medicaid expansion. By the fall of 2013, 606,805 Kentuckians were covered by Medicaid/CHIP. Between the fall of 2013 to December 2018, Medicaid/CHIP enrollment increased by 101 percent. As of June 2019, Kentucky has expanded coverage to low-income adults, children, and the elderly, and has 1,385,788 individuals currently enrolled with Medicaid and CHIP – approximately 90.64% of Medicaid eligible are enrolled in managed care. Approximately 92% of Kentucky's healthcare providers are enrolled with the Department of Medicaid Services. Kentucky has been one of the most successful states in reducing its uninsured rate through the ACA.[1]
D. *Community Mental Health Centers*. Pursuant to the Community Mental Health Act signed into effect by then-President John F. Kennedy in 1963, Kentucky was the first state in the nation to establish a statewide behavioral health safety net now called community mental health centers (CMHCs). There are currently 14 CMHCs operating in Kentucky. Each CMHC provides a comprehensive range of accessible, coordinated, direct or indirect health services (with an emphasis on prevention, treatment, and rehabilitation) to individuals with mental illness, addiction, intellectual and other developmental disabilities regardless of the ability to pay. Services offered through the CMHCs are evidence-based and designed to "wrap around" the individual and/or family in multiple facets of their lives – home, work, and school. The state contracts with CMHCs to provide services for people with complex, high-intensity needs typically not treated by other providers – including adults with severe mental illness, children with severe emotional disturbances, and those with co-occurring intellectual or other

[1] Centers for Medicare & Medicaid Services (2019). *Medicaid & CHIP in Kentucky*. Retrieved from https://www.medicaid.gov/state-overviews/stateprofile.html?state=Kentucky

developmental disability and mental illness. These CMHCs serve and support over 180,000 Kentuckians each year.

E. *Covered Community-Based Mental Health and Substance Use Services*. Services provided by participating CMHCs include:
   1. Individual Outpatient Therapy
   2. Group Outpatient Therapy
   3. Family Outpatient Therapy
   4. Collateral Outpatient Therapy (for individuals under age 21)
   5. Crisis Intervention Services
   6. Targeted Case Management
   7. Mobile Crisis Services
   8. Therapeutic Rehabilitation Services
   9. Psychological Testing
   10. Screening
   11. Assessment
   12. Partial Hospitalization
   13. Service Planning
   14. Screening, Brief Intervention, and Referral to Treatment for a Substance Use Disorder
   15. Assertive Community Treatment
   16. Intensive Outpatient Program Services
   17. Residential Services for Substance Use Disorders
   18. Residential Crisis Stabilization Services
   19. Day Treatment
   20. Peer Support Services
   21. Comprehensive Community Support Services
   22. Pregnant Women Substance Use Prevention Services

F. *Interagency Mobilization Program for Adolescent and Child Treatment (IMPACT).* The IMPACT program is community-based behavioral health services provided to eligible IMPACT recipients through an agreement between DMS and the Department for Public Health as the state agency for the federal Title V Maternal and Child Health Block Grant, 42 U.S.C. secs. 701 to 710. Kentucky's IMPACT program was established as a coordinated, interagency approach to service delivery for children/youth with serious emotional disabilities and their families.

   This program serves children between the ages of three and eighteen who have an emotional disability diagnosis from a qualified health professional. Referrals to the program can be submitted by a parent or professional involved with the child or family. Each referral is presented to the Regional Interagency Council, who, after reviewing the referral, determines whether the child meets program eligibility criteria. Once admitted into the IMPACT program, the child and the child's family work toward meeting treatment plan goals with the ultimate goal being a successful graduation with treatment plan goals met.

The IMPACT program 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 is to prevent children/youth with serious emotional disabilities from being placed outside of their homes and to provide support and assistance to those who were transitioning home from such residential placements. Dating back to 1999, Kentucky IMPACT was one of the first statewide Wraparound initiatives in the country. As of September 2019, approximately 7,730 children/youth are being served by this program.

G. *Waivers.* As part of its commitment to providing community-based services to individuals with disabilities, Kentucky has pursued Medicaid programs that provide tools to implement and expand home and community-based services. Under the current Medicaid program, there are six HCBS 1915(c) waiver programs available for those who qualify, each focused on keeping individuals out of institutions by providing community-based treatment.

1. *Traumatic Brain Injury Waivers.* The ABI Acute (ABI) and ABI Long-Term Care (ABI-LTC) waivers provide Medicaid-paid services to adults with an acquired brain injury. These services give participants the support they need to live in the community. Services under the ABI Acute and ABI Long-Term Care Waivers include adult day training, individual and group counseling, environmental and home modifications, respite care, and supervised residential care. Additional services provided under only the ABI Acute Waiver include companion services and personal care. Additional services provided under only the ABI Long-Term Care Waiver include community living supports and nursing supports. Benefits under this waiver are available to individuals who are 18 years or older, have suffered an acquired brain injury, are expected to benefit from waiver services, and meet the financial qualifications for Medicaid. Participants in the ABI waiver program have three options for how they receive their services: 1) traditional services; 2) participant-directed services (PDS); and 3) blended services. Choosing the PDS option gives waiver participants greater freedom of choice, flexibility, and more control over their supports or services. In 2013, 165 individuals were receiving services through the ABI waiver and 225 individuals were receiving services through the ABI-LTC waiver. Since that time, the number of available slots for each waiver has increased to 383 ABI waiver slots and 320 ABI-LTC waiver slots. There is currently not a waiting list for either of these waivers.
2. *Home and Community Based Services Waiver.* The Home and Community-Based Services (HCBS) waiver provides Medicaid-paid services and supports to the elderly or to adults and children with physical disabilities to help them live at home rather than in an institutional setting. Services covered under the HCB waiver include adult day health care, attendant care, environmental and minor home adaptation, home delivered meals, and non-specialized and specialized respite care. To qualify for this waiver, an individual must be elderly or have a physical disability, meet nursing facility level of care as defined in 907 KAR 1:022, and meet the financial

qualifications for Medicaid. Participants in the HCB waiver program have three options for how they receive their services: 1) traditional services; 2) participant-directed services (PDS); and 3) blended services. Choosing the PDS option gives waiver participants greater freedom of choice, flexibility, and more control over their supports or services. There are 17,050 HCB waiver slots available. There is currently not a waiting list for this waiver.

3. *Model II Waiver.* The Model II Waiver (MIIW) provides Medicaid-paid in-home services to individuals who use a ventilator for 12 or more hours a day. These individuals also require high-intensity nursing care 24 hours a day and, without MIIW services, would have to live in a hospital-based nursing facility. Services under this waiver include private duty nursing (PDN) for up to 16 hours a day from a registered nurse, a licensed practical nurse, or a respiratory therapist. The waiver participant's assessment, ventilator dependency needs, and provider staffing determine how many hours of PDN the participant receives. To qualify for MIIW services, the participant must be ventilator dependent for 12 or more hours a day, have a permanent tracheostomy for positive pressure ventilation, require 24-hour a day, high-intensity nursing care services, have a strong family support system including a primary and secondary caregiver, and meet the financial qualifications for Medicaid. There is currently not a waiting list for this waiver.
4. *Michelle P. Waiver.* The Michelle P. Waiver (MPW) provides Medicaid-paid services to adults and children with intellectual or other developmental disabilities. These supports allow individuals to live at home rather than in an institutional setting. Services available under the MPW include behavioral supports, day training, environmental and minor home adaptation, personal care, occupational, physical and speech therapies, and respite. To be eligible for the MPW, an individual must have an intellectual or other developmental disability, require a protected environment while learning living skills, gaining educational experiences, and developing an awareness of his or her environment, and meet the financial qualifications for Medicaid. Participants in the MPW program have three options for how they receive their services: 1) traditional services; 2) participant-directed services (PDS); and 3) blended services. Choosing the PDS option gives waiver participants greater freedom of choice, flexibility, and more control over their supports or services. There is currently a lengthy waiting list for the MPW.
5. *Supports for Community Living Waiver.* The Supports for Community Living (SCL) waiver provides Medicaid-paid services to adults with intellectual disabilities or other related conditions. These supports allow individuals to live at home rather than in an institutional setting. SCL offers a variety of services to support an individual's goals, choices, and priorities including residential support services, positive behavior supports, personal assistance, supported employment, community access, environmental accessibility adaptation, and vehicle adaptation services. To be eligible for the SCL waiver, the individual must have an intellectual or related condition and meet the intermediate care facility for individuals with an intellectual or other developmental disability (ICF/IID) level of care. The individual must also meet

the financial qualifications for Medicaid. Participants in the SCL waiver program have three options for how they receive their services: 1) traditional services; 2) participant-directed services (PDS); and 3) blended services. Choosing the PDS option gives waiver participants greater freedom of choice, flexibility, and more control over their supports or services. In 2013, there were 4,201 available SCL slots. Since then, the number of available slots have increased to 4,941. Currently, there are 107 people on the SCL waiting list.

In April 2017, the Cabinet selected Navigant to assess the 1915(c) waiver programs. Navigant reviewed program oversight and administration, quality of care, and service delivery, and provided recommendations to improve provider and participant experience in Kentucky's waiver programs. Navigant's final report was released to the public on September 20, 2018. In response, the Cabinet created three (3) priority Groups (A,B,C), with a timeline for implementing activities related to each group. Activities for Priority Group A and Priority Group B began in fall 2018, and activities for Priority Group C are set to begin in late 2019.

The Department of Medicaid Services (DMS), the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), and the Department for Aging and Independent Living (DAIL) will continue to explore new waiver options to serve individuals with intellectual and other developmental disabilities, individuals with SMI, and children with special health care needs. These agencies will work collaboratively to review, assess, and amend, as needed, existing waiver programs that serve these populations.

H. *Grants.* Kentucky relies on numerous federally funded grants to support its efforts in providing effective community-based services to individuals with disabilities. The following grants have been utilized to decrease the institutionalization of individuals with disabilities and to create quality community-based services:

1. *Federally Funded Non-Competitive Grants.* Kentucky has applied for and been awarded the following federally funded non-competitive grants:
   a) *Mental Health and Substance Abuse Prevention and Treatment Block Grant.* Kentucky's allocation of funding for 2018 was $8,889,372 for Mental Health (MH) and $20,380,520 for Substance Abuse Prevention and Treatment (SAPT), the majority of which was allocated to the 14 CMHCs for services. These are Title XIX funds to promote transformation of state behavioral health systems of care. The mental health funds are restricted for funding community-based services for adults with serious mental illness and children with severe emotional disabilities. There is a required 10% set-aside to be used to implement programming for First Episode Psychosis. The substance abuse funds are restricted for community-based treatment for individuals with substance use disorders (outpatient or community-based residential). There is a required 20% set-aside to be used to implement substance abuse prevention programming. For 2020 & 2021, funding amounts are anticipated at $8,894,128 MH and $20,375,923 SAPT. DBHDID submitted an application for a two-year cycle on September 3, 2019. On December 1st, DBHDID submitted a 2018 year-end

Behavioral Health Report to the Substance Abuse and Mental Health Services Administration (SAMHSA).

b) *Behavioral Health Services Information System (BHSIS)) State Agreement.* Section 505(a) of the Public Health Services Act (42 U.S.C. 290aa-4) requires the Secretary of Health and Human Services to collect data on a number of key behavioral health indicators. The funding and data submission protocols from BHSIS were developed to meet the statutory requirements for the data. The system consists of four national data sets that are maintained in collaboration with the Single State Agencies and the State Mental Health Authority. These data sets and the state and national results are available on the SAMHSA web site. The current funding amount is $62,156/year and the current agreement expires on December 15, 2019.

c) *Projects for Assistance in Transitioning from Homelessness (PATH).* Kentucky's current award for PATH is $469,000/year. DBHDID contracts PATH funds aimed at homeless services with seven CMHCs. Services funded by this grant include targeted case management, mental health treatment, mental health screenings, and 24-hour crisis management.

2. *Federally Funded Competitive Grants.* Kentucky has applied for and been awarded the following federally funded competitive grants:

a) *2019 Healthy Transitions: Improving Life Trajectories for Youth and Young Adults with Serious Mental Disorders Program – TAYLRD 2.0.* As part of the President's overall "Now is the Time" initiative, SAMHSA created a continuum of outreach, engagement, awareness, and prevention/intervention strategies known as Transition Age Youth Launching Realized Dreams (TAYLRD). DBHDID is dedicated to building on the existing infrastructure created by *TAYLRD* to enhance evidenced-based programming for youth and young adults with or at risk of developing serious behavioral health issues as well as their families. This grant is titled TAYLRD 2.0 (Transition Age Youth Launching Realized Dreams), as it is an expansion and continuation of Kentucky's 2014 Healthy Transitions Grant entitled TAYLRD.

With the assistance of this grant, Kentucky will increase the capacity of state and community sites to provide seamless and youth-directed supports and services to transition age youth 16-25 years of age with, or at risk of developing, serious behavioral health disorders (mental health and/or substance use) and their families. An array of behavioral health services that are developmentally appropriate, culturally- and linguistically-competent, and build on protective factors will cater to the individual needs of transition age youth in an environment that is easily accessible and inviting to them.

Since 2014, efforts aimed at healthy transitions have provided open access to a variety of behavioral health services and supports in a contemporary environment that is engaging to young people. The 2017 Healthy Transitions National Evaluation Draft Preliminary Findings Report indicates that at least 1,041 young people came in to TAYLRD pilot sites over the first 2 years. Of these individuals, 85% engaged in two or more sessions. These sites have now expanded from 4 original pilot sites to 16 sites across Kentucky. TAYLRD 2.0 will be an expansion of this drop-in center model of behavioral health care. The

drop-in center approach to behavioral health care will increase the possibility that transition age youth will receive the right services at the right time. At least two drop-in centers will be supported in each implementation site which will include both formal and informal services such as peer support, employment, education, and career planning, medication management, age specific behavioral health treatment, coordination of care, life skills, and health care navigation. Referrals to specialty behavioral health services through local providers will also be available. The current funding amount is $1 million per year for March 31, 2019 through March 30, 2024.

b) *Community Programs for Outreach and Intervention with Youth and Young Adults at Clinical High risk for Psychosis (CHR-P) iHOPE-Clinical High Risk.* DBHDID is dedicated to building on existing infrastructure to enhance evidence-based programming for youth and young adults with, or at clinical high risk of developing, psychosis as well as their families. This project, titled iHOPE-Clinical High Risk (iHOPE-CHR), focuses on youth and young adults between 12-25 years old who are at clinical high risk for psychosis as assessed by The Structured Interview for Psychosis Risk Syndromes (Miller et al 2003). By providing earlier interventions targeted to their developmental and individual clinical needs in a stepped-care model, these young people and their families will be able to maintain their roles in life, decrease the duration of untreated psychosis and decrease the potential of conversion to psychosis. The stepped-care model of services for this population will be provided by LifeSkills, Inc. CMHC. . The current funding amount is $400,000 per year for September 30, 2018 through September 20, 2022.

c) *Kentucky Care Integration (KCI) – SAMHSA 2017 Promoting Integration of Primary and Behavioral Health Care.* People with chronic health conditions are more likely to have related behavioral health concerns. The purpose of this cooperative agreement is to: (1) promote full integration and collaboration in clinical practice between primary and behavioral healthcare; (2) support the improvement of integrated care models for primary care and behavioral health care to improve the overall wellness and physical health status of adults with a serious mental illness or children with a serious emotional disturbance; and (3) promote and offer integrated care services related to screening, diagnosis, prevention, and treatment of mental and substance use disorders, and co-occurring physical health conditions and chronic diseases.

DBHDID will implement KCI promoting primary and behavioral health care integration via collaborative clinical practice, improved care models, and a comprehensive service continuum for focus populations who have physical health conditions or are at risk of developing chronic diseases, including adults (18 +) with substance use disorder, serious mental illness, and children/adolescents (ages 17 and under) with serious emotional disturbance. KCI will provide integrated services, including evidence-based screening/assessment, diagnosis, prevention, and treatment according to a shared, individualized care plan, as well as outreach, engagement, and retention strategies. The current funding amount is $2 million per year for September 30, 2017 through September 29, 2022.

d) *Grants for Expansion and Sustainability of the Comprehensive Community mental Health Services for Children with Serious Emotional Disturbances.* DBHDID is dedicated to building upon Kentucky's 30-year history of developing a comprehensive system of care for children and youth who meet criteria for having a serious emotional disability (SED), and their families, by expanding infrastructure and service delivery to those with child welfare involvement, defined for the purposes of this grant as those families for whom a child abuse and/or neglect investigation results in a substantiation or services-needed finding. The purpose of this grant is to improve mental health outcomes for children and youth who meet criteria for SED. Kentucky will build upon and expand these efforts through the below goals:
    1. Enhance interagency infrastructure to support the implementation, expansion, and integration of the System of Care approach for the population of focus.
    2. Improve availability of and access to high quality, culturally- and linguistically-competent, evidence-based/evidence-informed mental health services for the population of focus in the geographic catchments.
    3. Implement strategies to promote and sustain the voice of children, youth, and their families with child welfare involvement at all levels of the system of care.

e) *Community Health, Education, and Exercise Resources (CHEER).* CHEER is a CDC grant to improve the health of Kentuckians with cognitive and mobility limitations. The current funding amount is $165,000 per year for five years.

I. *State Supplementation.* State Supplementation is a money payment made to an aged, blind, or disabled individual who is age 18 years or older. These individuals have insufficient income to pay for care in a licensed Personal Care Home (PCH) or licensed Family Care Home, to maintain residence in a Community Integration Supplementation arrangement, or to purchase Caretaker Services to prevent institutionalization.

In 2013, the Cabinet for Health and Family Services worked to create Community Integration Supplementation (CIS), a subcategory of State Supplementation. CIS was implemented on November 15, 2013 to assist individuals who are currently residing in a PCH, or at risk of entering a PCH or other institution, with obtaining an alternative community-integrated living arrangement. Individuals must be at least 18 years of age, have the need for care and support above and beyond room and board, reside in a private residence with tenancy rights or currently reside in a personal care home but intend to move to a private residence with tenancy rights, and have a serious mental illness. There are currently 1,361 individuals receiving CIS.

J. *Medical Transportation.* Medicaid covered non-emergency medical transportation is provided for Medicaid members who do not have access to transportation that suits their medical needs and need to be transported to a Medicaid-covered service. This service allows members living in community-based settings to receive community-based treatment services in the least restrictive setting appropriate for their needs.

Consistency with Olmstead. To continue the movement toward community integration and inclusion for persons with disabilities, Kentucky continues to explore, develop, and implement programs designed to administer services and supports in the most integrated setting

appropriate to an individual's needs. The Cabinet serves as the single agency for both community-based and facility-based services, and coordinates policies and budgets to promote options across the continuum.

K. *State Statutes and Other Legislation.* In addition to federal legislation prohibiting discrimination against individuals with disabilities, Kentucky has implemented state statutes and other legislation that prohibit discrimination and require the provision of services to individuals with disabilities.

1. *Employment First.* On May 15, 2018, Governor Matt Bevin signed Executive Order 2018-328, establishing Employment First policies for people with disabilities. This Order will serve to break down barriers to employment for people with disabilities and requires all state agencies to work toward ensuring people with disabilities have opportunities to work in the community while receiving competitive wages.
2. *Achieving a Better Life Experience (ABLE) Accounts*. The Achieving a Better Life Experience Act allows people with disabilities who became disabled before they turned twenty-six to set aside up to $15,000 a year in tax-free savings accounts without affecting their eligibility for government benefits. An "ABLE Account" is an account established within any state having a qualified ABLE program as provided in 26 U.S.C. sec. 529A which allows families to save for children with disabilities without disqualifying them from government benefits like Social Security and Medicaid. In April 2016, Kentucky amended KRS 205.200 to prohibit the inclusion of contributions to, distributions from, or current amounts in ABLE accounts when determining an individual's eligibility for a means-tested public assistance program and the amount of assistance or benefits the individual is eligible to receive under the program.
3. *Larry's Law*. In August 2011, Joseph Larry Lee, who had been diagnosed with schizophrenia, bipolar disorder, and a traumatic brain injury from childhood, wandered away from the personal care home in which he was residing . Mr. Lee's remains were found approximately one month later on a nearby riverbank. In 2016, in response to Mr. Lee's death, Kentucky enacted KRS 216.765, which requires an individual to have a medical examination that includes a physical examination, medical history, and diagnosis within fourteen days prior to admission to a personal care home.
4. *Tim's Law*. In 2014, Tim Morton, a man who had been diagnosed with schizophrenia died at age 56 from neglected health problems. Mr. Morton's family had been unable to get him to undergo treatment. In response to Mr. Morton's death Kentucky enacted a series of statutes (KRS 202A.0811 - 0831) in 2017 which allow courts to order assisted outpatient treatment for individuals diagnosed with serious mental illness who have been involuntarily hospitalized at least twice in the past twelve months, are unlikely to adhere to outpatient treatment on a voluntary basis, and are in need of court-ordered assisted outpatient treatment as the least restrictive alternative mode of treatment presently available and appropriate. Kentucky has the ability to use Tim's Law as a means of providing treatment to persons with serious mental

illness and to create greater awareness within the judicial system of the benefits of treatment over punishment.

5. *Autism Spectrum Disorder*. In 2016, Kentucky established legislation that would make the Advisory Council on Autism Spectrum Disorders and the state Office of Autism permanent in an effort to ensure there are no gaps in services provided to individuals with an autism spectrum disorder.

L. *Administrative Regulations.* In addition to the administrative regulations already in place, the Cabinet has taken steps to perpetuate the deinstitutionalization of individuals with disabilities.

1. *908 KAR 2:065*. In 2016, 908 KAR 2:065 was created to establish housing assistance guidelines and the range of community transition services to be made available to qualified individuals diagnosed with serious mental illness residing in, or at risk of residing in, personal care homes.

M. *State Interagency Council for Services and Supports to Children and Transition-age Youth.* State Interagency Council for Services and Supports to Children and Transition-age Youth (SIAC) is a group consisting of state agency representatives, a youth, a parent of a child or transition-age youth with a behavioral health need, and a member of a nonprofit family organization. SIAC oversees coordinated policy development, comprehensive planning, and collaborative budgeting for services and supports for children and transition-age youth with or at risk of developing behavioral health needs and their families. Regional Interagency Councils operate as the locus of accountability for the system of care, providing structure for coordination, planning, and collaboration of services and supports at the local level for children, adolescents, and transition-age youth and their families, to help them function better at home, in school, in the community, and throughout life.

N. *Supportive Housing Assistance.* Beginning in 2018, the Cabinet began working with Technical Assistance Collaborative (TAC) to expand integrated community living options for people with serious mental illness in compliance with *Olmstead* and Title II of the Americans with Disabilities Act. The focus of this collaboration was to identify opportunities for Kentucky to create and maximize permanent supportive housing.

O. *Olmstead Committees.* Regional Olmstead committees, consisting of Cabinet representatives, CMHC staff, hospital staff, and other community stakeholders meet monthly at each state-run or state-contracted adult psychiatric hospital to discuss individual needs and allocate resources specific to each catchment area.

P. *Olmstead Funding.* Each of the state designated acute psychiatric hospital catchment areas receive $200,000 each year to serve individuals in their area that meet *Olmstead* criteria. The allocation of these funds is determined by each catchment area Olmstead Committee. These funds are typically used to assist individuals with meeting basic needs such as clothing, furniture, therapeutic equipment, and other expenses related to community-integrated living expenses.

Q. *Olmstead Housing Initiative.* The Olmstead Housing Initiative (OHI) is a partnership between Kentucky Housing Corporation and DBHDID. OHI addresses the pressing need for housing for people who are currently in, or at risk of entering, institutions. OHI is a

36-month bridge program, which enables participants to become leased in permanent housing. Participants who cannot find permanent housing options in the 36-month time frame may continue OHI assistance upon approval of DBHDID until permanent housing can be secured. Assistance through OHI includes rental assistance, payment of security and utility deposits directly to landlords and utility companies, moving expenses, household furnishings, pest eradication, and expenses interfering with transitioning such as unpaid previous utility bills.

R. *Kentucky Vocational Rehabilitation Services.* Kentucky Vocational Rehabilitation Services provides assistance, including job training and counseling, to individuals with disabilities who are having difficulty obtaining and/or maintaining employment. People who are already receiving Supplemental Security Income or Social Security Disability Insurance are immediately eligible for vocational rehabilitation services. These services can begin for an individual in their last two years of high school (11^{th} and 12^{th} grade) to help identify needed services early in an individual's employment trajectory.

S. *Transportation Initiative.* The Transportation Initiative was developed by the University of Kentucky's Human Development Institute and is funded through the support of the Commonwealth Council on Developmental Disabilities. The Transportation Initiative seeks to ensure that transportation options are available to Kentuckians with disabilities. Accessible transportation options are essential for individuals with disabilities to attain quality life outcomes in employment, education, healthcare, and community life. A lack of public, accessible transportation options in underserved areas presents a barrier for employment and economic independence and leads to isolation and decreased health outcomes. The Transportation Initiative engages citizens and assists individuals with transportation planning, including independent driving, use of fixed route bus systems, community paratransit, transportation through waiver services, natural supports, learning how to use Uber/Lyft, and social skill planning to set up a ride share arrangement with a coworker. The Transportation Initiative is made possible by the collaboration of state and local agency partners, community organizations, support from the private sector, and the work of tireless disability advocates.

T. *Kentucky Leadership and Self-Advocacy Project.* The Kentucky Leadership and Self-Advocacy Project collaborates with other training and mentoring efforts for people with intellectual or developmental disabilities, such as the Special Olympics, to promote self-advocacy. The organization holds quarterly community workshops that provide information on the importance of healthy eating and exercise, and aims to provide self-advocacy and leadership information to individuals with disabilities and their families.

II. Assessment and Transition

A. *Assessments.* The Kentucky Olmstead Compliance Plan includes goals to increase public awareness and knowledge about serious mental illness, first episode psychosis, intellectual or other developmental disabilities, and implements timely assessments for persons currently residing in, or at risk of being admitted to, institutions.

1. *Supports Intensity Scale*. The Supports Intensity Scale (SIS) is a standardized assessment tool designed to measure the pattern and intensity of supports required by a person aged 16 years or older with an intellectual or other developmental disability to be successful in community settings. The SIS evaluates practical supports that people with developmental disabilities need to lead independent lives.
2. *Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS).* The LOCUS, an assessment tool designed by the American Association of Community Psychiatrists (2009), is administered by psychiatric hospital or CMHC staff to determine an individual's necessary level of care. CMHCs are contractually required to determine Level of Care for each individual with serious mental illness served, using the LOCUS. The LOCUS assesses the following six parameters, which are ranked from least intense to most intense:
    a) Risk of Harm
    b) Functional Status
    c) Medical, Addictive and Psychiatric Co-Morbidity
    d) Recovery Environment
    e) Treatment and Recovery History
    f) Engagement and Recovery Status
3. *Larry's Law*. In August 2011, Kentucky enacted KRS 216.765 which requires an individual to have a medical examination that includes a physical examination, medical history, and diagnosis within fourteen days prior to admission to a personal care home. By requiring a medical examination and diagnosis prior to personal care home admission, Larry's Law helps to identify persons with a traumatic brain injury who may require more intensive services than can be provided by a personal care home. (See also *Larry's Law*, page 12.)

B. *Transition from Institutional Settings.* Kentucky's Olmstead Compliance Plan provides for the use of multiple services which facilitate the transition of individuals from institutions to community-integrated settings appropriate for their needs.
    1. *Second Amended Settlement Agreement*. On October 1, 2013, the Cabinet and the Kentucky Department for Protection and Advocacy (P&A) entered into the Interim Settlement Agreement (ISA). The Cabinet agreed to support voluntary transitions to integrated community-based housing over a three-year period of up to 600 individuals who reside in a personal care home or who are at risk of reentry to a personal care home. This agreement was to further the state's compliance with the "integration mandate" of the Americans with Disabilities Act (ADA). On October 1, 2015, the Cabinet and P&A amended the original agreement to further provide access to housing assistance to additional persons with necessary behavioral health supports. The Amended Settlement Agreement (ASA) extended the agreement another two years, expanded the target to 675 individuals, and provided for the creation of a regulation (908 KAR 2:065) by the Cabinet to perpetuate the terms of the agreement. On October 1, 2018, the two parties entered a Second Amended Settlement Agreement (SASA) extending the timeframe in which the agreement will monitor the provision of housing assistance with necessary behavioral health supports. The SASA monitoring will occur for another three years, with an additional fourth year

limited to assessment of the success of the transitions in the previous year. The SASA target is 350 people in addition to the 926 persons already served with housing assistance under ISA and ASA. This is a total transition target of 1,275 individuals transitioned since October 1, 2013 to integrated community-based housing directly from personal care homes or from situations where they are at risk for entering into personal care homes

Since October 1, 2013, the Cabinet has worked diligently to increase integrated community-based housing opportunities for these individuals. As of August 2019, the Cabinet has provided housing assistance to 926 individuals to encourage community integration for these individuals. Per the SASA, the Cabinet will continue to focus on providing housing assistance in support of this integrated community-based housing initiative through September 30, 2021.

2. *Justice System*. DBHDID works with the Kentucky Department of Corrections to decrease the institutionalization of lower-level youth offenders, and to support the reintegration of individuals with serious mental illness post incarceration.
   a) *Mental Health Court*. Specialty Court programs, including Mental Health Court, provided by the Administrative Office of the Courts, provide drug testing, treatment, and case management at no charge to participating defendants. Each court incorporates a multidisciplinary team consisting of treatment providers, Specialty Court staff, criminal justice officials, and community representatives who design a program specific to each jurisdiction. In order to participate in Mental Health Court, an individual must have a mental illness diagnosis with or without a history of psychiatric hospitalizations. Benefits of specialty court programs include lower recidivism rates, decreased medical costs, reduced incarceration costs, and an increased likelihood that participants will become healthy and productive community members.
   b) *Crisis Intervention Teams (CIT)*. CIT is a collaboration between law enforcement, mental health providers, and consumer advocacy groups for the purpose of providing a better response to persons with mental illness. This specialized training focuses on teaching signs and symptoms of mental illness, verbal de-escalation skills and active listening skills, and increasing awareness of medications used to effectively treat individuals with mental illness. Over 1,130 Kentucky law enforcement officers have received CIT training. In State Fiscal Year 2019, law enforcement officers responded to 53,597 encounters involving persons with mental illness, substance abuse disorders, intellectual disabilities, developmental disabilities, dual diagnoses, or unknown/undesignated diagnosis. Of those encounters, only 853 resulted in the person being charged.
   c) *Law Enforcement Response to Special Needs Populations.* To improve officer and consumer safety, DBHDID provides a 40-hour course for law enforcement titled “Law Enforcement Response to Special Needs Populations” twice a year. This course serves as an elective for any law enforcement officer in the state who wants to learn more about engaging with persons with mental illness, intellectual or other 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 participate as an instructor in this training to provide law enforcement with further insight into the struggles individuals with disabilities face.

d) *Re-Integration Programs.* Once released from a penal institution, re-entry back into the community can often be difficult. To assist with re-integration after penal institutionalization CMHCs throughout the state offer follow-up care for individuals released from jail or prison who seek a smoother transition into the community after incarceration.

One CMHC, Centerstone, receives special funding for community re-entry services for individuals with serious mental illness, substance use disorders, or co-occurring serious mental illness and substance use disorders who are being released from prison. These reintegration services include assistance with applications for medication supports, therapy, physical health appointments, and housing supports. The program begins with individuals prior to their release from prison, and continues post transition to provide assistance with obtaining supports that will enable the individual to remain in the community. DBHDID's Adult Mental Health Services and Recovery Branch and the Department of Corrections' Mental Health Division will continue to work together to develop data sharing and collection mechanisms to help facilitate smooth transitions for all parties.

e) *Juvenile Justice.* Within the Judicial Branch of the Commonwealth, the Administrative Office of the Courts' Court Designated Worker (CDW) program serves as the gatekeeper to the juvenile 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 is responsible for statewide detention services, residential placement and treatment services, probation, community aftercare and reintegration programs, and youth awaiting adult placement or court. The goal of the juvenile justice system is to increase the number of youth with co-occurring mental and substance use disorders diverted out of the court system and into appropriate community-based treatment services.

3. *Long-Term Care Facilities.* Since 2006, Kentucky has worked diligently to decrease the number of individuals with disabilities residing in its long-term care facilities. Due to the increase in availability of community-based services, there has been a decline in occupancy of Intermediate Care centers (IC), Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), and Personal Care Homes (PCH).[2]

   a) *Intermediate Care Centers.* The majority of Kentucky's IC center consumers are over the age of 75 and require care and services above the level of room and board but not extending to the need for medical services typically provided by nursing homes or skilled nursing facilities. According to data gathered and published on an annual basis by the Office of Health Data Analytics, there were

[2] Based on comparison of census for these facilities from 2013-2018 using information from the Kentucky Annual Long-Term Care Services Report published each year by the Kentucky Office of Health Data Analytics.

72 licensed IC center beds with 72.55% occupancy in 2013. Occupancy dropped to 64.13% by 2018 for the same number of licensed beds.

b) *Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).* Intermediate Care Facilities for Individuals with Intellectual Disabilities provide individualized healthcare, including comprehensive habilitation services, to individuals who need assistance with functional status and independence. ICF/IIDs are only available to those who require and are currently receiving aggressive and consistent active treatment and health services. According to data gathered and published on an annual basis by the Office of Health Data Analytics, there were 888 licensed ICF/IID beds with 51.46% occupancy, an average annual census of 457 residents, in 2013. That number dropped to 632 licensed beds with 64.26% occupancy, an average annual census of 406 residents, by 2018. The majority of Kentucky's ICF/IID consumers are under the age of 65.

c) *Personal Care Homes.* Personal care homes provide shelter, supervision and assistance with personal care, and meals for people who are unable to care for themselves due to physical, behavioral health, or cognitive disabilities. Personal care homes do not provide medical services typically provided by nursing homes or skilled nursing facilities. According to data gathered and published on an annual basis by the Office of Health Data Analytics, there were 6,144 licensed personal care home beds with 77.19% occupancy, an average annual census of 5,149 residents, in 2013. The number of licensed personal care home beds in operation increased to 7,285 beds by 2018, with 6,866 of those in operation; however, the occupancy rate decreased to 70.96%, an average annual census of 4,872 residents.

III. Diversion

Kentucky's Olmstead Compliance Plan contains multiple programs designed to meet the needs of individuals with disabilities in the least restrictive settings appropriate. Under this framework of available services, individuals with disabilities can live as independently as possible in the community of their choice. The following programs are used to divert individuals at risk of institutionalization:

A. *Direct Intervention: Vital Early Responsive Treatment System.* The Direct Intervention: Vital Early Responsive Treatment System (DIVERTS) is offered to adults with serious mental illness who are institutionalized or at risk of institutionalization, regardless of payor. DIVERTS services are made available to persons with serious mental illness who are transitioning to community-integrated living arrangements. These services assist with recovery while preventing admission and/or re-admission to psychiatric hospitals, long-term care institutions, or other congregate settings. DBHDID contracts with the fourteen CMHCs to provide DIVERTS services in all 120 counties of the state. DIVERTS services include:

1. Assessment
2. Service Planning
3. Person Centered Recovery Plan
4. Person Centered Recovery Transition Planning
5. Assertive Community Treatment (ACT)
6. Individual Placement and Support Supported Employment
7. Supportive Housing
8. Housing Specialist
9. Housing Plan
10. Peer Support
11. Targeted Case Management
12. Community Residential Support
13. Comprehensive Community Support
14. Purchased Goods and Services
15. Crisis Services

B. *Early Intervention.* Early intervention is critical to treating mental illness before it results in 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 first receives treatment, has been a predictor of outcomes 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 also may improve long-term prognosis. To combat the effects of untreated mental illness, Kentucky continues to explore and implement programs aimed at early diagnosis and treatment of mental illness to improve symptoms, reduce relapse, and create better outcomes for individuals with, or at risk of developing, serious mental illness.

C. *Person-Centered Planning.* The Person Centered Recovery Planning (PCRP) model focuses on the idea that people can and do recover from mental illness. Thus, people should and can have choices in decisions that affect their treatment and their lives. PCRP creates a partnership between the clinician and the person receiving services, which allows them to create their own support network by developing meaningful relationships with other members of their community. Beginning in 2004, Kentucky began moving toward this recovery model with the idea that everyone who receives behavioral health services in Kentucky should participate in designing their own Person Centered Recovery Plan.

Historically, treatment plans for adults with serious mental illness have followed a medical model. These plans were often written without the presence or input of the individual receiving services. This resulted in adults with serious mental illness often feeling excluded from their own treatment plan. More recently, the practice of simply managing symptoms has evolved into the use of a more holistic approach to treatment and recovery. In order to reach the individual's stated goal and create a more meaningful life in recovery, the PCRP looks at how the individual receiving services and the clinician

can work together to increase competitive employment and decrease inpatient days, self-harm, ER visits, and arrests. Kentucky's CMHCs have received training related to the use of the PCRP model and currently use this model of treatment with the individuals they serve.

D. *Crisis Response System.* Kentucky has developed an extensive and multifaceted emergency response system for persons in a behavioral health crisis. The emergency behavioral health and crisis services system has grown into a complex network of program elements. Today, it stretches over all 120 Kentucky counties and encompasses a network of providers and professionals at regional CMHCs, state psychiatric hospitals, and private hospitals with specialized psychiatric services. Kentucky will continue to work with law enforcement, mental health professionals, individuals with disabilities, housing coordinators and other community members to create services that will provide rapid crisis evaluations, increase Peer Support Services, improve crisis lines to include chat and text capabilities, and expand telehealth delivered services.

   CMHCs are required to provide an immediate on-site response to any situation where an individual is at risk of being institutionalized. Crisis teams are notified of admissions to state psychiatric facilities and immediately begin working with the facility to make arrangements for supports needed upon discharge to prevent facility readmission. CMHCs also assist with transitioning individuals from congregate living arrangements to independent, community-based housing by providing community supports, assisting with money and medication management, and coordinating appointments with healthcare specialists.

E. *Supportive Housing Assistance.* In addition to the Olmstead Housing Initiative, Kentucky works with private landlords and other property holders to establish reliable, quality housing for individuals currently residing in, or at risk of entry into, institutions. Each contracting housing agency agrees to take steps to bridge the housing gap for individuals with disabilities by making affordable housing available to individuals with psychiatric disabilities, co-occurring psychiatric disabilities and substance use disorders, and intellectual or other developmental disabilities. As with the OHI, these individuals are given priority status over other applicants.

F. *Individual Placement and Support: Supported Employment.* Individual Placement and Support (IPS) is a model of supported employment for people with serious mental illness, intellectual or other developmental disabilities. IPS helps individuals with disabilities work at regular jobs of their choosing. Although variations of supported employment exist, IPS refers to the evidence-based practice of supported employment. Considering IPS to be crucial to its recovery oriented system of care, DBHDID has been successfully implementing the evidence-based model of Supported Employment: Individual Placement and Support since 2010. The work began with a grant from the Robert Wood Johnson Foundation and four IPS pilot sites. The program has expanded to nineteen IPS sites today, with the number of Employment Specialists increasing from one IPS Employment Specialist to the current 218 Employment Specialists providing services.

   IPS supported employment is maintained and grown through a continued partnership between DBHDID, the Office of Vocational Rehabilitation (OVR), and the

fourteen CMHCs throughout Kentucky. IPS is implemented using coaches, training, and fidelity monitoring. Kentucky receives support through membership in the IPS International Learning Community. Currently, twenty-four states in the United States are represented in this international learning community. The IPS team of coaches, trainers, fidelity monitors, and state leaders attend the annual learning community meeting and facilitate an annual Kentucky IPS conference. The Kentucky IPS implementation team meets with OVR monthly.

G. *Assertive Community Treatment.* Assertive Community Treatment (ACT) is a team treatment approach designed to provide comprehensive, community-based psychiatric treatment, rehabilitation, and support to persons with serious and persistent mental illness such as schizophrenia. A team of professionals whose backgrounds and training include social work, rehabilitation, counseling, nursing, and psychiatry provide assertive community treatment services. Among the services ACT teams provide are targeted case management, initial and ongoing assessments, psychiatric services, employment and housing assistance, family support and education, substance use services, and other services and supports that are critical to an individual's ability to live successfully in the community. ACT services are available 24 hours a day, 365 days a year.

IV. Data and Research

Kentucky's Olmstead Compliance Plan includes goals for the collection and analysis of data as well as goals for quality assurance. Based on the data gathered and recommendations received from the following data sources, Kentucky will continue to work to improve the quality and delivery of services for individuals with physical and behavioral health disorders or conditions, and intellectual or other developmental disabilities.

A. *Department for Behavioral Health, Developmental and Intellectual Disabilities.* The Department for Behavioral Health, Developmental and Intellectual Disabilities collects data from a variety of sources to monitor the institutionalization of individuals with disabilities in hospitals, long-term care facilities, penal institutions, and other congregate living arrangements.
   1. *Community-Based Data.* DBHDID collects data from Community Mental Health Centers and other funded providers on a monthly basis. This data supports efforts to monitor client-level demographic and diagnostic statistics, service utilization, and provider and human staffing used to provide direct behavioral health services (including services for mental health, substance abuse, and intellectual or other developmental disabilities). DBHDID uses this data as a source for federal block grant reports, National Outcome Measures, Treatment Episode Data Set, Client Level Data reporting, Uniform Data Reporting System, and a variety of other uses related to program development and implementation.
   2. *Facility Data.* DBHDID collects data from its state-owned and state-operated adult psychiatric facilities, and its state owned and contracted Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), including client level admission and discharge information, demographics, diagnostic data, and living

arrangement status at admission and discharge. This data is used by DBHDID as a source for National Outcomes Measures, Client Level Data reporting, Uniform Data Reporting System, and a variety of other uses such as State Mental Health and Developmental Disability Authority Profiles and surveys.

3. *System Data.* Kentucky hosts three data-related standing teams that involve state and community partners. Each team plays a key role in defining data elements, defining processes to ensure accurate, complete, and timely data collection and defining indicators and measures of quality. Contributions of all three teams lead to successful implementation of data collection, issues resolution and measure development. The Data Users Group evaluates issues related to data collection, data analysis, data quality, data architecture, and structures that support the provision of quality services. The Joint Committee for Information Continuity provides direction and assistance in the continued development of the information system to manage a public behavioral health system. Finally, the Quality Management and Outcomes Team provides direction for the collection of information relevant to desired outcomes, methods of measurement, and design of processes for continuous outcomes management across DBHDID.
4. *Fidelity Monitoring.* Fidelity is the constancy with which a program is implemented so that key components and characteristics of the program are not compromised. Programs that are implemented with fidelity are more likely to result in consistent outcomes for participants. Kentucky uses fidelity monitoring to provide additional ACT training, technical assistance, program enhancements, and needed supports to ensure that individuals with SMI, intellectual or other developmental disabilities who are receiving ACT services are receiving appropriate services for their needs.
5. *Data Tracking Tool.* Pursuant to the terms of the Second Amended Settlement Agreement (SASA), DBHDID has established a Data Tracking Tool (DTT) to assist in the management of referrals under the SASA and to track the number of individuals who transition out of institutions and into community-integrated housing under the agreement. Upon receipt of a referral, notifications are sent to DBHDID as well as to the local Community Mental Health Center. Staff within these agencies collaborate to ensure the person referred receives the appropriate community-based services, which may include moving from a personal care home into community-based housing as well as ACT team services. Each referral in the DTT is maintained throughout the transition process and for one year after completion of transition in order to identify barriers to successful community transition. The DTT is the central point of data collection and reporting for the SASA. (See also *Second Amended Settlement Agreement*, page 15).
6. *Kentucky National Core Indicators.* Each year, the National Core Indicators Quality Improvement Committee collects and reviews multiple sets of data in order to better understand and improve services available to people with intellectual and other developmental disabilities. The Kentucky Quality Improvement Committee (KQIC) was established in 2010 at the request of DBHDID to review Kentucky's service programs and make recommendations regarding quality assurance of Kentucky's

developmental disability programs. In 2018, KQIC made recommendations in four main areas: employment; health and wellness; relationships and community inclusion; and psychotropic medication usage. Since then, DBHDID has worked to enhance programs that provide these services.

B. *Other Data Sources.*

1. *Office of Health Data Analytics.* The Office of Health Data Analytics collects data from nursing facilities, personal care homes, nursing homes, intermediate care centers, Alzheimer's facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities related to the following areas:
   a) Census data, including the number of licensed beds, beginning census, admissions, discharges, ending census, total patient days and occupancy percentage for each bed type;
   b) Payor source data including the primary payor source in number of patient days for each bed type;
   c) Patient age distribution data, including the age of patients residing in each facility on December 31 of each calendar year; and
   d) Patient death distribution data, including the age of patient deaths in each facility each calendar year.

   This information is published each year in the Annual Kentucky Long Term Care Utilization and Service Report. The following comparison of data gathered and published in 2016 and 2018 compares occupancy rates and patient age distributions for the following facility types (FT): Intermediate Care Centers (ICC), Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), and Personal Care Homes (PCH).
2. *Commonwealth Council on Developmental Disabilities.* The Commonwealth Council on Developmental Disabilities collaborates with other state agencies to collect information relevant to implementation of the Kentucky Olmstead Compliance Plan. In response to the Governor's Employment First Initiative, the Kentucky Works subcommittee, has created programs which track data related to employment barriers for individuals with disabilities. In addition to the creation of a database of employers who offer employment opportunities, the subcommittee works to research funding opportunities for employment programs, develop curriculum to aid family engagement, and present initiatives to new audiences interested in improving employment opportunities for people with disabilities.
3. *Kentucky Post School Outcomes (KYPSO).* The Kentucky Post School Outcome Center monitors the "percent of youth who had Individual Education Programs, are no longer in secondary school and who have been competitively employed, enrolled in some type of postsecondary school, or both within one year of leaving high school. The data represents information voluntarily reported in response to a statewide survey each year. This information is used to develop appropriate school curriculum for individuals with learning and other disabilities that will ensure positive post school outcomes.

CONSUMER INFORMATION AND COMMUNITY AWARENESS

In addition to collaborative programs with various public universities throughout the state, the following programs create public awareness and knowledge of services available to those with behavioral health disorders and intellectual or other developmental disabilities.

A. *Mental Health First Aid*. Mental Health First Aid is a program that teaches the public, including law enforcement and employers, the skills necessary to identify, understand, and respond to the signs and symptoms of serious mental illnesses and substance use disorders. Those who take the class learn how to connect individuals in crisis with appropriate community-based services such as peer support, self-help care, and professional assistance.
B. *Youth Mental Health First Aid*. Youth Mental Health First Aid is aimed at teaching teachers, parents, peers, neighbors, human service workers, and others how to provide assistance to adolescents in crisis. Topics covered include eating disorders, anxiety, depression, psychotic disorders, disruptive behavior disorders, and substance use disorders.
C. *Employment Education Project*. The Employment Education Project works with community leaders, employers and businesses on the following consumer information and community awareness projects:
    a) Collaboration with Higher Education Recruitment Consortium on a series of webinars for colleges and universities about employment of people with disabilities, the first of which occurred in October 2019.
    b) Collaboration with Kentucky Works to create an education video providing information on the impact of employment on SSI benefits for youth and families.
    c) Collaboration with My Choice Kentucky to create trainings and spread awareness of supported decision-making. These trainings provide individuals with assistance for rights restoration, avoiding guardianship, and information on guardianship reform.
D. *Kentucky Peer Support Network.* Making friends can be especially hard for students with significant disabilities. The University of Kentucky Human Development Institute, through funding from the Commonwealth Council on Developmental Disabilities, trains schools throughout the state to establish peer support networks which provide ongoing support and friendships to students with significant disabilities in and outside of the classroom.
E. *Community Services Project, Inc.* Community Services Project, Inc. (CSP) is a Community Rehab Program with the Kentucky Office of Vocational Rehabilitation. CSP assists individuals, including those with disabilities, veterans, and Youth in Transition) with finding fulfilling employment opportunities in work settings of their choosing. CSP offers job placement assistance, career counseling, and job coaching to teach skills needed to perform a job or a task.

CONCLUSION

Kentucky's Olmstead Compliance Plan is not intended to be a static document establishing set goals for state agencies which provide services for people with disabilities. This Plan is designed to serve as a "living plan" for realizing the Commonwealth's vision of people with disabilities working, learning, living and enjoying life in the most integrated settings appropriate to their individual needs. As these programs are implemented, Kentucky will continue to expand on the programs demonstrating positive outcomes on quality of life, and seek out new programs and opportunities to increase community integration for individuals with disabilities.

APPENDIX A: COMMUNITY ORGANIZATIONS AND RESOURCES

In addition to services provided by government programs, the following community-based organizations offer services to individuals with disabilities. These programs provide additional support to help individuals with disabilities overcome the many barriers often faced in the community, including isolation, lack of companionship, and boredom. Although not implemented or organized by the Commonwealth, community organizations play a key role in successful community integration. The following are examples of available community organizations.

Autism Society of the Bluegrass. The Autism Society of the Bluegrass provides support groups, education, and advocacy of individuals diagnosed with Autism. Offered services include Parents' Day Out, Parent Resource Center, and support with education decisions.

Cerebral Palsy Guidance. The Cerebral Palsy Guidance Team provides guidance and assistance to parents of children with cerebral palsy. Services include support groups, legal assistance, and special education assistance.

Down Syndrome of Louisville. Down Syndrome of Louisville offers support, education and advocacy for individuals with Down Syndrome of all ages. The organization holds monthly activities that provide social opportunities, such as dance parties, fitness classes, shopping events, and music festivals to help with the development of lifelong friendships. Weekly classes are held to teach independent living skills with a focus on cooking, cleaning, community, and communication. Down Syndrome of Louisville also provides assistance with education decisions, including the selection of career paths or assistance with college applications.

The ARC of Kentucky. The ARC of Kentucky advocates for the rights and full participation of children and adults with intellectual and developmental disabilities. This program holds community awareness events such as charity walks, and health and fitness programs. The program also provides "Wings for All" events that focus on teaching individuals and their families how to confidently navigate airports, TSA inspections, in-flight safety protocols and other aspects of air travel.

Miracle League of Louisville. The Miracle League of Louisville is a baseball league and complex for children with physical, cognitive, and/or emotional disabilities. This one-of-a-kind, fully-inclusive complex allows children of all abilities to safely play baseball in an organized league. The adjacent playground and splash-pad brings children, families and the community to the Miracle League for a common goal…to play together.

Special Olympics Kentucky. Special Olympics Kentucky provides year-round sports training to children and adults with intellectual disabilities. Meets, games, and tournaments are held for both summer and winter sports to encourage physical fitness, greater self-confidence, friendships, and positive self-image.

Kentucky Deaf-Blind Project. The Kentucky Deaf-Blind Project, established by the University of Kentucky, provides statewide technical assistance and training to persons who have a

combination of vision and hearing challenges. Services are offered to persons from birth to 22 years of age, and also to their families and service providers.

Environmental Factors and Plan

18. Children and Adolescents M/SUD 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.[63]. 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.[64]. 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.[65].

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.[66]. 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.[67].

According to data from the 2015 Report to Congress[68] 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 M/SUD 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).

[63]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[64]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.

[65]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.

[66]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[67]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 **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[68] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

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 M/SUD 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 M/SUD 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.)

The State Interagency Council for Services and Supports to Children and Transition-age Youth (SIAC) was created statutorily in 1990 and is comprised of representatives from state child- and transition-age-youth serving agencies, including commissioners, youth with lived experience with behavioral health challenges, parents of children with lived experience with behavioral health challenges, and a statewide family-run organization. It was created and continues to serve as a structure for coordinated policy development, comprehensive planning, and collaborative budgeting for services and supports to children and transition-age youth with or at risk of developing behavioral health needs and their families. The SIAC currently operates four (4) standing committees that support the work of the SIAC. The standing committees are Social & Emotional Health & Wellbeing, Racial & Ethnic Disparities, Disability, and Outreach & Promotion.
SIAC is charged with serving as the governing body for Kentucky's System of Care by:
• Making annual recommendations to the Governor and the Legislative Research Commission;
• Directing Regional Interagency Councils (RIACs) to 1) Operate as regional locus of accountability for the SOC, and 2) Participate on the Family Accountability, Intervention, and Response (FAIR) Teams;
• Assessing effectiveness of RIACs;
• Meeting monthly;
• Developing a comprehensive array of services and supports; and
• Adopting interagency agreements as necessary

SIAC has served as the interagency oversight body for federal grants related to children's mental health; adolescent substance use; school mental health; early childhood; transition-age youth; youth court diversion, and others. Additionally, agencies share information about initiatives aimed at improving child, youth, and family functioning across life domains. The SIAC mission statement is "Promoting healthy children across Kentucky: Building collaborative partnerships to promote children's social and emotional needs where they live, learn, play, and work."
To support the integrated work under the SIAC umbrella, DBHDID has ongoing collaboration with several state agencies specific to improving the mental health of Kentucky's children, youth, and their families.
DBHDID works with the KY Department for Education through the State Interagency Council's Social Emotional Health Standing Committee; the Project AWARE grant through which our Departments have collaborated to expand student access to TARGET (Trauma Affect Regulation Guide for Education and Therapy) statewide, write and deliver training on Secondary Traumatic Stress (STS) for Educators, and provide Trauma-Informed Care for Educators training in varied education settings including schools, districts, and educational cooperatives; the Kentucky Educational Collaborative for State Agency Children; the Kentucky Center for School Safety, the Kentucky Educational Collaborative for State Agency Children;, the Kentucky Center for School Safety and other initiatives and will strive to continue these to collectively address the needs of children, youth, and families.
As mentioned, the Kentucky Department for Community Based Services (DCBS), Kentucky's child welfare agency, was an early implementer of FFPSA, in October 2019. At that time, FFPSA fit within Kentucky's larger effort around Child Welfare Transformation aimed at three (3) broad areas of safely reducing the number of children entering out-of-home care; reducing caseloads; and improving timeliness to appropriate permanency. A steering committee and eight (8) subcommittees were in place and implementing activity-based work plans to achieve transformation goals. DBHDID had staff representation on these committees to ensure that the behavioral health needs of children with child welfare involvement was considered across groups and to provide consultation as needed.
On May 4, 2020, Kentucky realized its largest number of children in out-of-home care at 10,047. To safely decrease this number, the state needs a service array that expands the prevention continuum. Prevention services to address substance abuse in the home, in addition to other high-risk behaviors, are necessary to ensure children can remain safely in the home and avoid the additional trauma associated with removal. In-home services which provide services in the home or assist with transportation when needed, have shown great success within select areas of the state.

June 2, 2019 June 7, 2020 May 02, 2021
9,875 9,950 9,156
TWS-058 Foster Care Fact Sheet

In preparation for implementation, the department conducted a service array analysis that showed in some areas of the state, many families and children were receiving contracted in-home services; however, many gaps in service provision still existed. Additionally, the data showed that the availability of contracted services within each region varied.

DCBS held initial regional forums in all nine (9) service regions, and then partnered with Kentucky Youth Advocates (KYA) and the Administrative Office of the Courts (AOC), to provide an implementation update to state leaders and stakeholders after one year. Family First Prevention Services Act Implementation: 12 Months Later forums were held in October and November 2020. The kick-off occurred in October 2020, with an implementation update forum for state leaders. Following the forum for state leaders, forums were held in each of the nine (9) DCBS service regions, including presentations from DCBS, DBHDID, and a family court judge local to each specific region.

DCBS submitted its FFPSA five-year prevention plan in August 2019 and received approval from the Children's Bureau in April 2020. An amendment to Kentucky's Five-Year Prevention Plan was submitted in December 2020 to add High-Fidelity Wraparound to Kentucky's service provision, along with expanded use of Motivational Interviewing (MI) and is currently pending approval from the Children's Bureau. In 2020, additional contracting occurred to focus on serving children at risk for congregate care placement, implementing Functional Family Therapy (FFT), Motivation Interviewing (MI), and Trauma-focused Cognitive Behavioral Therapy (TF-CBT).

Kentucky has the opportunity to expand prevention services to more families and expand training in FFPSA evidence-based practices (EBPs). During the summer of 2020, through use of state general funds and title IV-E claiming, Kentucky Strengthening Ties and Empowering Parents (KSTEP), a service on Kentucky's prevention plan, expanded to the entire Northeastern Service Region, an additional seven (7) counties, for a total of fifteen (15) counties. Through leveraging a partnership with DBHDID and its SAMHSA State Opioid Response grant, KSTEP also expanded into three (3) counties in Salt River Trail Service Region in 2021. As a result of advocacy efforts for greater focus on prevention, an additional $20 million was appropriated to DCBS for prevention services during the most recent legislative session. A portion of this funding will be used to expand KSTEP into the remaining counties in Salt River Trail Service Region, as well as expansion into a third region during the next SFY.

Simultaneous to Kentucky's implementation of FFPSA, DBHDID was awarded its fifth SAMHSA System of Care (SOC) grant. The grant application was developed collaboratively with DCBS and intentionally aligned with FFPSA implementation activities. The mission of the SOC grant. System of Care FIVE (Families – Involved! Valued! Empowered!) is to improve behavioral health outcomes for children and youth (age birth to 21) who meet criteria for having a serious emotional disability, and their families, who have child welfare involvement and for whom child welfare does not have custody. The overarching goals related to the SOC FIVE population of focus are:

• Enhance interagency infrastructure to support the implementation, expansion, and integration of the System of Care approach for the population of focus.
• Improve availability of and access to, high quality, culturally- and linguistically-competent evidence-based mental health services for the population of focus in the geographical target areas.
• Implement strategies to promote and sustain the voice of children, youth and their families with child welfare involvement at all levels of the system of care.

System of Care FIVE efforts are overseen by a State Grant Management and Implementation Team that includes representation from DBHDID, DCBS, Department for Medicaid Services, Kentucky Partnership for Families and Children, and other relevant stakeholders. This team reports to the State Interagency Council (SIAC) as it serves as the state's SOC governing body.
One of the SOC FIVE-led accomplishments for SIAC in 2021 was the inclusion of an item in the SIAC annual report to the Governor's Office requesting to create a group that will examine the practice of unnecessary custody relinquishment by parents to child welfare in order to receive behavioral health services.
The Kentucky Department for Juvenile Justice (DJJ) is a recipient of a Second Chance Act "Ensuring Public Safety and Improving Outcomes for Youth in Confinement and while Under Community Supervision" grant through the Office of Juvenile Justice Delinquency Prevention (OJJDP). The focus of this federal grant is on treatment and successful reentry of youth into the community with co-occurring substance abuse issues and mental health needs. With the support of this grant, the DJJ is seeking to implement evidenced-based practices for staff training and support for substance use disorder services across the continuum in addition to identifying internal and external stakeholders to support successful reentry to the community for youth with co-occurring substance use and mental health challenges. DBHDID staff is on the steering committee for this grant and is providing information and resources to support planning, implementation, and evaluation.
DJJ is also working collaboratively with the Department for Medicaid Services and DBHDID to develop an 1115 Waiver application that would allow substance use treatment provided to youth who are in DJJ facilities to be billed to Medicaid. The application is being modeled after Kentucky's current 1115 Waiver for substance use treatment provided to adults in correctional facilities.
Kentucky has a network of Crisis Intervention Team (CIT) Regional Advisory Boards, community partners representing law enforcement, judicial system, hospitals, guardianship, behavioral health services and advocates who meet monthly to plan for local CIT trainings for law enforcement officers and to discuss ways to better meet the needs of community members with behavioral health disorders, including youth and young adults. As a new initiative, DBHDID is allocating funds to each CIT Regional Advisory Board to assist with community training events, emergency respite and crisis services for individuals who have frequent encounters with law enforcement.

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

The state has had an established statewide system of care approach in place since 1990 and recently received its fifth SAMHSA Children's Mental Health Initiative (System of Care) cooperative agreement. Youth substance use treatment was adopted under the System of Care umbrella over ten (10) years ago when Kentucky received its first CSAT grant that focused on building an infrastructure to support youth/adolescent treatment services and supports. Simultaneous to this, Kentucky received its second System of Care (SOC) grant and selected youth with severe emotional disabilities who had or were at risk of co-occurring substance use as its population of focus. The State Interagency Council for Service and Supports to Children and Transition-age Youth (SIAC), has served as the governing body for all SOC and adolescent CSAT grants, as well as other federal grants and state-level initiatives focused on children, transition-age youth, and their families with or at risk of developing mental health and/or substance use challenges. The SIAC was created statutorily in 1990 and is comprised of representatives from state child- and transition-age-youth serving agencies, youth with lived experience with behavioral health challenges, parents of children with lived experience with behavioral health challenges, and a family-run organization. It was created and continues to serve as a structure for coordinated policy development, comprehensive planning, and collaborative budgeting for services and supports to children and transition-age youth with or at risk of developing behavioral health needs and their families. The SIAC currently operates four (4) standing committees that support the work of the SIAC. The standing committees are Social & Emotional Health & Wellbeing, Racial & Ethnic Disparities, Disability, and Outreach & Promotion.
The Children's Behavioral Health and Recovery Services Branch embraces the SAMSHA-recognized System of Care (SOC) Values of youth- & family-driven; community-based; culturally- & linguistically responsive. The Children's Branch has adopted the additional SOC value of trauma-informed. The recently released update to the system of care values and principles is under review by Children's Branch staff and will likely result in updating Kentucky's definition. Contracted providers are required to operate their services and supports for children, youth, and families in alignment with the SOC values and principles and can access training and technical assistance related to operationalizing the SOC philosophy and framework across their agencies. Children's Branch staff is engaged in ongoing planning in order to be prepared for additional SAMHSA funding opportunities in the future and supports other state agencies in drafting grant applications (e.g. Public Health, Child Welfare, Education). Funding from these grants will provide additional support to both infrastructure and service delivery across the state.

The DBHDID provides training and coaching to service providers in a number of ways. Specific to youth and young adults, DBHDID hosts an annual System of Care Academy. This event brings together approximately 500 participants from across the system of care: primary care providers; clinicians; prevention specialists; educators; child care providers; Family Resource and Youth Service Centers staff; juvenile justice staff; community agency staff; public health staff; child welfare staff; families; youth, and interested community members. The theme for 2021 was Collaboration: Better Together. DBHDID hosted the Academy virtually in both 2020 and 2021. Additionally, DBHDID offers learning collaboratives in a variety of evidence-based practices through relationships with universities, training consortia, and experts in the field. Block grant, state general, and discretionary grant funding is utilized to

support this work. Finally, the DBHDID partners with other child-serving agencies to offer training related to topics such as Trauma–informed Care; Secondary Traumatic Stress; Health Equity; Implicit Bias; System of Care values and principles; the Child and Adolescent Needs and Strengths (CANS); Solution Based Casework; High Fidelity Wraparound; Nurturing Parenting; the Structured Interview for Psychosis-risk Syndromes Assessor Training, and other topics related to specific programs, populations, or identified needs such as First Episode Psychosis programming.

Twenty-one (21) is the age at which services from the child/adolescent system have traditionally ended. Currently much work is being done to address the population of transition aged youth, including those aging out of foster care/child welfare system. In October 2014, Kentucky was awarded a SAMHSA Healthy Transitions Grant. This grant, Transition Age Youth Launching Realized Dreams (TAYLRD), supported the implementation of a transition-age, youth-driven, specialized array and continuum of behavioral health care. The purpose of TAYLRD is to improve outreach, engagement, and access to treatment and support services for youth and young adults between 16 and 25 years old that either have, or are at risk of developing serious behavioral health (mental health and/or substance abuse) conditions. The focus was on building an array that interests young people, such as peer support, employment and education supports and career planning, life skills supports, medication supports, support in health care navigation, and age-specific and developmentally-appropriate behavioral health services in an environment that is engaging to youth and young adults. It is integral to provide these services and supports in an environment that is engaging to youth and young adults. Kentucky modeled this project after the nationally recognized Youth M.O.V.E. Oregon Program and their youth-guided Drop-In Centers. In March 2019, Kentucky was awarded a second SAMHSA Healthy Transitions Grant. Building on the success of the 2014 Healthy Transitions Grant entitled TAYLRD; TAYLRD 2.0 is an expansion of the drop-in center model of behavioral health care, as well as modifying practices and procedures in outpatient offices to make them more appropriate and engaging for young adults. The goals for this grant are: 1) Youth and young adults will be able to access behavioral health care more easily and in a more timely fashion; 2) Improvement in behavioral health service options available to youth and young adults based on their interests and clinical needs; 3) Increase in the coordination of a youth behavioral health leadership network; 4) Improvement in the public's awareness of behavioral health issues and supports for youth and young adults; 5) Improvement in coordination of services and supports for youth and young adults; and 6) Increase in behavioral health providers' expertise in working effectively with youth and young adults. There are now ten (10) drop-in center locations across the state that are connected to the community mental health centers and are using the TAYLRD model of care.

With the success of TAYLRD, more areas of the state have begun focusing on specialized care for transition age youth. All fourteen (14) community mental health centers (CMHCs) now have Transition Age Youth Leads in their agency. These staff provide networking and technical assistance regarding transition age youth issues. Several of the CMHCs are now focusing efforts on enhancing easy access to behavioral health care for this population, including the development of specialized drop-in centers. There are now 616 staff across all CMHC regions (an average of 44 staff per region) who work with both youth under 18 years old and young adults over 18 years old at the same time. There are 45 youth peer specialists across all CMHC regions who work with transition age youth. All regions also have an adolescent substance use lead, a child and adult lead for first episode psychosis programming, and eight (8) regions are providing Coordinated Specialty Care in their region through the iHOPE Program (see additional information under Environmental Factors and Plan - #4).

In addition to the DBHDID-led activities via TAYLRD, Kentucky's child welfare agency, the Department for Community Based Services (DCBS), was an early implementer of the Family First Prevention Services Act (FFPSA), beginning implementation in October 2019. Signed into law in 2018, the FFPSA implements widespread child welfare reform that specifically focuses on safely keeping families together to prevent children from entering the foster care system, and encouraging kinship or family foster home placements when they do have to be removed from their parents. The FFPSA does not provide any new funding, but it dramatically shifts how states' child welfare programs can use federal dollars. It expands the use of funds designated for child welfare programming, sometimes referred to as Title IV-E funding, for quality, evidence-based preventive services for children, parents and/or kin/relative caregivers that could prevent a child's entry into out-of-home care. Under the FFPSA, prevention services include in-home, skill-based parenting programs, substance use treatment and prevention provided by a clinician, and mental health treatment provided by a clinician. In 2019, Kentucky was able to build on Child Welfare Transformation efforts already underway to implement FFPSA, with goals to safely reduce the number of children entering out-of-home care, improve timeliness for children to have appropriate permanency, and reduce caseloads for frontline staff.

Fostering Success is another program that started during the summer of 2016. Fostering Success is a 10-week summer employment program for current and former foster youth (18 to 23 years old). The program provides a paid internship in either a local DCBS office or local business. The program matches participants with Job Coaches who will assist them with professional development and career planning support. High performing participants will have the opportunity to remain in the program for 9 months. Twenty-eight (28) local offices within DCBS' nine service regions served as worksite providers during fiscal year 2020, including both Protection & Permanency and Family Support divisions. Thirty-two (32) additional employers partnered with Fostering Success to serve as worksite providers. These employers included both public and private entities, such as public school systems, warehouses, state parks, private childcare agencies, information technology (IT) companies, and hair salons. One hundred and eighteen (118) youth interviewed for the program. Eighty-four (84) youth participated and fifty-two (52 completed the entire ten-week program during the last fiscal year. Thirty-one (31) high performing youth were given the opportunity to extend their participation in the program for an additional six months during the last fiscal year. Four (4) program participants were offered full-time employment at their worksites and many others, with the assistance of their job coaches, either secured employment other than at their worksites or attended college after the completion of the program. In 2020, the Fostering Success program grew to include additional opportunities for youth, known as the Summer Skill Series and Earn and Learn. The Summer Skill Series provides youth an opportunity to complete online curriculums focused on professional development, work readiness, and emotional intelligence. Earn and Learn provides youth an opportunity to be paid while completing a vocational program at their local community college.

The Consolidated Appropriations Act (CAA) was signed into law on December 27, 2020 resulting in significant modifications to

services and resources states are required to provide youth in out of home care or youth who have aged out of care between the ages of 18-26 who have been negatively affected by the national pandemic. DCBS is currently administering the funding and delivering additional services and resources to this population including direct stimulus payments, transportation assistance, and a navigator program.
Below are implications as a result of the act:

• Increased the eligibility age for Chafee services to 27 for this federal fiscal year
• Education Training Voucher requirements for enrollment in post-secondary education or requirement to make satisfactory progress are waived during the pandemic between 4/1/20 through 9/30/21
• Lifted the Chafee restriction on room and board for states to use more than 30%
• States may not require a youth to leave foster care solely due to age prior to October 1, 2021
• Permit any youth who left foster care solely due to age during 1/27/20 through 1/20/21 to voluntarily re-enter care
• Must continue to ensure safety, permanency and well-being of youth who re-enter foster care and ensure transition planning

Kentucky will monitor and track service utilization, costs and outcomes related to the population of focus in a variety of ways. These include:
• Data analysis, data sharing with other child serving agencies, and qualitative data gathering
• Annual Plan and Budget Submission with quarterly and semi-annual reporting requirements
• IMPACT Outcomes Management System for Children with SED who are receiving High Fidelity Wraparound/Targeted Case Management (TCM) services
• Adolescent Kentucky Treatment Outcomes System (AKTOS) for youth who receive substance use treatment services
• Regional Interagency Council strategic plans
• Functional Assessment and outcomes monitoring via the Child and Adolescent Needs and Strengths (CANS) for children in out-of-home care
• Functional Assessment and outcomes monitoring via the Child and Adolescent Needs and Strengths (CANS) for children with DCBS involvement but not in state custody through System of Care FIVE grant

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

N/A

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:
A collaborative plan to work with the Department for Juvenile Justice is currently in development.

Environmental Factors and Plan

19. Suicide Prevention - Required for 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 M/SUD 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 using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD 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 (1) Full Time Equivalent (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 (RPCs) to deliver clinical care and community prevention efforts across the fourteen (14) CMHC regions in the state. DBHDID provides focused and intentional training and technical assistance to staff of these centers to ensure the broadest reach of suicidal care to the residents of Kentucky who experience SMI/SED, as well as others. In addition, the training and technical assistance is available to other key stakeholders and other providers outside the CMHC system.

Regional Prevention Centers - Each year, the Regional Prevention Centers develop work plans that identify priority substances and mental health needs within their regions. For SFY 22, all fourteen (14) RPCs have identified suicide prevention as a priority based on local needs. Identified Intervening Variables include social and community norms, access and availability of means, low capacity for addressing needs, and perception of risk and harm. Identified Contributing Factors include bullying, stigma, ineffective school policies, stigma around help-seeking, high access to lethal means, need for increased capacity, low perception of risk of youth suicide, home access to lethal means, and peers who have died by suicide.

Using the federal State Suicide Prevention Infrastructure, Kentucky's Prevention team is building, unifying, and leveraging community partnerships in the following ways:

Authorize - Designate a lead division or organization for suicide prevention in the state, and give it the resources and authority to carry out all of the recommendations.
Lead - Maintain a dedicated leadership position, as well as core staff positions and capacity, in order to carry out the recommendations and create cross-agency and cross-sector collaboration within the state government.
Partner - Ensure a broad, inclusive public-private partnership or coalition at the state level with a shared vision and commitment to suicide prevention.
Examine - Support high-quality suicide data collection at the state and local levels to inform and evaluate prevention efforts.
Build - Create a multi-faceted lifespan approach to suicide prevention across the state, and allocate sufficient resources to fully implement and evaluate it.
Guide - Support all state, county, and local efforts in the planning, execution, and evaluation of their efforts, including allocation of needed resources.

All suicide prevention efforts are data-driven and based on a surveillance plans that allows decision-making based on the contexts in the state. Data is collected from a number of locations/entities, including:

State Epidemiological Outcomes Workgroup – subgroup focused on suicidal behaviors and deaths across the state
Child Fatality Review Committee
Maternal Mortality Review Committee
Local coroners

These services focus on preventing the issue of suicide and related consequences, ideally well before the issues occur by increasing resiliency and coping skills of youth, parents and other adults, including the delivery of evidence-based prevention curricula.

In addition to preventing suicide, staff members support intervention efforts for those in crisis, including individuals with SMI/SED, as well as Postvention for organizations and communities after a suicide death among a client or students. Intervention efforts include recognition of a suicidal crisis, referral to appropriate care, and then follow up as necessary. Postvention services include resources to address specific needs for a community after a suicide death.

DBH staff support the increase of capacity among providers, especially clinicians employed by the Community Mental Health Centers, to ensure that providers are trained to deliver appropriate services to those at risk of dying by suicide. In addition, staff provide TA to schools related to appropriate policies and procedures to identify and refer youth at risk of suicidal behavior to appropriate care.

Specific suicide prevention projects include:

988 Planning Coalition
In July 2022, 988 will become the national three-digit dialing code for the National Suicide Prevention Lifeline, replacing the current phone number of 1-800-273-TALK (8255). Americans needing support should continue to call 1-800-273-TALK (8255) until then. The new 988 number, once implemented, will continue to be America's mental health safety net by providing emotional support for people in distress, reducing suicides and mental health crises, and providing a pathway to well-being for all.

988 represents a long past due opportunity to shift from a law enforcement and justice system response to one of immediately connecting to care for individuals in suicidal, mental health and substance use crises. The number is the first step to make a fundamental shift in how people in crisis are engaged in our communities. When you have a police, fire or rescue emergency, you call 911. When you have an urgent mental health need, you will call 988.

Kentucky was one of the states awarded a 988-planning grant in January 2021. Funding is being used to evaluate current system capacity to meet the projected demand for 988-related services, create a roadmap to fill any assessed system/community gaps, and solidify a crisis system to deliver focused crisis resources for those in need. DBHDID has convened a 60+ member planning coalition to develop the plan for 988 implementation and that coalition is meeting regularly. Kentucky's line will allow for both those in both suicide and substance use crisis to access services.

Crisis Services
CMHC crisis services are an important part of the state's behavioral health safety net for children and families. Crisis services facilitate ongoing community care and reduce psychiatric hospitalization, psychiatric boarding in hospital emergency departments, and disrupted placements. A variety of funds are blended to support Kentucky's 24/7 call center and intervention services (e.g., state general funds, Medicaid, Medicare, commercial insurance and private pay.)
CMHCs are preparing for 988 in July 2022; eleven (11) CMHCs are members of the National Suicide Prevention Lifeline (NSPL) and two (2) additional CMHCs are in the onboarding process. CMHCs respond to regional crisis calls in additional to NSPL calls. In addition to increasing 988-call center service capacity, CMHCs are also working to increase their mobile crisis services capacity. Current challenges include the state's rural landscape, workforce shortages, funding deficiencies and technology limitations such as cellular and broadband access. Other models of community-based crisis stabilization are in place across the state in addition to mobile crisis services; they include the following:

Residential Crisis Stabilization Units
Intensive In-Home Services
Walk-In Crisis Services
Intensive Outpatient Services
Crisis Case Management
Call Center Services, including Warm Lines
Crisis Respite

Kentucky Emergency Response for Suicide Prevention
Kentucky was awarded an emergency suicide prevention grant in August 2020. The focus of the grant project is to support those at risk and reduce suicide attempts and deaths, utilizing the statewide infrastructure capacity for suicide prevention, intervention, and treatment in KY to expand capacity, add recovery supports, and focus efforts on the COVID-related highest-risk populations of those who attempt suicide, use substances, are victims of domestic violence and are homeless in a single geographic location.

The geographic catchment area for the Kentucky Emergency Response for Suicide Prevention (KERSP) grant will be Jefferson County, where nearly 24.1% of KY's COVID-10 cases have been confirmed, but where 17% of the state's population reside. Jefferson County COVID-19 deaths come in at 36.4% of the state's total deaths (578). Within that community, a disparate number of Black and Brown residents are affected by COVID-19 and suicide. Statewide, Black residents represent 8.4% of the population but 22.0% of the population in Jefferson County.

Kentucky's populations of focus for the direct services portion of the grant include those who access emergency department (ED) services due to experiencing (1) suicidal behaviors; (2) substance use disorders; (3) domestic violence and sexual assault, and (4) homelessness within the geographic catchment area. Efforts focus on identifying and assessing those at greatest risk of dying by suicide; connecting them via care transition protocols to appropriate resources, including inpatient facilities; and providing peer

support to aid in recovery.

Efforts focus on:

Develop and implement a plan for rapid follow-up: Continuously monitor the individual's progress through their EHR and provide a living document on the client's safety plan including strategies to decrease access to lethal means.
Establish follow-up and care transition protocols: Continuously monitor the individual's progress through their EHR and include strategies to decrease access to lethal means and identify natural supports.
Provide suicide prevention training: Increase capacity of community members and clinicians to recognize warning signs and risk factors for suicide, connect individuals at risk for suicide to appropriate care, and to provide appropriate care to manage and reduce risk.
Work across state and/or community departments and systems: Create a community-level council to build collaboration among key stakeholders and support development of a community- level suicide prevention needs assessment and strategic plan to guide a comprehensive suicide prevention response to increased issues arising from COVID-19.
Screen all individuals: Screen every client at every visit and in every service provided utilizing a validated screening instrument to assess suicide risk.
Provide community recovery supports: Provide, or access through community collaborations, recovery support services as needed by the client.
Provide services via telehealth as needed: Provide services via telehealth to meet the needs of clients.
Provide enhanced services for victims of domestic violence: Embed the Zero Suicide Framework within the current operating procedures to ensure that victims of domestic violence are screened for suicide risk.

Partners include:
UofL Health and Seven Counties Services, Inc.:
Louisville Metro Public Health & Wellness:
Louisville Health Advisory Board:
The Center for Women and Families:
Kentucky Injury Prevention and Research Center;
Department for Public Health.

Crisis Text Line/Question, Persuade, Refer (QPR) Expansion Project
Kentucky Violence and Injury Prevention Program in partnership with DBHDID is using CDC grant funds to enhance the Crisis Text line by establishing a Crisis Text Lifeline dashboard for Kentucky. The dashboard provides a real-time mental health data set, which is being used to spot trends and identify community needs.

Creating and utilizing a dashboard of Crisis Text Line data provides real-time surveillance data to allow targeted delivery of prevention, intervention and treatment services. Designated crisis counselors to respond to texts from Kentucky residents are identified.

The dashboard contains daily updated information on:
Number of texters and conversations by 3-digit area code, volume (day of week, time);
Issues with which texters present;
Geography demographics to identify hot spots;
Population demographics to identify populations of focus;
Comparisons to national Crisis Text Line data (day, time, issue).

The project also funds Question, Persuade, Refer (QPR) train-the trainers, and gatekeeper trainings across the state. Funding has been designated to allow 51 trainers to be trained, and to purchase digital license to support the delivery of gatekeeper trainings to as many as 10,000 people over the course of the next year.

National Suicide Prevention Lifeline/NSPL Capacity Building Efforts
The National Suicide Prevention Lifeline (NSPL) is a national network of local crisis centers that provides free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours 7 days a week.

The Kentucky NSPL crisis centers are located within the fourteen (14) local Community Mental Health Centers (CMHC) across the state and provide support for their respective regions. Kentucky has ten, (10) centers that are accredited with the NSPL and three (3) additional centers in the process of onboarding. Current accredited centers include: Four Rivers, Pennyroyal, RiverValley, LifeSkills, Centerstone, Mountain, Adanta, New Vista and Cumberland River. Onboarding centers include: Communicare, Kentucky River and NorthKey Community Care. One (1) of the Lifeline certified centers, Pennyroyal, is equipped to answer texts sent to the NSPL. Use of the NSPL number in Kentucky is significant and as such ensuring available capacity is imperative. Current data related to the NSPL number usage:

In 2018, Kentucky was accountable for 30,964 calls of the 2.5 million across the United States.
Nearly 40% of those calls accessed services through the Veteran's Crisis Line.
Nearly 160 accessed services through the Spanish Language Line.

On average, Kentucky residents call the NSPL line 300 times each week.
A newly approved, national three-digit number, 988, will go online in July 2022 and make accessing mental health and suicide prevention resources as easy as calling 911 for physical health care.
In 2018, Kentucky had an answer rate of 44%, which equals to 8,201 incoming calls. With an increase in capacity and advocating, the answer rate increased up to 70% at the end of the second quarter in 2021.

The SFY 20 contracts between KDBHDID and the fourteen (14) CMHCs require non-certified centers to participate in a needs assessment process to determine the barriers that are prohibiting certification and work with the department to ensure that calls to the NSPL from their region are answered in state. All centers are required by contract to become certified by July 2023 or to contract with another accredited center to answer calls within the region.

Rural Suicide Prevention Project
The Rural Suicide Prevention Project is focused on creating and disseminating a Kentucky farmer cultural humility training for behavioral health providers; increasing capacity of behavioral health care providers to deliver suicide care to those at risk; increasing number of individuals able to recognize suicide risk through gatekeeper trainings; and increasing surveillance to identify high-risk geographic areas based pm self-harm emergency department data.

The initiative is managed through the Prevention and Promotion Branch of DBHDID under the direction of Kentucky's State Suicide Prevention Coordinator, and includes partnerships with University of Kentucky's Southeast Center for Agricultural Health and Injury Prevention, University of Louisville, Western Kentucky University, the state's fourteen (14) Community Mental Health Centers, Kentucky Department of Public Health, Kentucky Cooperative Extension Service, and the Kentucky Farmer Stress and Suicide Group.

The program's strategies and deliverables include:
• Increase awareness of resources available in Kentucky to address mental health and suicide, focused on rural communities.
• Develop communication/marketing plan
• Implement marketing plan to increase rural/farmer awareness of resources related to suicide prevention.
• Increase the number of calls made by Kentucky residents to the National Suicide Prevention Lifeline answered by a Kentucky crisis center.
• Update crises line software/hardware to increase capacity to answer calls from rural Kentucky communities.
• Train crisis staff in Farmer Cultural Humility Training.
• Support rural/farmers who call the NSPL to access appropriate care for their risk level.
• Development and dissemination of Kentucky Farmer Cultural Humility Training.
• Utilize those with lived experience (farm families) to develop Kentucky Farmer Culture Humility Training.
• Deliver Kentucky Farmer Cultural Humility Training to organizations/agencies, crisis centers, etc. serving rural/farmer families in Kentucky.
• Increase awareness of Kentucky's rural youth to recognize increased suicide risk, and connect with appropriate providers.
• Create video module focused on elementary and middle school students.
• Create video module for school support staff.
• Create video module for ancillary school staff (bus drivers, cafeteria, etc.).These materials will increase the safety of rural students, especially in light of increased anxiety and stress in times of COVID-19.
• Increase capacity of behavioral health care providers to deliver suicide care to those at risk.
• Purchase materials to deliver Assessing and Managing Suicide Risk – Outpatient training to 325 clinicians in rural/farmer communities.
• Increase access to care providers by increasing awareness of National Suicide Prevention Lifeline and Crisis Text-line.
• Purchase Lifeline and Crisis Text branded materials to increase awareness of resource lines.
• Distribute materials to Co-ops, Farm Machinery Dealerships, Kentucky Farm & Machinery Show, etc.
• Increase the number of rural community members to identify those at risk of suicide.
• Train Extension Office, Local Health Department, and Commodities in QPR T4T. (50 Trainers)
• Support those trained in delivering QPR to their community members, especially rural/farmer connected individuals.
• Increase surveillance of self-harm incidents in rural/farmer communities.
• Access to Electronic Surveillance System (ESSENCE) for Kentucky Emergency Department Self-Harm data.
• Outreach to rural community hospitals to encourage submission of Emergency Department data to ESSENCE system.
• Onboarding of rural community hospitals to ESSENCE system to report Emergency Department Self-Harm data.

School Curricula Implementation
DBHDID provides support for the implementation of evidence-based curriculums, including Lifelines and Too Good for Drugs in 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. 15 of each school year.

Lifelines Trilogy Implementation
Lifelines was first implemented in Kentucky in 2012, through a Garrett Lee Smith suicide prevention grant. Since, it has been funded through the Kentucky Incentives for Zero Suicide and Kentucky's Substance Abuse Prevention and Treatment Block Grant.

Lifelines is a comprehensive youth suicide prevention program that targets the entire school community, and it is designed to be

implemented grades 5-12. A brief video description by the primary program developer, Maureen Underwood, can be viewed at https://hazelden.wistia.com/medias/z9cib2v8l8.

Program goals are 1) to increase the likelihood that members of the school community can more easily identify potentially suicidal youth, know how to initially respond to them and how to rapidly get help to them, and 2) to increase the likelihood that troubled adolescents are aware of and have immediate access to helping resources and that they seek such help as an alternative to suicidal actions.
Part 1: Prevention - The first part of the Lifelines Trilogy educates middle and high school faculty, parents, and students on the facts about suicide and their roles in suicide prevention.
Part 2: Lifelines Intervention: Helping Students at Risk for Suicide - The second installment in the Lifelines Trilogy provides information on how to be prepared to address and respond to threats or signs of suicide and intervene—before it is too late.
Part 3: Lifelines Postvention: Responding to Suicide and Other Traumatic Death - This comprehensive third installment of the Lifelines Trilogy educates everyone in middle and high school community on how to successfully address and respond to not only suicide, but also any type of traumatic death that profoundly affects the school population. Effective postvention also is effective prevention of additional suicidal events.

Subscriptions to the program are in approximately 200 schools in Kentucky, with many districts implementing across all middle and/or high school students. This curriculum meets the Kentucky legislative mandate that all students in middle and high school receive evidence-based suicide prevention information by Sept. 15 of each school year.

Sources of Strength
In 2015, Kentucky's Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), Division of Behavioral Health (DBH), Prevention and Promotion Branch received its third consecutive Garret Lee Smith (GLS) Youth Suicide Prevention Grant from SAMHSA. To target the grant's strategic direction for Healthy and Empowered Individuals, Families and Communities, funding for the peer-led, mental health wellness program, Sources of Strength for middle, high and college-age audiences was included. When the GLS grant ended in 2019, the State Opioid Response (SOR) grant from SAMHSA, which is part of Kentucky's Opioid Response Effort (KORE), provided funding to continue implementation of the program based on the shared risk and protective factors between substance misuse and suicide. The initial round of SOR funding continues to support implementation of the program in middle and high schools, and the new round of SOR funding (SOR2) provides funding for the newly developed SOURCES Elementary program rolled out in spring 2021.

Sources Middle and High School employs a strength-based approach to suicide prevention by focusing on developing and promoting strengths, aka protective factors, and tapping into the students' power of social networking through creative and regular message campaigns. Those campaigns utilize visual arts, storytelling, music, competitions, social media, drama, and other forms of expression to encourage healthy norms.

Sources Elementary moves the work of prevention and health promotion even further upstream. As a universal classroom curriculum that is activity based, the program not only incorporates solid Social Emotional Learning content, but also includes a robust focus on mental health and proactive prevention for elementary schools, grades 3-6.

Sources of Strength has been implemented in 103 middle and high schools across the state. Between October 1, 2018, and October 1, 2020, Kentucky has trained 845 adults in Sources of Strength and 2,934 Peer Leaders.

Currently, the state has:
82 schools implementing the middle and high school Sources program
35 people trained as trainers for this program
45 people trained as Sources Elementary coaches
11 elementary schools who have order curriculum for the coming school year.
571 people served during SFY 21 with technical assistance and training around the program.

DBHDID provides both training and materials for schools who are interested at no charge; however, there are certain expectations that are required. Participating schools are expected to work with the Regional Prevention Center (RPC) staff to review their current policies related to substance use/misuse and suicide prevention and also participate in the evaluation process conducted by REACH Evaluation.

Zero Suicide Initiative
Each of the fourteen (14) Community Mental Health Centers are required to conduct a Zero Suicide Assessment each fiscal year and develop a workplan that drives the capacity building and training efforts for staff during the coming fiscal year. Each continue to receive Technical Assistance as they move forward with implementation of the Zero Suicide Framework. All clinical partners within suicide prevention efforts are also required to conduct an assessment, develop a workplan and implement the Zero Suicide Framework within their organization.

Coalitions, Collaborations and Partnerships
KDBHDID works collaboratively and in partnership with many different agencies and organizations to implement suicide prevention activities. A state interagency council – Kentucky Incentives for Suicide Prevention – has been developed and members

are currently in the process of developing a five (5) year suicide prevention plan. The council has four (4) workgroups: prevention, intervention/treatment, postvention and data/surveillance.

Some of those working within the interagency council 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.

KDBHDID also increased statewide capacity during SFY 2018/2019 by hiring a collaboration specialist at each of the fourteen (14) Community Mental Health Centers/Regional Prevention Centers. Collaboration specialists are tasked with increasing the connection of community partners with not only substance use but also suicide prevention and mental health promotion efforts.

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. In 2017, a Kentucky Suicide Data and Surveillance Committee was formed to investigate suicide trends, specifically related to a large increase in youth suicide deaths seen in a one (1) year period. This interdisciplinary group of data scientists and suicide prevention experts include representatives from the Department of Behavioral Health, Developmental and Intellectual Disabilities, the Department for Public Health, the Department of Vital Statistics, the Department of Education, the Child Fatality Review Team, the University of Kentucky's Injury Prevention and Research Center, the Kentucky Violent Death Reporting System, and the Kentucky Poison Control Center of Norton Children's Hospital. This team examined multiple sources of morbidity and mortality data by demographic and geographic characteristics over time. After this initial investigation, this group has continued to meet annually and on an ad hoc basis when needed to address particular concerns. The formation of this group has greatly improved communication across these agencies and allowed for improvements in surveillance efforts of the state. These improved surveillance efforts help to inform Kentucky's suicide prevention efforts, in identifying vulnerable populations, high-risk geographic areas or "hot spots", and improving data available to evaluate suicide prevention efforts.

Over the last year, DBHDID has been partnering with the Dept. of Public Health, Kentucky Violent Death Reporting System, Kentucky Injury Prevention and Research Center, and other entities that have access to suicide and self-harm related surveillance. As a result, DBHDID has been able to make real time decision around suicide and self-harm to deploy prevention, intervention, treatment and postvention services.

In addition to the administrative data collected through the partner agencies in the Surveillance Committee, KDBHDID relies upon data from the Kentucky Incentives for Prevention (KIP) Survey of over 128,000 students in 151 middle and high school across the state for prevalence of suicide ideation and behaviors among youth, as well as numerous suicide risk factors. Because of the large size and broad scope of the survey, KDBHDID has access prevalence data and conduct detailed analyses at a small geographic level. The latest administration occurred in 2018 and was scheduled for 2020. That KIP Survey administration was delayed because of COVID-19. The next administration of the KIP Survey is slated for the fall of 2021.

Finally, the Child Fatality Review Team now has a direct communication channel with the Department of Behavioral Health's suicide prevention staff so that the Department is notified of suicide deaths within days after the death so that suicide postvention and prevention outreach can occur in the communities affected.

DBHDID continues to work with the Kentucky Violent Death Reporting System; Child Death Review; 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.

Training and Technical Assistance to Schools

In addition to supporting implementation of the Sources of Strength, Lifelines, and Too Good for Drugs programs, 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 district-wide school staff and suicide prevention information for middle and high school students.

Military-connected initiatives

Service members, veterans, and their families are at higher risk for suicide across numerous data sources and studies. In Kentucky, one (1) unique identified population identified is youth with military connections. Through self-report, these youth identify (Kentucky Incentives for Prevention Survey) as being at a higher risk of substance use, serious psychological distress, and suicidal thoughts and behaviors. Because of this elevated risk, Kentucky's prevention network has been working with military partners and in areas with high populations of military youth to better reach these youth.

Kentucky is in the process of implementing The Purple Star program. The Purple Star School program is designed to help schools respond to the educational and social-emotional challenges military-connected children face during their transition to a new school and keep them on track to be college, workforce, and life-ready. Military-connected refers to children of service members on active duty, and in the National Guard and Reserves. The first Kentucky schools to participate will onboard in the fall of 2021.

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 2020-FFY 2021 plan was submitted? (●) Yes ( ) No

If so, please describe the population targeted.

Rural Residents, focused on farmers and their families.
Please see the narrative under Question 2.

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

Information regarding alternative funding streams for crisis care; including and beyond access to care through a crisis call system.

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Footnotes:

Kentucky's suicide prevention plan is expected to be updated by the end of 2021.

Environmental Factors and Plan

20. Support of State Partners - Required for 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 M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

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?

In April of 2020, DBHDID became the state affiliate of the National Alliance for Recovery Residences (NARR). Since then, DBHDID has worked with NARR to create the Kentucky Recovery Housing Network (KRHN), a voluntary certification program for recovery houses. DBHDID also hosts a monthly open call for networking, education and training, and development of the recovery housing community.

In addition, as DBHDID looks to revitalize our faith-based recovery initiative, DBH has looked to outside organizations with planning of faith projects regarding recovery. During the last year, DBHDID has created and utilized partnerships with Sign of Dove Church in Radcliff, Kentucky, Campbellsville University's Ministerial Institute, and the Lexington Rescue Mission. Representatives from these organizations attend monthly planning meetings and provide unique faith perspectives to the recovery initiative.

Although DBH has had a partnership with the Department for Public Health (DPH) for a long while, DBHDID recently partnered with the Kentucky Perinatal Quality Collaborative (KYPQC) through DPH, as a means to enhance networking and collaboration with other statewide programs that work in the realm of improving material and infant health. KYPQC's mission and vision is to "make Kentucky a great place for every woman to have a baby and a great place for every baby to be born".

DBHDID recently partnered with the University of Kentucky, Prevention Enhancement Sites (PES), and the Department of Public Health regarding Fetal Alcohol Spectrum Disorders. A committee has been created with these organizations to work on community and professional training development for this area, including updating language, support options, and current data and information on adults with Fetal Alcohol Spectrum Disorders. This is a new partnership for this specific purpose.

The Kentucky Association of Sexual Assault Programs (KASAP) is a coalition that includes Kentucky's thirteen (13) Regional Rape Crisis Centers. This organization is committed to serving all survivors and works toward the prevention of sexual violence. KASAP provides technical assistance to many organizations including advocates for improvement in public policy, programs that touch

violence survivors, and other professionals. DBHDID is partnering with KASAP on the Prevention, Awareness and Response (PAR) Project, which is designed to enhance prevention of sexual harm efforts while providing targeted outreach, awareness and access of response services throughout the state. The PAR Project includes a strategic focus on marginalized survivors, particularly survivors in the Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual (LGBTQIA+), and Black and Indigenous People of Color (BIPOC) communities who also have substance addiction. Individuals within these communities, who have been subjected to sexual harm, will have access to safe, comprehensive, and responsive person-centered services.

DBHDID received an Assisted Outpatient Treatment (AOT) Program for Individuals with SMI grant, from SAMHSA in July of 2020. Through the work on this grant, DBHDID has formed partnerships with Kentucky's Department for Public Advocacy (DPA), the Administrative Office of the Courts (AOC), the Office of Vocational Rehabilitation (OVR), the University of Kentucky College of Social Work, and the Treatment Advisory Center. A state-level AOT team was created as a policy advisory group that includes these partners. DPA has worked to create a client rights brochure for AOT, and AOC is working to develop a formal court supervision process for AOT. In addition, the Crisis Intervention Team (CIT) Advisory Boards are included on the state-level team. The Treatment Advocacy Center is providing technical assistance to this group for AOT, and the University of Kentucky College of Social Work is providing the evaluation component.

DBHDID Prevention is working the Court Designated Workers (CDWs) to disseminate and implement the evidence-based curriculum Too Good For Drugs (TGFD). Thirty-three (33) CDWs have been trained as TGFD implementers, which allows them to deliver the curriculum to youth who are justice-involved. The curriculum focuses on developing essential skills like setting reachable goals, making responsible decisions, and identifying and managing emotions to build self-awareness and social awareness. Cooperative learning activities immerse the students in the learning to promote content retention and foster analysis and discussion of the effects of Alcohol, Tobacco and Other Drugs (ATOD) use including prescription and OTC drug misuse.

Additionally, DBHDID is connecting CDWs and Regional Prevention Centers to facilitate training of CDW staff in additional prevention opportunities as well connection of youth to direct service.

DBHDID and Regional Prevention Centers are working with the Kentucky Chamber of Commerce to schedule business-specific Opioid Overdose Toolkit Trainings in local communities. The toolkit trainings include current data around opioid use/misuse and overdose deaths, as well as provide specific prevention action steps local businesses can take to prevent use/misuse of opioids. They also include a naloxone use training. In addition to the business community, DBHDID has developed additional toolkits for the following: general community, first responders, prescribers, municipalities/governments, faith-based organizations, child welfare involved entities, justice-involved involved entities and schools.

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

N/A

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Footnotes:

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and 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 an Advisory/Planning Council (PC).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 PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[69]

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 M/SUD 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.

[69] **https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf**

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

Department staff utilize multiple mechanisms to identify, plan and implement prevention, treatment and recovery services: There are multiple data sources used to identify substance misuse trends and treatment outcomes that help to inform the planning and implementation process.

Program Administrators deliver technical assistance and training on assessing the needs of the communities in which the Regional Prevention Centers (RPC) provide technical assistance and training to coalition members and key stakeholders. The needs assessment process is guided by contracted prevention providers but is completed in concert with coalition members and key stakeholders at the community level. Community members are a vital component within the needs assessment process and their input guides the work of the RPC.

Every three (3) years, a statewide needs assessment is conducted using a standardized template to guide local assessments for consistency and accuracy, but also to create a state level guide for work. Beginning in SFY 2022, this process is being redesigned to include provision of data related to incidence and prevalence through a dashboard that will guide county-level assessments. The dashboard and data will be utilized to develop risk indexes for alcohol, tobacco, marijuana, opioids, stimulants and mental health issues taking into consideration incidence, prevalence, morbidity, mortality, community contexts (poverty, lack of housing, discrimination) and health disparities. Once the index is established, RPC staff will share with community members to identify their agreement with the issues in the community, and conduct key stakeholder and focus group qualitative data collection to further identify local contexts that contribute to substance use and mental health issues, creating a focused action plan for each Kentucky county. They will also assess the readiness and capacity of the community to implement the identified strategies and guide communities in selecting those that are aligned with the community's current readiness level. Additionally, an analysis of the activities delivered to each county will be conducted to determine if they have the strength and reach necessary to create change in that community (basically, is the dosage high enough to help change behavior?).

Prevention program administrator provide monitoring and technical assistance to DBHDID-funded prevention programs by meeting one-on-one with providers at least monthly as well as holding virtual peer group meetings twice a month (one formal, one a peer sharing call). Based on these calls, and coupled with the needs assessment, a training and technical assistance plan is developed for each region. Needs noted across the regions are used to identify trainings and other skill-building opportunities for the RPCs.

The Kentucky Prevention Network, in conjunction with DBHDID, holds an annual conference in the fall of each year and provides four (4) substance-specific trainings in the spring, guided by discussions with DBHDID program administrators and identified training needs from the funded programs.

DBHDID Program Administrators meeting in a yearly strategic planning session to review available information from the

regions, updated trend data on substances, and changes in readiness levels to develop an internal strategic plan that guides the work of the branch in supporting the delivery of training and technical assistance to communities based on local needs.

Department staff provide ongoing monitoring and technical assistance for DBHDID-funded substance use disorder treatment programs statewide. Program Administrators maintain a constant contact with CMHC and other contracted agencies in administering their specific programs.

Department staff solicits input from the regional substance use treatment directors and other community partners on an ongoing basis. This consultation occurs at quarterly peer group meetings with SUD Directors, participation in local, regional and state community partner meetings and in regular in-person consultation with individual CMHCs. In addition, each CMHC has an identified department liaison who attends CMHC Board Meetings to facilitate communication between the Department and community partners.

The Planning Council's membership provides rich information about prevention, treatment and recovery supports needed for individuals in recovery, their parents and family members. The Council and its committees meet approximately eight (8) times per year.

Traditionally, the Department's annual alcohol and other drug prevention and treatment conference called the Kentucky School of Alcohol and Other Drug Studies (KY School) is a valuable opportunity for input on the system of care. Due to the pandemic, the conference was not held in 2020 or 2021, but the Department plans to recommence the conference in July 2022.

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? (●) Yes ( ) No

3. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The Planning Council is comprised of the following individuals who bring their diverse experiences and the input of those they represent to the Council:

Six (6) adults in recovery from mental health disorders and/or substance use disorders;

Six (6) parents/grandparents/guardians/foster parents who have custody of a child (birth through age 20) with behavioral health challenges;

Six (6) family members of an adult in recovery from behavioral health disorders;

Two (2) young adults in recovery from behavioral health disorders (age 18-25);

One (1) organization for individuals in recovery from substance use disorders;

One (1) organization for individuals in recovery from mental health disorders and/or co-occurring substance use disorders;

One (1) organization for family members of adults in recovery from mental health disorders and/or substance use disorders; and

One (1) organization for youth and family members of youth with significant behavioral health challenges.

Representatives from many state Departments that touch people with behavioral health disorders in Kentucky. (e.g. Department for Juvenile Justice, Department for Corrections, Department of Education, Department for Public Health, etc.)

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 lead and serve as members to the following committees: Membership, Finance and Data, and Bylaws.

Each of the Planning Council's statewide behavioral health advocacy organizations share the information about the Council periodically. They are a valuable resource for sharing information across the state via email and newsletter.

During the past year, the Council has increased membership and meeting participation. In SFY 2019, an average of 28 stakeholders attended Council meetings; in comparison, in SFY 2021, there was an average of 37 participants per meeting. Parent representatives have historically been difficult for the Council to recruit and retain; virtual meetings have reduced barriers to participating in meetings. The Council currently has only two (2) vacancies; one for Parents of Children with Behavioral Health Challenges and one for Individuals in Recovery. The Council has a total of 37 member seats.

Council staff and officers have increased collaborative meeting planning and decision making. Virtual meeting platforms have made it easier to meet frequently, review documents together, and complete Council tasks faster.

As the MHBG funds are restricted for use with individuals with SMI and/or SED, this Council continually reviews and provides input on many levels for services and advocacy issues for the SMI/SED population.

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

N/A

Additionally, please complete the Advisory Council Members and Advisory Council Composition by Member Type forms.[70]

[70]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.

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Footnotes:

Diversity is important to the Kentucky Behavioral Health Planning and Advisory Council. When choosing new members, the Membership Committee pays attention to the 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 Behavioral 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 2020-2021, most applicants chose to answer this question. Committee members report that this is extremely valuable as they consider applicants. 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 2020-2021:

"I am a grandmother, a veteran, a foster care mother, a certified peer support specialist and a certified English/Spanish interpreter raising a special needs grandson."

"I am an African American woman who has raised eight children. I am a grandmother who has full custody of my grandson."

"I am a single mother of three wonderful children, two of them in services. As a mother, I fight for what is best for my children."

"I was a foster parent for 18 years and I've cared for 105 children in that time. I also adopted five children, with four of those children having behavioral health disorders and learning disabilities."

"I am a family member and an active community member. I help children and adults with behavioral health issues every day. My interest continues to be housing for the homeless and the elderly with behavioral health issues."

"I am a 25-year-old working mother, wife, and master's student."

One tool that the Membership Committee uses to ensure geographic diversity is a state map with the county of residence of current members indicated. The Committee considers applicants who would represent an area of the state that is not currently represented or is underrepresented. The Council has trouble in recruiting applicants from the western portion of the state. Parents and young adults report the following barriers: education/employment responsibilities, child caring responsibilities, transportation and financial barriers. Barriers for recruiting individuals from western Kentucky include distance and a different time zone.

Planning Council members also identified the following underrepresented populations to focus recruitment: Latinos/Hispanics, individuals who identify as LGBTQ, and African Americans/Blacks. Members are sharing Council brochures and applications at identified organizations to increase awareness of the Council and recruit potential members. The Council shares its brochure at annual conferences to increase awareness of the Council and to recruit applicants from underrepresented populations.

The Kentucky Behavioral Health Planning and Advisory Council (Planning Council or Council) reviews the annual Behavioral Health Assessment and Plan during quarterly meetings in August and Behavioral Health Reports during November meetings. Department staff draft the plans and reports; Council members, stakeholders and the public are encouraged to provide recommendations and feedback. Staff send a draft of the plan/report to individuals on the Planning Council listserv and place it as a "Hot Topic" on the Department's homepage. An archive of draft, submitted and approved plans and reports is maintained on the Council's website. Various methods for providing comments are outlined.

Council meetings provide one opportunity for individuals to provide verbal and/or written feedback. Meetings have been virtual for the past year and membership is at an all-time high! All Council members with a term (which includes Individuals in Recovery, Family Members, Parents and Young Adults in Recovery) receive a stipend to support their attendance. Handouts are mailed to members who request paper handouts. During the August and November Council meetings, staff mail copies of the plan/report and a PowerPoint presentation of the drafted plan/report. Time is provided on the agenda for attendees to provide feedback and recommendations. Council members may provide verbal or written feedback (written feedback via chat). The Council creates a letter confirming the Council's participation and opportunity to review and provide feedback on the plan/report. At the meeting, staff encourage Council members and the public to continue to submit feedback/comments on any drafted, submitted or approved plan or report. Information is provided on how to submit comments after the meeting via the department website, email, or US Mail to the Block Grant State Planner (Missy Runyon). Comments and recommendations are reviewed and incorporated into the documents as applicable.

Kentucky has state law requirements (KRS 45.350 – KRS 45.359) for block grant applications. Per KRS 45.351, the Department provides a draft of the plan to the Legislative Research Commission (the administrative and research arm of the General Assembly) for review by the Interim Joint Committee on Health, Welfare, and Family Services. The public may go to the Committee's webpage for the meeting calendar, meeting materials and minutes. The calendar is also available on many social media platforms. Kentucky Educational Television (KET), the PBS affiliate, provides live and archived coverage of legislative meetings via television and the KET Legislative App for iOS and Android. Live and archived Kentucky Legislative Research Commission Committee meetings are also available on YouTube.

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.

Start Year: 2022 End Year: 2023

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Susan Abbott	State Employees		Kentucky Protection and Advocacy Frankfort KY, 40601 PH: 502-564-2967	susan.abbott@ky.gov
Betty Sue Abshire	Family Members of Individuals in Recovery (to include family members of adults with SMI)		2017 Ogden Ridge Road Mount Olivet KY, 41064 PH: 606-842-1041	bettysuedavis@gmail.com
Mike Barry	Persons in recovery from or providing treatment for or advocating for SUD services		People Advocating Recovery Louisville KY, 40206 PH: 502-552-8573	mike@peopleadvocatingrecovery.org
Becky Clark	Family Members of Individuals in Recovery (to include family members of adults with SMI)		Ewing KY, 41039 PH: 606-267-4101	simplifylife321@gmail.com
Sharon Darnell	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Ewing KY, 41039 PH: 606-584-2716	sharon@namibuffalotrace.org
Emily Eldridge	Parents of children with SED/SUD		3752 Barnesburg Road Somerset KY, 42503 PH: 606-425-7692	eeldridge@adanta.org
Sherri Estes	Providers		Regional Prevention Center Director Somerset KY, 42501 PH: 606-679-9425	sestes1@adanta.org
Tracy Gross	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		2037 Lakeview Drive Fort Wright KY, 41017 PH: 859-415-6958	tracygross71@gmail.com
Kelly Gunning	Others (Advocates who are not State employees or providers)		NAMI Lexington Lexington KY, 40504 PH: 859-309-2856	kelly@namilex.org
David Gutierrez	State Employees		State Social Services and Child Welfare Agency Frankfort KY, 40601	david.gutierrez@ky.gov

			PH: 502-564-9433	
Stephanie Hager	Parents of children with SED/SUD		2011 Meadows Edge Lane Louisville KY, 40245 PH: 502-262-4325	hanson4517@gmail.com
Lynn Haney	Family Members of Individuals in Recovery (to include family members of adults with SMI)		PO Box 54 Florence KY, 41022 PH: 859-240-5603	haneyl@fuse.net
Bill Heffron	State Employees		Department for Juvenile Justice Frankfort KY, 40601 PH: 502-573-2738	billm.heffron@ky.gov
Ella Kremer	Youth/adolescent representative (or member from an organization serving young people)		3648 Pondside Court Elmsmere KY, 41018 PH: 859-814-9238	ella.n.kremer@gmail.com
Steve Lyons	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Shelbyville KY, 40065 PH: 502-321-1951	lyonssadsack@aol.com
Phyllis Millspaugh	State Employees		State Mental Health Agency Frankfort KY, 40601 PH: 502-564-4456	phyllis.millspaugh@ky.gov
Jennifer Mingo	Parents of children with SED/SUD		2508 Elder Drive Owensboro KY, 42301 PH: 270-577-4346	jenny.mingo31@gmail.com
Valerie Mudd	Family Members of Individuals in Recovery (to include family members of adults with SMI)		2206 Alexandria Drive Lexington KY, 40504 PH: 859-230-3978	val@namilex.org
Ron O'Hair	State Employees		State Vocational Rehabilitation Agency Morehead KY, 40351 PH: 606-783-8615	ronniel.o'hair@ky.gov
Robin Osborne	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		215 Limestone Street Apt 434 Maysville KY, 41056 PH: 513-972-7221	redbird_12001@yahoo.com
Carmilla Ratliff	Others (Advocates who are not State employees or providers)		Kentucky Partnership for Families and Children Frankfort KY, 40601 PH: 502-875-1320	carmilla@kypartnership.org
Lauren Reynolds	Youth/adolescent representative (or member from an organization serving young people)		205 Prince Street Princeton KY, 42445 PH: 270-601-6707	jcr112@icloud.com
Jeanette Rheeder	State Employees		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
Rebecca Seavers	Parents of children with SED/SUD		8211 Candleglow Lane Louisville KY, 40214 PH: 502-338-0102	Rbecky502@gmail.com
Sherry Sexton	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		2328 Old Sand Road Owingsville KY, 40360 PH: 606-336-4106	sherry.l.sexton606@gmail.com
Steve Shannon	Providers		Kentucky Association of Regional Programs Lexington KY, 40515 PH: 859-272-6700	sshannon.karp@iglou.com
Matthew Smith	Family Members of Individuals in Recovery (to include family members of adults with SMI)		2980 Trailside Drive Lexington KY, 40511 PH: 859-388-0559	msmith@campbellandsmithlaw.com
Angela Sparrow	State Employees		State Medicaid Agency Frankfort KY, 40601 PH: 502-564-6890	angela.sparrow@ky.gov
Kathryn Tillett	State Employees		State Education Agency Frankfort KY, 40601 PH: 502-564-4970	kathryn.tillett@education.ky.gov
Sandy Weaver	Parents of children with SED/SUD		17782 Morehead Road Wallingford KY, 41093 PH: 606-207-6309	sandyweaver47@gmail.com
Tonia Wells	State Employees		State Agency on Aging Frankfort KY, 40601 PH: 502-330-6861	toniaa.wells@ky.gov
Connie White	State Employees		State Health Agency Frankfort KY, 40601 PH: 502-564-3970	connie.white@ky.gov
Russell Williams	State Employees		State Criminal Justice Agency LaGrange KY, 40032 PH: 502-222-9441	russell.williams@ky.gov

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Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2022 End Year: 2023

Type of Membership	Number	Percentage
Total Membership	**34**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	5	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	6	
Parents of children with SED/SUD*	5	
Vacancies (Individuals and Family Members)	2	
Others (Advocates who are not State employees or providers)	2	
Persons in recovery from or providing treatment for or advocating for SUD services	1	
Representatives from Federally Recognized Tribes	0	
Total Individuals in Recovery, Family Members & Others	**21**	**61.76%**
State Employees	11	
Providers	2	
Vacancies	0	
Total State Employees & Providers	**13**	**38.24%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	1	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	2	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**3**	
Youth/adolescent representative (or member from an organization serving young people)	2	

* 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?

The Planning Council will review the current application beginning the week of August 9, 2021, and will discuss in detail at the meeting on August 19, 2021. All recommendations will be collected. The Planning Council will have several venues to provide recommendations and/or comments including, email, phone, and website forms, in addition to verbal and written comment during the meeting on August 19, 2021. The application will post to the Department website prior to the August 19, 2021 Council meeting. All comments and recommendations will be taken into account prior to submission of the application.

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Footnotes:

Environmental Factors and Plan

22. 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
	If yes, provide URL: https://dbhdid.ky.gov/dbh/kbhpac-bg.aspx	
c)	Other (e.g. public service announcements, print media)	( ) Yes (•) No

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Footnotes:

The Kentucky Behavioral Health Planning and Advisory Council (BHPAC) reviews the annual Combined Behavioral Health Assessment and Plan during quarterly meetings in August and Behavioral Health Reports during November meetings. Department staff draft the plans and reports. Council members and the general public are encouraged to provide recommendations and feedback. Staff send a draft of the plan/report to individuals on the Planning Council listserv and place it as a "Hot Topic" on the Department's website homepage. The 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 is maintained on the Council's webpage. Council meetings provide an additional opportunity for individuals to provide verbal and/or written feedback. All Council members with a term (which includes Individuals in Recovery, Family Members, Parents, and Young Adults in Recovery) are offered lodging, travel reimbursement, childcare reimbursement, and a stipend to remove barriers to attendance. During SFY 2021, due to the pandemic, Council meetings were held virtually. All Council members with a term continued to receive stipends for attending meetings. Virtual Council meetings are recorded, with permission of members, and all verbal/written comments that are offered during the meetings are captured in the dialogue/recording function, and then transcribed into meeting minutes. During the August and November Council meetings, staff provide copies of the plan/report and a PowerPoint presentation of the drafted plan/report. Time is provided on the agenda for attendees to provide feedback and recommendations. Council members may provide verbal and/or written feedback. The Council creates a letter confirming the Council's participation and opportunity to review and provide feedback on the plan/report. At the Council meeting, staff encourage Council members and the public to continue to submit feedback/comments on any drafted, submitted or approved plan or report. Information is provided on how to submit comments via email, US Mail, or voicemail to the Block Grant State Planner (Melissa Runyon). Comments and recommendations are reviewed and incorporated into the documents as applicable.

Kentucky has state law requirements (KRS 45.350 – KRS 45.359) for block grant applications. Per KRS 45.351, the Department provides a draft of the plan to the Legislative Research Commission (the administrative and research arm of the General Assembly) for review by the Interim Joint Committee on Health, Welfare and Family Services. The public may go to the Committee's webpage for the meeting calendar, meeting materials and minutes. The calendar is also available via Twitter at @LRCTweetBot. Kentucky Educational Television (KET), the PBS affiliate, provides live legislative coverage of meetings via television and the KET Legislative App for iOS and Android.

Department of Behavioral Health, Developmental and Intellectual Disabilities
275 East Main Street, 4W-G
Frankfort, KY 40621

Mental Health and Substance Abuse Prevention and Treatment Block Grants
Comments on Application for 2022/2023

(1) A Behavioral Health Planning and Advisory Council meeting was held on August 19, 2021, in a virtual, zoom-based format, from 10:00am – 12:30pm Eastern Time. The Block Grant process and pending application were discussed at this meeting. Council Members had received hard copies of the draft block grant application to review prior to the meeting. Individuals were instructed to submit comments to Melissa.Runyon@ky.gov. Individuals who did not receive hard copies, and members of the public in attendance, were instructed to go to the Department website at https://dbhdid.ky.gov and review available written portions of the application and submit comments to Melissa.Runyon@ky.gov by August 31, 2021. Individuals were also welcomed to provide comments to Melissa Runyon via a Public Comment form on the website as well as to call her at 502-782-6238.

(2) DBHDID received the following comments:

1. Comment: Is the HIV and TB work for all people or only for people who use substance use disorder services?

   Response: DBHDID staff explained that Block Grant funds are used for individuals receiving substance use disorder services and those individuals are the ones referred to for HIV/TB in this application.

2. Comment: Once a grant is reviewed, is there a group that reviews the work that was done?

   Response: DBHDID staff explained the Block Grant reporting process, including the Behavioral Health Reports due December 1 of each year that are reviewed each November by the Planning Council. DBHDID staff also explained the Performance Indicators and other Block Grant deliverables that are embedded into contracts with providers, and the process for monitoring those contract deliverables.

3. Comment: What are HDI funds used for?

   Response: DBHDID staff explained that the University of Kentucky Human Development Institute provides training, coaching and fidelity monitoring for the evidence-based practice, Individual Placement and Support (IPS) Supported Employment.

4. Comment: This has been a great meeting with lots of important information shared.

   Response: DBHDID staff thanked the Council.

Environmental Factors and Plan

23. Syringe Services (SSP)

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction[1,2] on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the **Consolidated Appropriations Act**, 2018 (P.L. 115-141) signed by President Trump on March 23, 2018[3].

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers[4]. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs[5]: These documents can be found on the Hiv.gov website: **https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs**,

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy **https://www.hiv.gov/sites/default/files/hhs-ssp-guidance.pdf ,**

2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe ServicesPrograms,2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention **http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf,**

3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf ,**

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
  - Include proposed protocols, timeline for implementation, and overall budget
  - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

End Notes

[1] Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds ***only*** and is consistent with guidance issued by SAMHSA.

[2] Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C.§ 300x-31(a)(1)(F)) and 45 CFR § 96.135(a)(6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

[3] Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

[4] Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

[5]***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a **description of the elements of an SSP** that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

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Footnotes:

Kentucky's Syringe Exchange Programs are directed by the Department for Public Health and no Block Grant funds support these programs.

Environmental Factors and Plan

Syringe Services (SSP) Program Information-Table A

If the state is planning to expend funds from the COVID-19 award, please enter the total planned amount in the footnote section.

Syringe Services Program SSP Agency Name	Main Address of SSP	Planned Dollar Amount of SABG Funds Expended for SSP	SUD Treatment Provider (Yes or No)	# Of Locations (include mobile if any)	Narcan Provider (Yes or No)
No Data Available					

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Footnotes: