# Kentucky

## UNIFORM APPLICATION
## FY 2024/2025 Combined MHBGSUPTRS BG ApplicationBehavioral Health Assessment and Plan

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

OMB - Approved 04/19/2021 - Expires 04/30/2024
(generated on 08/29/2023 1.19.19 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 | 2024 |
| End Year | 2025 |

### State SAPT Unique Entity Identification

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|---|---|
| Unique Entity ID | LECJQDCLHVE5 |

### 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 Unique Entity Identification

| | |
|---|---|
| Unique Entity ID | LECJQDCLHVE5 |

### 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 | Katie |
| Last Name | Marks |
| Agency Name | Department for Behavioral Health, Development, and Intellectual Disabilities |
| Mailing Address | 275 East Main Street 4W-F |
| City | Frankfort |

| | |
|---|---|
| Zip Code | 40621 |
| Telephone | 502-782-6106 |
| Fax | 502-564-5478 |
| Email Address | katie.marks@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 | 8/29/2023 1:16:16 PM |
| Revision Date | 8/29/2023 1:17:10 PM |

### VI. Contact Person Responsible for Application Submission

| | |
|---|---|
| First Name | Melissa |
| Last Name | Runyon |
| Telephone | 502-782-6238 |
| Fax | |
| Email Address | Melissa.Runyon@ky.gov |

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

## State Information

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

**Fiscal Year 2024**

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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| Section 1947 | Nondiscrimination | **42 USC § 300x-57** |
| Section 1953 | Continuation of Certain Programs | **42 USC § 300x-63** |
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| 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).
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 [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 C. 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: 04/19/2021 Expires: 04/30/2024

**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, MD 20857

To Whom It May Concern:

As the Governor of the Commonwealth of Kentucky, for the duration of my tenure, I delegate authority to the current Cabinet Secretary, or anyone officially acting in this role in the instance of a vacancy, for all transactions required to administer the Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SABG).

Please contact Melissa Runyon, Substance Abuse Block Grant Planner within the Division of Behavioral Health, if you have any questions. You may reach Ms. Runyon electronically at Melissa.Runyon@ky.gov or by phone at (502) 782-6238

Sincerely,

Andy Beshear
Governor

## State Information

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

**Fiscal Year 2024**

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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.
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## 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 [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: KENTUCKY

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

Signature of CEO or Designee[1]: Eric C. Friedlander

Title: Cabinet Secretary

Date Signed: 7/11/2023

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: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

## State Information

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

**Fiscal Year 2024**

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** |
| Section 1920 | Crisis Services | **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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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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    1. Abide by the terms of the statement; and
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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.
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 Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Eric C. 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 your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**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, MD 20857

To Whom It May Concern:

As the Governor of the Commonwealth of Kentucky, for the duration of my tenure, I delegate authority to the current Cabinet Secretary, or anyone officially acting in this role in the instance of a vacancy, for all transactions required to administer the Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Block Grant (MHBG).

Please contact Melissa Runyon, Mental Health Block Grant Planner within the Division of Behavioral Health, if you have any questions. You may reach Ms. Runyon electronically at Melissa.Runyon@ky.gov or by phone at (502) 782-6238

Sincerely,

Andy Beshear
Governor

## State Information

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

**Fiscal Year 2024**

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** |
| Section 1920 | Crisis Services | **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).
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 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 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 [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.

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.)
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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.

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

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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)**

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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.

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.
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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 C Friedlander

Signature of CEO or Designee[1]: Eric C. Friedlander

Title: Cabinet Secretary

Date Signed: 7/11/2023

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: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

# DISCLOSURE OF LOBBYING ACTIVITIES

**Complete this form to disclose lobbying activities pursuant to 31 U.S.C.1352**

OMB Number: 4040-0013
Expiration Date: 02/28/2025

**1. * Type of Federal Action:**
- [ ] a. contract
- [x] b. grant
- [ ] c. cooperative agreement
- [ ] d. loan
- [ ] e. loan guarantee
- [ ] f. loan insurance

**2. * Status of Federal Action:**
- [ ] a. bid/offer/application
- [x] b. initial award
- [ ] c. post-award

**3. * Report Type:**
- [x] a. initial filing
- [ ] b. material change

**4. Name and Address of Reporting Entity:**

[x] Prime [ ] SubAwardee

*Name: KY ST Cabinet/Health/Family Services

*Street 1: 275 E. Main Street  Street 2:

*City: Frankfort  State: KY: Kentucky  Zip: 40601

Congressional District, if known:

**5. If Reporting Entity in No.4 is Subawardee, Enter Name and Address of Prime:**

**6. * Federal Department/Agency:**
Substance Abuse and Mental Health Servic

**7. * Federal Program Name/Description:**
2024-2025 MH-SUD Combined Block Grant

CFDA Number, *if applicable*:

**8. Federal Action Number, *if known:***

**9. Award Amount, *if known:***
$

**10. a. Name and Address of Lobbying Registrant:**

Prefix:  *First Name: NOT  Middle Name:

*Last Name: APPLICABLE  Suffix:

*Street 1:  Street 2:

*City:  State:  Zip:

**b. Individual Performing Services** (including address if different from No. 10a)

Prefix:  *First Name: NOT  Middle Name:

*Last Name: APPLICABLE  Suffix:

*Street 1:  Street 2:

*City:  State:  Zip:

**11.** Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when the transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

*Signature: Eric L. Friedlander

*Name: Prefix: Mr.  *First Name: Eric  Middle Name:

*Last Name: Friedlander  Suffix:

Title: Cabinet Secretary  Telephone No.:  Date: 8/27/2023

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Standard Form - LLL (Rev. 7-97)

# Kentucky BSCA Funding Plan 2024

**1. Describe any plans to utilize the BSCA supplemental funds to develop/enhance components of your state's mental health emergency preparedness and response plan that addresses behavioral health. Please include in your discussion how you plan to coordinate with other state and federal agencies (behavioral health, law enforcement, justice systems, local agencies, public health, etc.) to leverage crisis/mental health emergency related resources.**

In December 2021 and July 2022, two natural disasters (a tornado in Western Kentucky – DR-4630-KY- and a flood in Eastern Kentucky – DR-4663-KY), various community-level crisis situations (officer-involved accidents, fires, officer-involved shootings, etc.), in addition to continued impacts from COVID-19 have increased the need for improved mental health preparedness and response plans, especially for those with Serious Mental Illness and Severe Emotional Disturbance (SMI/SED) and Substance Use Disorders (SUD). In previous years, disaster and crisis responses were provided by the Kentucky Community Crisis Response Board/Team in connection with the Kentucky Emergency Management (KYEM) and supported by the Kentucky Department for Public Health (DPH). As a result of KYEM's stated lack of capacity to respond to the behavioral health needs of Kentucky residents effectively and efficiently during disasters and community crisis situations, the program was attached by Memorandum of Understanding to the Department for Behavioral Health, Developmental & Intellectual Disabilities (DBHDID) effective Aug. 1, 2022. This transfer occurred during one of the largest and most devastating floods and subsequent disaster response in Kentucky history. The Kentucky Community Crisis Response Team was officially moved by legislation to the Department for Behavioral Health, Developmental & Intellectual Disabilities in July 2023, providing the accountability, sustainability, and ongoing emergency preparedness funding from DPH to DBHDID.

Concurrently, the Kentucky Department for Behavioral Health, Developmental & Intellectual Disabilities (DBHDID) reorganized the Division of Behavioral Health into two separate divisions, Division of Mental Health (DMH) and Division of Substance Use Disorder (DSUD). As part of the reorganization and awareness of the needs related to community crisis and disaster response, a new branch was created in the DMH. The Promotion, Prevention and Preparedness Branch is led by a program manager with experience in community crisis response. The branch includes staff members who lead Kentucky's Community Crisis Response Team (KCCRT), which supports efforts related to Kentucky disasters, focusing on those with SMI/SED. In addition, this Branch includes staff members who lead community-based crisis programming across the state, including suicide prevention, intervention and postvention. The staff also supports mental health promotion, and the implementation of 988, allowing and encouraging efforts to leverage the different components to support and engage those with SMI and SED in crisis and disaster services.

Prior to the July flooding in Eastern Kentucky and DBHDID's reorganization to include disaster preparedness for behavioral health, the Department provided grant writing and project oversight and implementation of the state's Individual/Regular Services Program (ISP/RSP) and Disaster Case Management Program (DCMP) for Western Kentucky (DR-4630-KY). Additionally, DBHDID applied for and received the ISP/RSP and DCMP grants for the Eastern Kentucky floods (DR-4663-KY) after the Department's absorption of community crisis and disaster response responsibilities. Management of the Western Kentucky RSP continued throughout the life of that grant, ending in March 2023, with more than 23,000 people served. The Eastern Kentucky RSP, and Eastern and Western Kentucky DCMP are

under way. More than 40,000 people have been served by the Eastern Kentucky RSP since it began a little over a year ago. There are currently nearly 900 open and closed cases through the Disaster Case Management grants.

These two major disasters, coupled with the reorganization of the Division of Behavioral Health into two divisions (Mental Health and Substance Use Disorder) and the creation of a branch with specific focus on preparedness efforts, highlighted the need to not only update the state's behavioral health emergency preparedness and response plan, but also to rebuild the KCCRT and support community mental health agencies in increasing their ability to maintain continuity of operations in the event of a natural disaster or other community crisis.

To facilitate this process, BSCA allotment 1 funds are being utilized to engage a facilitator, who is supporting a statewide behavioral health landscape analysis and soliciting feedback for the update of the state's behavioral health emergency preparedness and response plan, which was last renewed in 2016. This process is under way. When complete, the plan will emphasize continued services during a crisis or disaster for those with SMI/SED/SUD. An initial convening will bring together community and state-level behavioral health providers and behavioral health advocacy organizations, including persons with lived experience, to solicit initial information. Additionally, the facilitator will support the convening of state emergency management agencies and other first responders, including law enforcement, to secure their buy-in and feedback on the development of an updated plan. Agencies and entities to be included in this level of the landscape analysis process are representatives from Kentucky Emergency Management, Federal Emergency Management Agency (FEMA), Voluntary Organizations Active in Disasters, KCCRT members, American Red Cross, and other disaster response entities. A third meeting will be held to convene state- and community-level agencies (Dept. for Public Health (DPH), local health departments, Department of Education (KDE), Family Resource and Youth Services Centers (FRYSC), Cabinet for Justice and Public Safety agency representatives, including those from the Department of Juvenile Justice and the Department of Corrections (DOC), the Administrative Office of the Courts, Department for Community Based Services (DCBS), Department for Aging and Independent Living (DAIL), and the Department for Medicaid Services (DMS)). Also included will be state-level agencies that support the delivery of behavioral health services, including substance use disorders, for youth and adults and include representation of those with lived experience (State Interagency Council for Services and Supports to Children and Transition Age Youth (SIAC), Behavioral Health Planning & Advisory Council Members, Kentucky Interagency for Suicide Prevention). Individual key stakeholder interviews will be conducted representing the various sectors involved. The information gleaned during the summits will then be used to craft an update to the behavioral health emergency preparedness and response plan that will guide future efforts in the event of natural disasters and community crisis responses. By convening all noted stakeholders, DBHDID will be able to leverage the variety of resources available to address behavioral health needs of residents of the Commonwealth in future disaster responses.

As many of these entities have been active, engaged and collaborative during the two major disasters that have occurred in Kentucky since December 2021, they have recent experiences that will be insightful in the crafting of the state's behavioral health emergency preparedness and response plan. Also, because of the recent disasters, these entities have been working collaboratively over the last year to provide behavioral health services, reducing the amount of time needed to build relationships and gain trust to begin this process. **As this process is in place with funds from Allotment #1 and are**

**sufficient for completion of the plan as well as dissemination, no additional funds will be requested from Allotment 2.**

**2. Describe any plans to utilize the BSCA supplemental funds to develop/enhance a state behavioral health team that coordinates, provides guidance, and gives direction in collaboration with state emergency management planners during a crisis (anticipated/unanticipated).**

DBHDID is committed to providing behavioral health support to community-level emergency management planners during a crisis and have demonstrated that commitment during the two recent disasters in the state – a tornado in Western Kentucky (DR-4630-KY) and a flood in Eastern Kentucky (Dr-4663-KY in Eastern Kentucky. DBHDID provided 24/7 staffing for both the tornado and flooding responses during the first 90 days of each disaster, demonstrating state leadership's commitment to disaster response in relation to behavioral health services. Engaging with emergency managers during community crises and disasters ensures that those with SMI/SED and SUD can maintain medication and treatment during a heightened time of stress and trauma.

With the reorganization of the Division of Behavioral Health and the inclusion of preparedness as a key component of a new branch's duties, DBHDID demonstrates further commitment to building relationships with emergency managers across the state to ensure that community behavioral health needs are identified and included in early response efforts, that planned efforts are in alignment with actual response parameters, and that staff participate in training exercises to simulate a response in a crisis or natural disaster and debriefs of those exercises to identify capacity gaps. Additionally, DBHDID will work with Kentucky Emergency Management to provide the Incident Command System/Emergency Operations Center training to key staff at the state level, as well as within the Community Mental Health Center system. This training is offered at no cost and no funds from the BSCA will be utilized for this initiative.

Two staff members (one on staff currently, one who will begin Sept. 16, 2023) are being tasked with supporting emergency planning. Additionally, the Department is actively recruiting internal staff members who will be part of a response team to coordinate KCCRT responses as well as to provide support during a crisis or disaster. Initially, participation will be on a volunteer basis (staff will be compensated for time spent) and those who are interested in coordinating a response will be able to do so. Eventually, all staff with relevant jobs will have community crisis and disaster response support as a task included in their job descriptions. No funds were utilized for these components in Allotment 1, as emergency preparedness funds and other Block Grant funds were leveraged to ensure that those with SMI and SED are served as a result of these services. **We are requesting that $100,000 in Allotment 2 be utilized for the hiring of a Program Coordinator to support these efforts, as responses and disasters are quickly exceeding the current capacity of the newly developed system. This individual will serve in a programmatic function, supporting coordination of disaster and KCCRT responses.**

As capacity is being enhanced through staffing, the Director of the Division of Mental Health is actively seeking learning opportunities and relationship building events to make connections with emergency managers at the community level. She attended the International Association of Emergency Management conference in Savannah, GA on Nov. 14-17 and interacted with approximately 10 of the state's emergency managers (EMs). During that time, she was able to discuss opportunities for utilization of the KCCRT, as well as plans to begin one-on-one and regional meetings with EMs. She also discussed the importance of Community Mental Health Centers being a visible entity within any crisis or

disaster response and highlighted the importance of the CMHCs being included in any community training exercise. She and the current staff member for disaster preparedness began 1:1 meetings with EMs after the holidays to build relationships and make connections between EMs and the CMHC providing services to their community. Additionally, the Director of the Division of Mental Health is an invited speaker at the IAEM Conference in Long Beach, California in early November, and will discuss lessons learned, as well as steps emergency managers can take to engage behavioral health providers in their community for preparedness efforts.

**Additionally, staff are reviewing opportunities to trainings that will support their efforts to address community crisis response and are requesting $10,000 from Allotment 2 for specific trainings to enhance their capacity to serve the community.**

Once the second staff member is hired, the Division Director, Program Manager, and the two preparedness staff will provide technical assistance to the CMHCs as they update their emergency operations plan (EOP) as well as their continuity of operations plan (COOP). The recommendations for the COOP plans will include the identification of a "buddy" CMHC who will provide support if a CMHC goes offline during a crisis or disaster. During the Eastern Kentucky flood in July, one of Kentucky's 14 CMHCs had 50 staff members lose their homes in the disaster. During the initial days of the flood, two other CMHCs in the state provided backup services to ensure that their clients received continuity of care during the time it took them to come back online. Additionally, their 988 calls were transferred to a backup center in the state for the month of August to provide assurances that residents of the region had access to immediate 988 responses. These types of strategies will be operationalized in the CMHCs EOP and COOP plans to ensure that those with SMI/SED continue to be served during an emergency.

Costs for these efforts are being implemented through state General Funds, Mental Health Block Grant, Substance Abuse Prevention and Treatment Block Grant, American Rescue Plan Act and the 2021 Coronavirus Response and Relief Supplemental Appropriations (CRRSA). **No Allotment 1 funds were utilized for this component. Kentucky is requesting $110,000 for a Program Coordinator and training participation for staff from Allotment 2.**

**3. Describe any plans to utilize the BSCA supplemental funds to develop/enhance a multidisciplinary mobile crisis team that can be deployed 24/7, anywhere in the state rapidly to address any mental health components during a crisis.**

The Kentucky Community Crisis Response Team (KCCRT) provides critical incident stress management (CISM) and peer support crisis response services from pre-incident training, acute crisis response, and post-incident support to emergency services personnel who have encountered a traumatic event. Traumatic events include line of duty deaths, multi-casualty incidents, use of deadly force, suicide of a first responder, events involving children, prolonged incidents, terrorism, and any other overwhelming event the community first responder determines impacts their readiness to deploy effectively. These services are provided at no cost to the community to prevent the destructive effects of emotional trauma, job-related stress, and to accelerate recovery from critical incidents before stress reactions can negatively impact an individual's career, health, and family. The KCCRT supports emergency services and emergency management personnel, school communities, business and industry and disaster survivors with volunteer peers.

As noted in Response 1, the DBHDID reorganization and the recent attachment by Memorandum of Understanding (MOU) moved the Kentucky Community Crisis Response Team from Kentucky Emergency Management to DBHDID. The KCCRT is currently administered through the Division of Mental Health, Promotion, Prevention and Preparedness Branch, which was developed during the reorganization of the department in July 2022. The MOU assigns the responsibilities of recruitment, retention, training, and response of the KCCRT to DBHDID.

However, because of lack of capacity to support the KCCRT over the last few years, the team has diminished in strength and capacity. More than 370 people are currently on the team roster, however, during recent requests to deploy for community crisis events, it has been difficult to elicit sufficient team-member commitment to adequately respond to all situations. Additionally, the number of response requests appears to be increasing. In the past, on average, the team deployed three times per month. Since October 2022, there have been 36 KCCRT non-disaster specific responses and more than 150 individuals served. Often the same three to five volunteers respond to multiple requests for support.

As a result of the low number of respondents for these crisis responses, as well as the fact that credentials have lapsed for many of the members, DBHDID has undertaken extensive recruitment, training and credentialling. Funds from the BSCA monies will be utilized to support this effort, in addition to funds from the Department for Public Health, which provides the base costs for support of the team, allowing DBHDID to leverage multiple funding streams to support the rebuilding of this initiative.

BSCA Allotment 1 funds are being utilized to provide access to multiple trainings that will allow recredentialing of those team members who wish to continue their efforts with KCCRT. DBHDID team members surveyed those who are on the roster to determine their interest in continuing involvement with KCCRT. BSC funds also allow for the recruitment of behavioral health providers, especially those who currently work within the state's Community Mental Health Center network. These individuals include Peer Support Specialists, Assertive Community Treatment teams, Targeted Case Managers, prevention staff, houseless outreach specialists, and others identified by the CMHCs to respond in a community crisis or natural disaster. Additionally, marketing will be utilized to solicit the involvement of first responders and emergency management professionals to round out the KCCRT's membership.

A training plan is being developed after a statewide training of all team members held in June. During this training, refreshers were provided for veteran team members. Additional trainings will be offered to those who join the team because of recruitment efforts. Trainings to be offered during the statewide training, as well as throughout the remainder of 2023 and early 2024, include:

- Assisting Individuals in Crisis
- Psychological First Aid
- Skills for Psychological Recovery
- Basic Eye Movement Desensitizing and Reprocessing (EMDR)
- Cognitive Processing Therapy (CPT)
- Cognitive Behavioral Interventions in Schools (CBITS)
- Trauma Effected Regulation: Guide for Education and Therapy (TARGET)
- Trauma Focused Cognitive Behavioral Therapy (plus consultation calls)

Additionally, DBHDID will develop a Psychological First Aid 201 that is specific for Kentucky disaster responses. **Allotment 1 funds for training equaled $87,150, while an additional $60,000 is being requested from Allotment 2 to continue the expansion of the KCCRT roster.**

DBHDID recently completed a two-year, $7 million Disaster Resilience Grant awarded by SAMHSA. During the implementation of that project, partner agencies implemented portable telehealth stations that were available to consumers who might not otherwise access behavioral health services. Additionally, during the last two disasters, there was a need for these types of services in the communities most effected by the tornadoes and the flooding. As a result, DBHDID is assembling 5 portable ATLAS (Accessing Telehealth through Local Area Stations) to be deployed to the Disaster Resource Centers (DRCs) in the event of a community disaster. DRCs are considered a one-stop shop for accessing multiple services that disaster survivors need (food, clothing, replacement driver's license, FEMA applications, etc.). By locating an ATLAS station in the DRC, survivors begin to normalize the emotions they may be feeling because of the disaster and recognize that accessing behavioral health services is equivalent to replacing clothing and furniture they may have lost during the disaster. **These ATLAS stations were covered by Allotment 1. No additional funds are requested for this purpose in Allotment 2.**

The portable ATLAS Stations will be equipped with a laptop with camera, hotspot which can be activated at the time of deployment, privacy desk screen, extension cord reel, tuff box for storage/transport, zoom license, folding table, and white noise machine. CMHCs will be advised of the stations and asked to provide support at the DRC to support clients and other impacted survivors in making the connection with their providers. DBHDID will also work with Kentucky Emergency Management and FEMA when they are setting up the DRCs to ensure there is a separate space, preferably with a door, to locate the ATLAS stations. This will help to ensure privacy for those who choose to access services in this manner.

DBHDID also administers the Olmstead Housing Initiative program and the PATH grant, which includes funds to support the unhoused in accessing permanent housing. DBHDID also provides a small amount of flexible state General Funds to CMHCs for adults with SMI, to assist with non-recurring case management/housing needs with no other source. Additionally, a Homeless Outreach Team has been in existence for 21 years in Jefferson County, Kentucky (urban). The team model used in Louisville features the use of Targeted Case Managers and Peer Support Specialists in addition to other Behavioral Health professionals. The model will be translated for additional areas (suburban, rural) and will be mobilized in support of returning disaster survivors to their home quicker, providing non-recurring resources to support housing and utility deposits, outstanding debts that prevent the individual from accessing housing, pest treatments, and essential home goods (beds, cookware, etc.). The resources will be available on a non-recurring basis up to a maximum allotment of $2,000 per household and will follow the requirements of the state's PATH grant Policies and Procedures. All other sources of funding for these types of payments will be accessed prior to utilizing the BSCA funds for this purpose. Several of the CMHCs have already established outreach teams who work with unhoused individuals. They are already providing other types of support during traumatic events and adding the housing assistance program to their program portfolio will enhance their acceptance as well as their effectiveness in time of crisis or natural disaster. **Allotment 1 included $32,242 in funds for this purpose. An additional $25,000 are designated in Allotment 2. SMI and SED program administrators will work in concert with Disaster Case Managers to identify needs of individuals who are identified as SMI/SED to determine if there are resources that can be provided to those impacted by the Floods and Tornadoes.**

**A total of $124,632 was approved for this section in Allotment 1. A total of $85,000 is requested from Allotment 2 for training and housing assistance.**

**4. Describe any plans to utilize the BSCA supplemental funds to develop/enhance crisis/mental health emergency services specifically for young adults, youth and children, or their families, including those with justice involvement and having SED/SMI. (Should build collaboration with child welfare organizations, schools, juvenile justice authorities, and children's BH services. Should develop multidisciplinary youth-serving state/regional advisory groups to provide input on infrastructure and policy development).**

The State Interagency Council for Services and Supports to Children and Transition-Aged Youth (SIAC) is a group consisting of 12 state agency representatives, a transition-age youth (TAY) with or at risk of a behavioral health need (SED/SUD), a parent of a child with a behavioral health need (SED/SUD), a member of a non-profit family organization, and the chair of the Subcommittee for Equity and Justice for All Youth of the Juvenile Justice Advisory Board. SIAC oversees 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. SIAC strives to design and implement a system of care that is community-based, youth- and family-driven, and culturally and linguistically responsive. SIAC conducts monthly meetings that are open to the public.

The Regional Interagency Councils (RIAC) operate as the locus of accountability for the system of care, providing a structure for coordination, planning and collaboration of services and supports at the local level to children, adolescents, and transition-age youth, and their families, especially those experiencing SED and SUD, to help them function better at home, in school, in the community and throughout life. There are 18 RIACs across the state. Each council is composed of members representing: CMHC, AOC, DCBS, FRYSC, Office of Vocational Rehabilitation, Kentucky Education Cooperatives/Special Education Services, Department of Juvenile Justice, local health departments, a parent of a child with BH needs who is or has been a consumer of system of care services and supports, and one TAY youth who has BH disorder who is receiving or has received a service to address MH, SU, or co-occurring. Collaboration is also encouraged with any other local public or private agency that provides services and supports to these populations.

Efforts to develop Kentucky's state behavioral health emergency and response plan will include members of the SIAC and RIAC, as noted in question 1. School and other youth-serving agencies will be educated on the steps needed to activate the team for a response at their location. Additionally, schools will have the opportunity to participate in the CBITS, TARGET, Psychological First Aid, Skills for Psychological recovery, and CPT trainings, as noted in Question 3, to increase their awareness of the trauma that can occur because of a community crisis or a natural disaster in their county. RIACs recently received disaster preparedness funds and are expected to work closely with the KCCRT moving forward. Regional Prevention Centers (RPCs) also provide technical assistance to schools related to early identification, referral and follow-up of youth who are at risk of serious psychological distress, suicide, or substance misuse and provide support to school in developing MOUs with providers to create care pathways for students in the event that they will be needed in the future.

RPCs have also received information on the "Handle With Care" program and have started promoting this program in their respective communities. Handle With Care involves a consistent relationship between first responders and emergency services personnel who alert the school that the child was

involved in a situation and may be at increased risk of trauma symptoms in the days and weeks to follow. Schools are trained to understand these symptoms and how to utilize trauma-informed best practices to support the student during the time following the crisis. These programs will be expanded over the next two years to support the many Kentucky children who have been exposed to trauma in the aftermath of the Western Kentucky tornadoes and the Eastern Kentucky flooding. The goal is to reduce the impact of these events on all children, but especially those who are identified as SED.

Additionally, as noted above, RIACs are established in 18 regions across the state and include mandated representation from each agency listed in the second paragraph of this response. Their charge is to implement a youth-and family-driven system of care to promote children's and transition-aged youth's social, emotional, and behavioral well-being where they live, learn, work, and play. With BSCA funds, the RIACs will expand their efforts to ensure more inclusive representation from the youth they serve; develop a Family Accountability, Intervention and Response (Fair) Team pilot to support youth at risk of or already being involved in the juvenile justice system; and, provide Peer Support Specialists to assist parents whose children have become involved with the child welfare system. BSCA funds in Allotment 1 were used to:

- Provide reimbursement to youth with lived behavioral health experience for service on RIACs and RIAC youth council to increase youth voice in the community level work of the council. This will ensure that youth needs are identified, especially in relation to community crisis and natural disasters. Youth will be paid a reimbursement for attendance at each meeting as a reimbursement of their time. They will also receive resources for any travel costs to support attendance as many of the communities are in rural areas and do not have mass transit. Funds are for 1 youth for each RIAC for 12 meetings in a year. TAY Program Administrators would provide technical assistance to the teams to ensure that the youth voice is utilized in effective and meaningful ways, and that they are not just tokenized members of the RIACs. **These funds have been doubled in Allotment 2 to increase the number of youth who can participate in these efforts. Allotment 1 totaled $11,760 while Kentucky requests approval for $24,000 from Allotment 2.**

- A FAIR Team pilot will be developed in two high need sites where there is a disproportionate number of youth involved in the juvenile justice system. The FAIR teams were created by SB 200, which went into effect in July 2015, with the intent to frontload services to youth in need and their families to help them get back on track in school and not end up in the court system. Each judicial circuit or district has or will establish FAIR teams, comprised of a multidisciplinary group whose primary role is to take a case-by-case look at each child referred to them by the Court Designated Worker. Together, they utilize an enhanced case management process to develop a plan of services for the children and their families. When youth and/or family needs are addressed through these types of services, they can be more effective and less costly than juvenile justice interventions. These teams will play a critical role in connecting youth and families to services and getting involved early when the situation can be addressed without court intervention.

  The two pilot locations will hire a behavioral health therapist to serve specifically on the team and support the youth and their families in accessing services. Additionally, a youth Peer

Support Specialist will be hired for two pilot site teams to specifically support the youth who are involved and increase the likelihood that they will have agency and voice in the decisions made affecting them. Youth will be connected to the youth Peer Support Specialist on their first offense to create an early diversion initiative away from the problem behaviors.

When not working directly with youth and families, these individuals will provide mental health promotion and prevention curricula in the schools, focused across the continuum (universal, selected and indicated).

**The approved Allotment 1 amount for this initiative was $210,000. Kentucky is requesting the same amount from Allotment 2 to continue this initiative.**

- One curricula that will be utilized by the FAIR Team pilots as well as the Regional Prevention Center prevention specialists is the Too Good for Violence (TGFV) program from the Mendez Foundation. Kentucky has been implementing Too Good for Drugs for about four years and more than 200 schools across the state have implemented.

  TGFV is structured in a similar manner, making it easier for schools to embed in their current programming schedule. It builds protection among students by providing opportunities for pro-social involvement, establishing positive norms, promoting bonding to pro-social peers, and increasing personal and social skills. It also mitigates risks associated with problem behaviors by addressing poor social skills, peer rejection, inappropriate social behaviors, and friends who engage in problem behaviors. Curricula is available for all age groups from elementary through high school levels.

  For this pilot project, DBHDID will partner with the New Vista Regional Prevention Center, located at one of the CMHCs, to provide training and technical assistance on the Too Good for Violence (TGFV) curriculum to a minimum of two schools in Fayette County. At least 12 teachers or other school personnel will be trained to implement the curriculum, and a minimum of five implementers will be trained as trainers. Approximately 2,400 students in four grades and at least two schools will complete the TGFV curriculum. **This project continues through Allotment 1. No additional funds are requested from Allotment 2.**

- Additionally, three pilot sites were identified and family Peer Support Specialists have been made available to support parents whose children have become involved in the child welfare system in accessing services in the community. These services might include Nurturing Parents, Kentucky Strengthening Ties and Empowering Parents (KSTEP), Self-Management and Recovery (SMART), Parent Cafes, and other parent focused programs and resources. **Approved funds for Allotment 1 were $80,000. Kentucky is requesting $90,000 to continue this effort with Allotment 2.**

- Plans also include providing support to Jefferson County (Louisville) to develop a strategic plan to address Youth Gun and Violence Prevention as one additional step to reduce the impacts of

violence in that community**. This initiative will continue utilizing the $10,000 approved in Allotment 1. No additional funds are requested from Allotment 2.**

Also, DBHDID is in the early stages of investigating the use of the Mobile Response and Stabilization System (MRSS) in Kentucky as the mobile crisis response system for youth and their families.

MRSS is a specific kind of mobile crisis service and stabilization service for children and youth with behavioral health conditions. It is an upstream intervention for children and youth that are beginning to experience an acute behavioral health issue and are in crisis. This evidence-based service can help prevent unnecessary emergency department utilization and hospitalization.

MRSS entails rapid deployment of a team of specialized child and adolescent trained staff that can provide interventions that build on natural support structures. Unlike a hospital emergency department or crisis center-based stabilization services, mobile crisis services are provided in children's natural environment, wherever the crisis occurs, whether that is the home, school, or other setting. The services should be available 24 hours a day, 7 days a week. After responding to the immediate crisis, the team provides stabilization services, including connections to follow-up services and supports and any needed treatment services.

MRSS will be delivered to young people under the age of 21, who is experiencing escalating emotional symptoms, behaviors, or traumatic circumstances that have impacted their ability to function within their family, living situation, school, or community. MRSS will be – once fully implemented - available to youth and families (birth, kinship, foster, guardianship, and adoptive).

BSCA funds will be utilized to support the initial installation of MRSS, to include:

- conducting an environmental scan to include relevant state policy, procedure, and scope of work/contracts documentation review;
- conducting a rapid statewide scan and gap assessment of the current crisis response models, programs, and services, including all child serving agencies and funding streams;
- conducting a system readiness assessment; and including the MRSS readiness indicators as part of the System Reform Support Instrument (SRSI), which will guide a whole system strategic plan process; and
- identifying recommendations for implementation.

DBHDID is leveraging 988 Supplemental funds with BSCA funds for this initiative. **Allotment 1 included the approval of $50,000 for this initiative. For Allotment 2, Kentucky is requesting $123,991 to continue this effort. This request meets the required 5% crisis set aside for crisis (minimum $41,650).**

DBHDID has developed a strong working relations with the Kentucky Administrative Office of the Courts and their Mental Health Judicial Commission. Through the commission, communities across the state are developing collaboratives with the express purpose of improving the systematic handling of individuals with SMI and SED who become involved with the judicial process. A statewide summit was held in May where action planning at the community level began. Town hall listening sessions are being held over the next month to complete a landscape analysis of needs across the state. Finally, each community will convene a local collaborative to develop its own action plan. The action plan will include the delivery of Mental Health First Aid and Youth Mental Health First Aid to justice involved partners to increase awareness of Serious Mental Illness, Severe Emotional Disabilities, Substance Use Disorders,

and other behavioral health conditions that may make individual vulnerable for increased involvement in the judicial system. **Kentucky is requesting $50,000 from Allotment 2 to organize and hold a training of trainings in MHFA/YMHFA in order to increase the capacity of DBHDID to ensure that each community has the ability to train key stakeholders in the evidence-based program.**

**Total approved Allotment 1 funds for this section were $411,760. Kentucky is requesting $497,991 from Allotment 2 to continue and expand the RIAC, FAIR Team, Child Welfare and MRSS initiatives, and to add the MHFA/YMHFA TOT for justice involved stakeholders.**

**5. Describe any plans to utilize the BSCA supplemental funds to develop/enhance services provided to communities that are affected by trauma and mass shootings/school violence. (Should provide BH crisis response trainings e.g., therapeutic crisis intervention and de-escalation training to agencies and providers identified in the statewide plan. Should also develop and provide specific, evidence-based services for those affected by MH emergency/crisis-related trauma, including mass shootings/school violence).**

While no funds from BSCA will go specifically toward developing and enhancing services to communities affected by trauma and mass shootings/school violence beyond those indicated in previous answers (KCCRT development and implementation, MRSS, support for SIAC/RIAC efforts, etc.), DBHDID will continue to leverage other funding sources to continue to address traumatic stress in schools and communities. DBHDID works with Ginny Sprang, PhD and her team at the University of Kentucky Traumatic Stress Innovations and Solution Center to ensure that schools and other youth-serving agencies have access to trainings and implementation support to implement trauma-informed best practices in the school settings. DBHDID has a cadre of Trauma Informed Care (TIC) trainers who offer a TIC training of trainers on a quarterly basis throughout the year to those working with youth across the state. These initiatives will continue and are supported by other funding streams.

The DBHDID Promotion, Prevention and Preparedness branch has recently completed a toolkit designed to help disaster survivors deal with anniversaries. Supporting Behavioral Health Wellness (Western Kentucky Natural Disaster Anniversary Kit for Schools) was released in November 2022 in advance of the one-year anniversary of the Dec. 10 and 11 tornadoes that ripped through Western Kentucky. And a similar toolkit for Eastern Kentucky was released in May 2023. Schools have been provided the toolkit and a webinar providing an overview and an understanding of the different components that will be provided in early December to all interested school partners. As part of a school preparedness initiative with DPH the anniversary kits will be digitally and physically distributed, and 12 virtual synchronous training will be held to disseminate the information included. Additionally, personalized technical assistance will be offered to schools to review current policies and procedures related to preparedness to reduce trauma-related impacts of traumatic situations.

Additionally, DBHDID was awarded a Garrett Lee Smith (GLS) Suicide Prevention grant in August 2022. This grant focuses its initial efforts in Western Kentucky and the anticipated increase in mental health needs following the disaster there. Research shows that behavioral health needs tend to increase about a year to 18 months after the event during the reconstruction phase of a disaster. It is at this time that survivors are still working through their grief and dealing with their new normal after the disaster. The project focuses on implementing an evidence-informed intervention entitled “CODE RED,” which is

described as a universal safety planning tool. All students in four pilot districts as well as middle and high school staff are receiving the intervention, which focuses on identifying specific people and activities that can support a person when in crisis. Local educational cooperatives will also be trained and will begin to disseminate the intervention in other school districts. Additionally, with the 988 Supplemental funding provided by SAMHSA from Bipartisan Safer Communities funding, this initiative will be expanded to include all educational cooperatives in the state to create streamlined access to mobile crisis services. Each delivery of CODE RED includes information related to 988 and how to access and utilize the Crisis and Suicide Lifeline. As part of a school preparedness effort with DPH, the DBHDID will be training up to 50 trainers in CODE RED and providing key items for them to utilize when implementing the trainings (wristbands and journals). Additionally, there will be mini-grants provided to 30 communities to utilize to roll out the trainings among youth serving agencies. By spreading CODE RED across the state, more individuals can be prepared for their worst days, which can span a multitude of disasters impacting the community.

Also, DBHDID currently administers the ISP/RSP grant for both Western and Eastern Kentucky as well as the DCMP grant in both areas. Crisis Counseling efforts will continue through mid-January in Western Kentucky and through mid-August in Eastern Kentucky. Disaster case management continues for approximately two years post disaster.

DBHDID has also served on the Department for Medicaid's Mobile Crisis Planning grant, providing insight and subject matter expertise around implementation of a new model of mobile crisis response system with a standardized triage system for calls coming into the state's 988 centers. CMHCs in 13 of 14 regions are accredited to answer 988 calls (one center provides coverage for the 14$^{th}$ region, giving the state 100% coverage for calls and nearly 100% coverage for backup calls). While many of the callers can have their crises resolved during the phone call, CMHCs serve as one provider of mobile crisis services in the state. Once implemented by DMS, mobile crisis services are expected to be available 24/7 to all residents in the state.

The Division of Mental Health will also begin the development of a statewide learning series focused on increasing the capacity of the behavioral health workforce related to addressing trauma from crisis and natural disaster survivors. While no BSCA funds are anticipated to be utilized for this process, it will grow from the training list identified in Question 3 of this plan. The goal will be to ensure that those providing services in communities that have been impacted by crisis and disasters have the capacity to provide appropriate trauma-informed care. Also included will be crisis intervention/de-escalation trainings to support providers in establishing initial rapport in a way that minimizes additional stress and trauma for survivors.

Additionally, DBHDID is working with DPH to implement a series of efforts focused on increased preparedness among school systems across the state. One of those efforts includes the establishment of a School Response Team under the umbrella of KCCRT. The team would deploy to a school system when that system experienced a disaster or death of a student or staff member. The team would be comprised of a mix of educational professionals and behavioral health professionals, who would be partnered with first responders as needed. The team would be available to support schools during traumatic events and deaths of students and staff with grief counseling, postvention (after a suicide) support, peer support, etc.

A second initiative focuses on training DBHDID staff and key state agency partners in in the implementation of the PREPaRE School Crisis Prevention and Intervention Training model to address school safety and crisis preparedness. As trainers, these team members can support schools not only as they experience a crisis, but also in preparing for future situations that may put the perception of school safety at risk.

**No funds for this section were requested from Allotment 1 and none are being requested from Allotment 2 as DBHID is leveraging other funding sources for these initiatives.**

**6. Describe any plans to utilize the BSCA supplemental funds to develop/enhance culturally and linguistically tailored messaging to provide information about behavioral health in a crisis/mental health emergency and/or to identify culturally/linguistically appropriate supports for diverse populations. (Should leverage relationships with Lifeline 988, statewide call centers, peer recovery organizations, faith-based organizations, warmlines, telehealth and provider mutual aid agreements to disseminate) Should ensure that electronic bed registries include information about the availability of culturally/linguistically accessible services.**

Through Kentucky's 988 Capacity grant, Kentucky is implementing a Bootcamp Translation project to ensure that all 988 marketing is accessible to Black, Indigenous and People of Color and those who identify as Lesbian, Gay, Bisexual, Transgender, etc. (LGBTQA+). The Bootcamp Translation project is an evidence-based multi-component method designed to create and disseminate marketing messages in a community. Boot Camp Translation employs a community-based participatory research approach to develop and test message and dissemination strategies for healthcare issues with topics chosen based on community and state priorities, and/or funding opportunities. With funding from Allocation 1 of the BSCA, the project will be expanded to create and disseminate marketing materials with a focus on those with SMI/SED in rural areas of Kentucky. The process includes multiple synchronous and asynchronous data collection points from those with lived experiences within the community priority population. The feedback will then be utilized to create messages, which will be tested to ensure they resonate with the target populations. Once approved, the messages will be disseminated in the target geographic regions of the state. **Allocation 1 included approval of $50,000 for the Bootcamp Translation Project focused on the SMI and SED in rural areas of Kentucky. No additional funding is requested in Allocation 2.**

Additionally, the state is committed to increasing access to those who are deaf and hard of hearing and is leveraging funding from other sources to increase interpreter services to ensure that this population has access to appropriate services and are informed of those services through marketing that is linguistically appropriate. **Allocation 2 includes $30,000 in funds to support access to trainings and services to individuals with SED/SMI who identify as deaf and hard of hearing.**

The state is also working with providers across the Commonwealth to support increased capacity to culturally meet the needs of the diverse peoples who are residents of Kentucky. Over the next year, we will implement an environmental scan to identify the diverse resources in the state, creating a map of resources to increase access. Areas on which we will focus are LBGTQ+ therapists, clinicians fluent in Spanish and ASL, and materials available in various languages as indicated by a region's needs. We will work with state licensure boards to start tracking this information. Workforce initiatives are also focused on creating workforce pipelines that support diverse candidates, increasing the likelihood that an individual will be able to locate a service provider who mirrors their diversity. While this process will take some time, significant baseline work is already occurring in this space.

In the 988 space, efforts are under way to create a bed registry and resource directory that reflects the cultural and linguistic characteristics of identified people groups (BIPOC, LGBTQ, rural, SMI/SED) as well as the geographic uniqueness that underscores each respective geographic region. (Appalachian, rural, farm community, suburban, urban). The FindHelpNowMentalHealthky.gov website will include a variety of resources, including available appointments and treatment beds, in each county in Kentucky's 120 counties. The resource directory/bed registry is linked to the FindHelpNowKy.gov site that has been in existence for several years and focused on resources for those experiencing substance use disorders. The co-branding with this site will allow increased exposure and will also allow the site to serve as a first line resource for 988 call centers, warm lines, and other crisis centers in the state.

Both the 988 Capacity grant and the GLS grant included training for providers to meet the needs of a diverse population. Efforts from these funding streams will be leveraged with the BSCA funds to increase access to cultural and linguistically competent services.

Additionally, DBHDID will leverage existing partnerships with advocacy organizations, including persons with lived experience, faith groups, peer support networks, 988 crisis centers, CMHCs, Certified Community Behavioral Health Clinics, and other behavioral health providers to ensure that messages are disseminated as broadly as possible to increase awareness of cultural and linguistic specific services. While message dissemination is important, it is also imperative that those providing services are trained as well to understand the nuances needed to serve the individual populations.

**Total requested from Allocation 2 for this area is $30,000 to support increased access for those with SMI/SED who are deaf and hard of hearing. Allocation 1 included approval of $50,000 for the Bootcamp Translation Project focused on those identified as SMI/SED in rural Kentucky.**

**7. What other mental health emergency/crisis behavioral health practices or activities does the state plan to develop or enhance using the BSCA supplemental funds? (Should include coordination with Medicaid and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) to ensure access to comprehensive mental health services for children and youth diagnosed with SED).**

Utilizing BSCA funds, DBHDID will partner with Mental Health America-Kentucky (MHA-KY), an advocacy organization, to implement a statewide learning series designed to increase workforce capacity to address Early Serious Mental Illness (ESMI) and First Episode Psychosis (FEP). Given the increased stress and trauma resulting from two major disasters in the state over the last year coupled with nearly three years of COVID-19 impacts, behavioral health needs have skyrocketed among Kentucky's children, transition age youth, and young adults. Identifying early their mental health issues will support them in returning to non-traumatic functioning without further progression of their symptoms. Kentucky currently has eight FEP teams across the state. The focus of this learning series will be to enhance the services these FEP teams provide, as well as to build awareness and education in areas of the state without current FEP teams. Early identification, through awareness and effective screening, with subsequent early and effective service delivery, can dramatically affect negative trajectories traditionally associated with early psychosis and serious mental illness. For that to happen, clinical providers and youth-serving agencies must be trained to recognize early issues related to mental health and to provide developmentally appropriate clinical care. The learning series will focus on supporting them to do just that.

The learning series will focus on global topics as well as provide skill building opportunities. The Early Assessment and Support Alliance (EASA), who are the national consultants for Kentucky's first episode psychosis (FEP) program, will be utilized in the overall development and in the delivery of some of the trainings. In addition, current FEP teams and statewide CMHC staff identified as key contacts for FEP will be utilized in the development of this learning series. Global topics will not have a participant limit and will be targeted statewide to providers who serve youth and young adults. Some sessions will include a focus on the implementation process to ensure more effective early implementation of these services as well. CMHC clinical staff serving this population will be encouraged to attend as DBHDID currently supports FEP sites and is building capacity to support additional sites with other funding sources. MHA-KY will coordinate and host the trainings and support marketing and registration efforts as well. Individuals with relevant lived experience, including some Peer Support Specialists will be involved with some of the learning series and will be compensated for their time and effort in creating/providing the training sessions if doing so is not included in their current employment. Allocation 1 included approval of $113,000 for the learning series as noted above.

**From Allocation 2, Kentucky is requesting $110,000 to support enhancement of the fidelity review process for the nine Coordinated Specialty Care (CSC) teams that exist in the state. Kentucky's state program staff have provided initial fidelity reviews for CSC teams, but the programming has grown, and additional implementation assistance is needed to adequately review, train and coach CSC teams across the state. This request meets the required 10% set aside for ESMI/FEP (minimum $83,299)**. The fidelity review process will ensure that FEP services follow the Coordinated Specialty Care evidence-based program, a recovery-oriented treatment program designed for individuals with first episode psychosis. The fidelity review process will support behavioral health providers in ensuring their service delivery meets the high standards that help ensure the best outcomes for these individuals and provide adequate coaching and trained based on the needs identified in the review process.

In addition to the funded components noted above, the state is working to expand Screening, Brief Intervention, and Referral to Treatment (SBIRT) into the suicide prevention space. SBIRT is a screening process used to identify, reduce, and prevent substance use disorder. Working with the Pacific Institute of Research and Education, Kentucky's Division of Substance Use Disorder has created a statewide initiative to inform and enhance usage of SBIRT through a train-the-trainers implementation approach. Plans for Kentucky are to include suicide prevention screenings into this process to impact identification and treatment and enhance suicide prevention efforts. The goal is that each time SBIRT is presented, that suicide screening is included. No BSCA funds will be utilized for this effort.

Additionally, EPSDT is an existing resource related to Medicaid where children can get services that are medically necessary not covered by other state Medicaid benefits. Within the state's Medicaid plan, EPSDT services may be preventive, diagnostic/treatment or rehabilitative and include a medical history and physical exam, screenings, immunizations, and health education. All services are available through the last day of the month in which an individual turns 21. However, clinical providers need guidance on how and when to bill Medicaid using the EPSDT code for behavioral health services. Efforts over the next two years will focus on educating providers on utilizing EPSDT for payment of these types of services for youth. No BSCA funds will be used for this effort.

DBHDID is also undertaking the development of a strategic plan that will guide the direction of the system of care work over the next 3-5 years. The Children's Behavioral Health Branch is working with

The Innovations Institute at the University of Connecticut to assess and identify system factors impacting how children, youth, young adults, and their family's access and experience the system to inform needed changes and additions to Kentucky's service array. The effort will begin with a mapping of care pathways for families and will include an environmental scan related to the systems policies, practices and programs related to mobile crisis response, as noted above. Multiple stakeholder input opportunities will be provided, and the results of the feedback and guidance will be utilized to develop the strategic plan. Once developed, the plan will be presented to those who provided feedback initially, and then to members of the entire system of care. No BSCA funds will be used for this effort.

Additionally, DBHDID will be evaluating the Fair Team and DCBS pilot projects, as well as training initiatives for effectiveness and long-lasting impact. Funds for this work were included and approved in Allocation 1. Not additional funds from Allocation 2 are requested.

**Total approved for this section in Allocation 1 was $196,599. Total requested for Allocation 2 is $110,000 for the fidelity review process enhancement.**

**The overall Allocation 2 request is $832,991, the BSCA allocation for Kentucky. See the budget below for a complete overview of these costs. The requests for Allocation 2 include 10% to meet the ESMI/FEP set aside requirements and 5% to meet the crisis set aside requirements.**

**2024-2025 Budget/Allocation 2 for Kentucky BSCA Funding Plan**

*No BSCA funds were expended in FY22

| | | **BSCA Allocation 1** | **BSCA Allocation 2** |
|---|---|---|---|
| | | **$832,991** | **$832,991** |
| **Question #** | **Project** | **Approved Funding Allocation 1** | **Requested Funding Allocation 2** |
| #1 - Develop/enhance components of your state's mental health emergency preparedness and response plan | Update state behavioral health emergency preparedness plan (three facilitated sessions with key stakeholders for input, development of plan and report back out to the communities) | **$50,000** | **$0** |
| | | **Total Question 1 Approved - $50,000** | **Total Question 1 Requested - $0** |
| #2 - Develop/enhance a state behavioral health team | Development of a branch to include preparedness; including crisis/disaster language in job descriptions, professional development/learning opportunities (crisis conference), relationship opportunities, hiring new staff member (program coordinator) | **$0 (costs leveraged from other funding streams)** | **$110,000** |
| | | **Total Question 2 Approved- $0** | **Total Question 2 Requested -$110,000** |

| | | | |
|---|---|---|---|
| #3 - Develop/enhance a multidisciplinary mobile crisis team | Recruitment, credentialing, training of Kentucky Community Crisis Response Team for responses during community crisis and natural disasters related to behavioral health needs/trainings to support crisis intervention/de-escalation | **$87,150** | **$60,000** |
| | Establish 5 portable Atlas Stations for use in DRC | **$5,240** | **$0** |
| | Housing assistance for those who are unhoused | **$32,242** | **$25,000** |
| | | **Total Question 3 Approved -$124,632** | **Total Question 3 Requested - $85,000** |
| #4 - Develop/enhance crisis/mental health emergency services specifically for young adults, youth and children, or their families, including those with justice involvement and having SED/SMI | Youth engagement in RIACS | **$11,760** | **$24000** |
| | Fair Team Pilot Project | **$210,000** | **$210,000** |
| | Too Good for Violence TOT and curriculum | **$50,000** | |
| | Child Welfare Pilot Project | **$80,000** | **$90,000** |
| | Jefferson County Youth Gun and Violence Prevention Strategic Plan | **$10,000** | |
| | MRSS – **5% recommended set aside for crisis** | **$50,000** | **$123,991** |
| | YMHFA/MHFA Trainings to justice involved staff (in concert with community action plan development) to support clients who are SMI/SED | **$0** | **$50,000** |
| | | **Total Question 4 Approved - $411,760** | **Total Question 4 Requested - $497,991** |
| #5 - Develop/enhance services provided to communities that are affected by trauma and mass shootings/school violence | Work with University of Kentucky Trauma Informed Care Institute, wellness toolkit, CODERED implementation, RSP implementation, crisis response, statewide learning series to support workforce capacity to address trauma (all costs are leveraged from other funding streams) | **$0** | **$0** |
| | | **Total Question 5 Approved - $0** | **Total Question 5 FY24 Requested- $0** |
| #6 - Develop/enhance culturally and linguistically tailored messaging | Utilize Bootcamp Translation Process to develop and implement culturally and linguistically appropriate | **$50,000** | **$0** |

| | | | |
|---|---|---|---|
| | messages for those with SMI/SED in rural areas. | | |
| | Increasing access to services for those with SMI/SED who are Deaf and Hard of Hearing, implement an environmental scan of diverse resources in the state, creation of bed registry/resource directory for 988 crisis call takers, trainings to support increased capacity to serve diverse populations, leveraging of existing populations for message dissemination | **$0** | **$30,000** |
| | | **Total Question 6 Approved - $50,000** | **Total Question 6 FY Requested- $30,000** |
| #7 - What other mental health emergency/crisis behavioral health practices or activities does the state plan to develop or enhance | ESMI/FEP Learning Series- 10% set aside for FEP/ESMI | **$113,300** | **$0** |
| | Expansion of SBIRT to include suicide prevention, provide technical assistance to providers on utilizing EPSDT funding from Medicaid to cover behavioral health services, development of a strategic plan for the Children's Behavioral Health System of Care (all costs are leveraged from other funding streams) | **$0** | **$0** |
| | Evaluation of FAIR Team Pilots, Child Welfare Pilots, training delivery | **$83,299** | **$0** |
| | Implement more robust Fidelity Review for Current Funded First Episode Psychosis Teams **(10% set Aside for FEP/ESMI)** | **$0** | **$110,000** |
| | | **Total Question 7 Approved- $196,599** | **Total Question 7 FY24 Requested- $110,000** |
| | | **Total Approved Allocation 1- $832,991** | **Total Requested Allocation 2 - $832,991** |

# 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

Not Applicable

Title

KY Cabinet For Health and Family Services

Organization

Behavioral Health, Developmental and Intellectual Disabilities

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

Not Applicable

## 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 (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD 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 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. In general, the overview should reflect the MHBG and SUPTRS BG criteria detailed in "Environmental Factors and Plan" section.

Further, in support of the **Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government**, SAMHSA is committed to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Therefore, the description should also include how these systems address the needs of underserved communities. Examples of system strengths might include long-standing interagency relationships, coordinated planning, training systems, and an active network of prevention coalitions. The lack of such strengths might be considered needs of the system, which should be discussed under Step 2. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

**Planning Steps**

The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) has a mission to promote health and well-being by facilitating recovery for people whose lives have been affected by mental illness and substance use; supporting people with intellectual or developmental disabilities; and building resilience for all. The DBHDID vision 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, natural and man-made all-hazards events, 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 current key priorities include:

- Increase access to behavioral health and intellectual disability services and supports;
- Improve quality of care in the behavioral health and intellectual disability service delivery system; and
- Reinforce a resilient, inclusive, and equitable organizational culture.

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 also working to enhance 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 this Cabinet:

Office of the Secretary (includes the Office of Data Analytics that manages Kentucky Health Information Exchange, Kentucky Health Benefit Exchange and Telehealth Services);

Office of the Ombudsman and Administrative Review;

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

Department for Public Health (Local and State Public Health Programs, Health Equity Branch, and Office for Children with Special Health Care Needs);

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

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

Department for Community-Based Services (Adult and Child Protection, Child Welfare, Public Assistance; Guardianship; Family Resource Centers);

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

Within DBHDID, there are five Divisions, including: Administration and Financial Management; Developmental and Intellectual Disabilities; Program Integrity; Substance Use Disorder; and Mental Health. As a result of a reorganization effective July 1, 2022, the previous Division of Behavioral Health was split into the Division of Substance Use Disorder and the Division of Mental Health. This reorganization occurred due to the expanded program growth in both of these areas, and both Divisions continue to work closely together.

The Division of Substance Use Disorder Director's Office includes a broad dashboard of subject matter expertise. The Division Director, an Assistant Director, and several cross division program leaders including a Federal Grants Specialist, a Communications lead, the lead for Co-occurring Disorders/Integrated Care, and an administrative assistant are all included in the Division office.

The Division of Mental Health Director's Office also includes a broad dashboard of subject matter expertise. The Division Director, an Assistant Director, several cross division program leaders, including Deaf and Hard of Hearing Services and Early Interventions for First Episode Psychosis are included in this Division. A Division budget specialist, a training program coordinator, and the block grant planner, as well as Behavioral Health Services Information System (BHSIS) staff are also included in this Division office.

DBHDID's Division of Substance Use Disorder is comprised of the Director's Office and two (2) Branches, including:

*Substance Use Prevention and Promotion Branch* – Oversees and supports programs across the state in the use of evidence-based prevention strategies to decrease risk factors and enhance protective factors and resilience, with the goal of reducing rates of substance use among residents of Kentucky. Prevention and Promotion Branch efforts focus on reducing or delaying the initiation of substances and related consequences.

*Adult Substance Abuse Treatment and Recovery Services Branch* – Oversees and supports the administration of 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 across the Commonwealth.

The Substance Use Disorder Division also includes staff supporting the *Kentucky Opioid Response Effort (KORE)*, which primarily focuses on the administration of State Opioid Response (SOR) funds made available by SAMHSA. KORE is guided by the Recovery-Oriented System of Care Framework and strives to expand access to a full continuum of high quality, evidence-based opioid prevention, treatment, recovery, and harm reduction services and supports in high-risk geographic areas of the state.

DBHDID's Division of Mental Health is comprised of the Director's Office and three (3) Branches, including:

*Mental Health Promotion, Prevention and Preparedness Branch* – A newly created Branch that oversees and supports programs across the state to serve residents experiencing the most significant aspects of their behavioral health issues. Efforts in this Branch include the statewide 988 initiative, statewide disaster preparedness, crisis services, problem gambling and statewide suicide prevention. This Branch also includes a position that oversees programming for adults with SMI who are involved with the justice system in Kentucky. This programming involves Crisis Intervention Team (CIT) training for law enforcement officers across the state, collaboration with a community mental health center in Lexington, Kentucky, to provide jail triage services across the state, and collaboration with a community mental health center in Louisville, Kentucky, to assist individuals with SMI who are serving out or being paroled from the Kentucky State Reformatory. In addition, this Branch includes oversight of the KCCRT (Kentucky Community Crisis Response Team), a multidisciplinary team that is deployed during state emergencies and disaster situations.

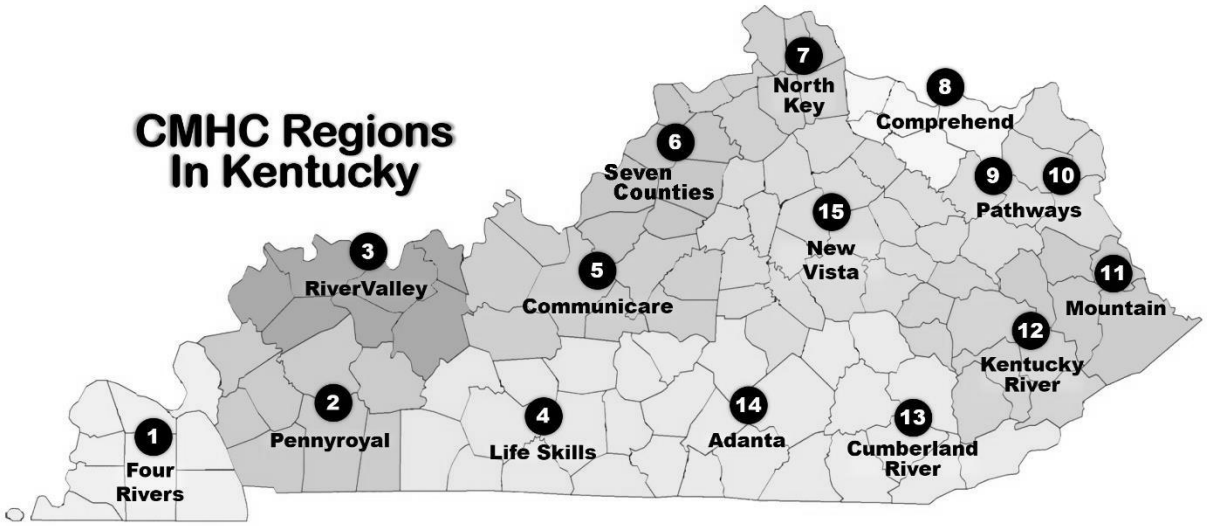
*Children's Behavioral Health and Recovery Services Branch* – Oversees the services and supports for children and youth across the state who have or are at-risk of developing behavioral health concerns and their families. This Branch works with community providers across the state to provide oversight and technical assistance regarding the delivery of a continuum of behavioral

health care that includes 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 services, youth and family peer support, early childhood mental health services, 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 treatment and recovery services and supports for adults with serious mental illness. Specific evidence-based practices include Assertive Community Treatment (ACT), Peer Support, Supported Employment, utilizing the Individual Placement and Support (IPS) model, and Permanent Supportive Housing. This Branch also includes statewide leadership for programming related to older adults with SMI, targeted case management for adults with SMI, liaisons to state psychiatric hospitals, Kentucky's Projects for Assistance in Transition from Homelessness (PATH) coordination, and Olmstead coordination for adults with SMI.

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 https://apps.legislature.ky.gov/law/statutes/chapter.aspx?id=38158 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 individuals with lived experience, 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 2023, four (4) of the Community Mental Health Centers merged to become the state's largest behavioral healthcare organization. Four Rivers Behavioral Health (Region 1), the Pennyroyal Center (Region 2), LifeSkills, Inc. (Region 4) and Communicare, Inc. (Region 5), became a merged entity with a total of more than 1700 employees, serving 35 counties in the western part of Kentucky. The combined entity continues to operate under their regional 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 use disorder 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 misuse, they also support some Secondary and Tertiary 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 services to populations of focus.

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 experience homelessness.

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 racially diverse state with less than 16% identifying as a race other than white. There are currently no federally designated tribes present within the state. Despite the lack of statewide racial diversity, DBHDID has begun to identify and implement strategies to enhance access to and engagement with culturally responsive behavioral health services among marginalized and minoritized populations.

The Commonwealth 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 2022 population estimates from the Kentucky State Data Center, Kentucky State Data Center – Empowering data users across the Commonwealth (louisville.edu) located at the University of Louisville, the population of Kentucky is 84% White alone, 8.3% Black or African American alone, 1.7% Asian alone, 2.3% Other, and 4.2% of Kentucky's population report as Hispanic. According to the Small Income and Poverty Estimates (SAIPE) data report SAIPE (census.gov), as of 2021, approximately 16% of Kentuckians were considered impoverished.

According to a report from the Appalachian Regional Commission, an organization created as a partnership between several federal agencies to focus on 423 counties across Appalachia, Kentucky has higher mortality rates than the nation for several physical health conditions. Deaths from heart disease are at a rate 45% higher than the national rate. Deaths from cancer are at a rate 35% higher than the national rate. Deaths from chronic obstructive pulmonary disease (COPD) are at a rate 88% higher than the national rate. Deaths from diabetes are at a rate 32% higher than the national rate. Kentucky Health Disparities and Bright Spots - Appalachian Regional Commission (arc.gov)

CHFS and DBHDID are committed to addressing health disparities, particularly mitigating adverse behavioral health outcomes exacerbated by the pandemic, racial inequity, and other areas of 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. 988 implementation and suicide prevention efforts are focused on Black, Indigenous, and People of Color (BIPOC); the LGBTQIA, farm connected, military connected and rural, all of whom have greater risks of dying by suicide if they don't receive appropriate behavioral health services. Providers are responsible for ensuring all staff participate in cultural responsiveness training regularly and that their policies and procedures do not discriminate but rather encourage inclusion of all citizens. Many CMHCs also focus on cultural responsiveness, 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 DBHDID. A Department-wide Racial Equity Action Plan was developed that focused on applying the principles of intersectionality and targeted universalism to the delivery of behavioral health services. 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 and 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 Spalding 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 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. Similar actions were taken to collect prevention data within the Prevention Data System.

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<br><br>Operation | ADC*<br><br>SFY 2018 | ADC*<br>SFY 2019 | ADC*<br>SFY 2020 | ADC*<br><br>SFY 2021 | ADC*<br>SFY 2022 |
|---|---|---|---|---|---|
| Western State Hospital/ Hopkinsville<br><br>State Operated | 115 | 112 | 107 | 112 | 116 |
| Central State Hospital/ Louisville<br><br>State Operated | 58 | 54 | 51 | 46 | 48 |
| Eastern State Hospital/Lexington Contracted | 127 | 102 | 104 | 111 | 119 |
| Appalachian Regional Hospital (ARH) Psychiatric Center/Hazard Contracted | 54 | 57 | 55 | 61 | 71 |
| **TOTAL** | **354** | **325** | **317** | **330** | **354** |

*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 for competency and criminal responsibility 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 2022 was 25 people.

Kentucky does not operate any state-funded inpatient facilities for children/youth under eighteen (18) years of age. There are currently 623 operational child psychiatric beds located in thirteen (13) hospitals that are geographically located in eight (8) of the fourteen (14) regions. *The 2021 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 % |
| 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% |
| 2020 | 13 | 714 | 613 | 9,720 | 127,074 | 347 | 13.04 | 48.63% |
| 2021 | 13 | 724 | 623 | 10,126 | 147,167 | 403 | 13.63 | 55.69% |

*Data Source: Office of Inspector General*
*https://www.chfs.ky.gov/agencies/os/oig/dcn/Pages/annualreports.aspx*

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 the behavioral health system in Kentucky has traditionally been underfunded and unbalanced between community based services and inpatient/institutional care. Over the last decade, progress has been made to balance more funding from the residential/facilities side of the equation to enhance the community-based service continuum and increase community access. In addition, Kentucky has traditionally been near the bottom of state spending as rankings have ranged from 44th to 47th in recent years. Due in part to the increase of federal funding over the last few years Kentucky now ranks approximately 32nd in state spending according to SAMHSA. Mental Health Spending By State Across the US - Drug Rehab Options (rehabs.com) This report also indicates that Kentucky provides services to 3.6% of the population and ranks lowest in the percentage of expenditures per client. However, costs associated with opioid use disorder and fatal overdose, such as costs of health care, substance use treatment, criminal justice, lost productivity, reduced quality of life, and the value of statistical life loss, are higher in Kentucky. According to a CDC report that highlighted the economic impact of the opioid crisis, Kentucky ranked fourth in highest economic impact. Kentucky's combined per-resident costs from opioid use disorder (OUD) and its resulting deaths in 2017 was $5,491, including $3,007 for OUD deaths. Total state costs were nearly $24.5 billion, about $11.7 billion for OUD and $13.4 billion for OUD deaths.

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 four (4%) 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. Over the past few years, the COVID 19 pandemic forced behavioral health providers to rethink their methods of delivering service. All fourteen (14) CMHCs delivered services via telehealth during the pandemic, and several CMHCs developed creative ways to continue to safely provide in-person services as necessary and preferred. Many providers continue to provide hybrid service packages. The effects of the pandemic are still being analyzed for behavioral health care in Kentucky. Still, the CMHCs remain a strong and viable safety net provider 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 managed care organizations (MCOs) to provide services to Kentucky's Medicaid enrollees. Behavioral health was included in the managed care model, which extended to all of Kentucky's 120 counties. A new procurement process was initiated during SFY 2020 and as of SFY 2021, MCO contracts for six (6) managed care entities have been awarded. These MCOs include Aetna, Anthem, Humana, Molina, United Healthcare, and Wellcare.

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 % of the federal poverty line to enroll in an insurance plan. Kentucky created Kynect, an online health insurance marketplace to allow citizens to learn about and select health insurance plans, as well as access other public assistance benefits. This system allows Medicaid eligible individuals to sign up for coverage through the marketplace. Medicaid coverage for the expansion population began Jan. 1, 2014. By July 2022, total Medicaid/CHIP enrollment in Kentucky was up 172%, to more than 1.6 million people. That amounted to nearly 37% of all Kentucky residents covered by Medicaid. Nationwide, Medicaid enrollment was up 54% as of early 2022, and Kentucky's 154% increase at that point was by far the highest in the nation. The growth was driven by Medicaid expansion as well as the COVID 19 pandemic (including the Families First Coronavirus Response Act, which paused Medicaid eligibility redeterminations throughout the COVID 19 public health emergency). According to the Kentucky Department for Medicaid Services, as of April 2023, there are 1,733,465 Kentuckians enrolled in Medicaid and of those 663,176 are enrolled as part of Medicaid expansion.

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 clinical, 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 Clinical Alcohol and Drug Counselors. In addition, Registered Peer Support Specialist (for SUD services) was created as a new provider type by the Kentucky Board of Alcohol and Drug Counselors. This is in addition to Certified Peer Support Specialists with lived experience in substance use disorders who are certified as providers to provide services through various agencies. 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 Federal Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Primary Care Providers are developing new or expanded behavioral health services. Furthermore, Kentucky has identified four (4) CMHCs to participate in a Certified Community Behavioral Health Clinic (CCBHC) demonstration to show effectiveness in the provision of comprehensive quality care reimbursed through a prospective rate based on historical costs. (Two additional CMHCs received separate SAMHSA CCBHC grants). CCBHCs are required to provide the following comprehensive scope of services: crisis mental health services; screening; assessment and diagnosis; outpatient mental health and SUD services; person centered treatment planning; primary care screening and monitoring of key health indicators; targeted case management; psychiatric rehabilitation; peer support, including family and youth; and community-based mental health care for members of the armed forces and veterans. 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 overdose crisis in Kentucky. According to the Office of Drug Control Policy's 2021 Overdose Fatality Report, more than 2,250 Kentuckians died from drug overdose in 2021 – an increase of 14.5% from the 1,965 resident deaths in 2020. Fentanyl was identified in 72.8% of those overdose deaths. While the COVID 19 pandemic has been a contributing factor, the increased presence of highly potent synthetic fentanyl within the drug supply is a significant driver in the rise of overdoses. Synthetic fentanyl is now found in a variety of substances including heroin, pressed pills, methamphetamine, cocaine, and benzodiazepines. As such, Kentucky continues to enhance access and availability of evidence-based practices, including overdose reversal medications, medications for opioid use disorder (MOUD), harm reduction strategies, strategies that support families with a loved one suffering from addiction, and public education, awareness. and stigma

reduction. Such interventions are effective at reducing risk of overdose, improving treatment retention, and increasing the likelihood of long term recovery. The Kentucky Opioid Response Effort (KORE) is housed within DBHDID, and with the provision of SAMHSA's State Opioid Response funding, KORE supports the implementation of high quality, evidence-based opioid and stimulant use prevention, treatment and recovery support programs and initiatives throughout the Commonwealth. All age groups have been affected by this epidemic and concerted efforts to support children and youth, including substance exposed infants, and children placed in out-of-home care due to substance use, overdose, or incarceration of parents, is a top priority. Additional funding has been made available to the Kentucky Office of Drug Control Policy to address heroin and opioid addition through Senate Bill 192. A portion of those funds are contracted to DBHDID for the provision of services, including services for substance exposed infants and their parents.

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, parents, and family members, including the National Alliance on Mental Illness (NAMI) (Lexington and Louisville chapters), Kentucky Partnerships for Children and Families (KPFC), People Advocating Recovery (PAR), Young People in Recovery (YPR), Mental Health America of Kentucky (MHA-KY), and Bridgehaven (a nationally recognized therapeutic rehabilitation program for adults with SMI located in Louisville, KY), as well as other organizations dedicated to supporting recovery experiences for individuals. 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.

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 23 hour crisis beds, some have mobile crisis units that travel for outreach, and others have robust walk-in services as needed. With the effects of the pandemic, statewide behavioral health crisis services have become even more relevant. As of July of 2022, Kentucky began implementation of the 988 initiative, and thirteen (13) of the fourteen (14) CMHCs participate in that effort. In addition, during a reorganization effective July of 2022, the KCCRT (Kentucky Community Crisis Response Team) oversight and operation was moved to the Division of Mental Health. This Team provides organized, rapid and effective response in the aftermath of a crisis event. The KCCRT (Kentucky Community Crisis Response Team), is Kentucky's crisis response mechanism with regards to emergency and disaster situations, and which is comprised of a broad array of professional personnel including law enforcement, first responders, mental health professionals, public health workers, and many more. As a result of this reorganization, DBHDID also became the designated agency to apply for and administer federal behavioral health related disaster funds in the instance of a declared disaster with individual assistance designation. In light of Kentucky's 2021 tornado outbreak in Western Kentucky and 2022 1,000-year flooding in Eastern Kentucky, the Department has applied for and administered more than $10 million in Crisis Counseling Program and Disaster

Case Management funds from the Federal Emergency Management Agency in partnership with SAMHSA.

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 staffing used to provide direct behavioral health services. This data (including service data for mental health, substance use and developmental/intellectual disabilities) 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, including SMHA/SSA Profiles and surveys. 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 for behavioral health, including 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 (EHR); 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.

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 use disorders among the residents of the Commonwealth. Information is collected on:

- Implementation of strategies based on community needs assessment and selected for that specific population's needs
- Delivery of prevention services, including collaborations with schools, businesses, government agencies and individuals, policy changes, and curricula implementation,
- Use of the six CSAP strategies of information dissemination, education, alternative activities, community based processes, environmental, and problem identification, and referral strategies
- Identification of the demographic composition of population served, including number served, age, gender, race, ethnicity, and whether part of high-risk population.

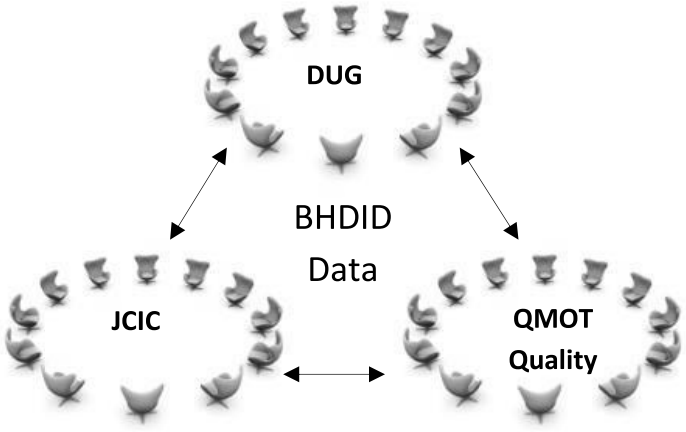
The Prevention Data System is maintained by Substance Use Prevention and Promotion Branch staff. Reports are developed in conjunction with Regional Prevention Center (RPC) Directors and other special projects of the Branch. Reports are reviewed monthly by Branch staff collaboratively with the RPC staff.

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 use disorder prevention efforts on a monthly basis. The PDS data is used in the compiling of Kentucky's annual SAPT Block Grant Report. The system is also used for the collection of mental health promotion and prevention and suicide prevention efforts in the state.

The Kentucky Incentives for Prevention (KIP) survey is the primary data source used to set block grant priorities and track outcomes for Substance Use Disorder Prevention. The KIP survey is implemented biannually in a majority of Kentucky's 172 school districts, and provides data on substance use, risk and protective factors, mental health, suicide, and school safety on the county or school district level for grades 6,8,10, and 12. It is a population-level survey, meaning that all students present on the dates of administration in the identified grade levels would participate, compared to a randomized sample survey. This type of administration provides a broader applicability for Kentucky's diverse culture pockets and ensures that local school districts have access to their data for grant applications as well as identifying local needs and relevant strategies.

The KIP survey is modeled after the National Monitoring the Future Survey. During the last survey period (2021), 93,812 students from 127 school districts across the state participated in the KIP Survey. This new survey represents a new cohort of students. Prior to the COVID 19 pandemic the KIP Survey was implemented in even numbered years. However, due to the pandemic, the survey could not be administered in 2020. Recently, as a result of Kentucky legislation which required active versus passive consent for participation, the 2023 administration was paused to ensure that processes could be developed that align with the state statute's requirement for parental consent for all health and wellbeing surveys administered in Kentucky schools. The next administration is now, tentatively, planned for the fall of 2024. Kentucky also 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 (YRBSS). The most recent administration of the YRBS in Kentucky occurred early in 2023 prior to the enactment of the consent legislation. 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 and mental health 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 (14) 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 systems, as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system, including for other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps. The state's priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Use Disorder Treatment Services (N-SSATS), the Behavioral Health Barometer, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the **Uniform Reporting System** (URS), and state data. 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 with current Partnership for Success discretionary grants are required to have an active SEOW.

This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the MHBG and SUPTRS BG priority populations, as well as a discussion of the unmet service needs and critical gaps in the current system for underserved communities, as defined under **EO 13985**. States are encouraged to refer to the **IOM reports**, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* and ***The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding***[1] in developing this narrative.

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**Footnotes:**

**Planning Steps**

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

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. DBHDID and stakeholders have participated in several activities regarding needs and comprehensive data to drive planning efforts, including:

- Analyzed data reports for performance indicators and deliverables in provider contracts;
- Communicated data trends to providers in a variety of forums and formats;
- Review of the Children and Youth System of Care components and the initiation of the development of a strategic plan, with a focus on prevention as well as acute care, especially for children, youth and families involved in the child welfare and justice systems;
- Administered the 2021 Kentucky Incentives for Prevention survey with the addition of questions related to the impact of COVID-19, social injustice and racial equity, and protective factors such as trusted adult, sleep, and involvement in extracurricular activities.
- Completed readiness assessments and other assessments for a variety of competitive grant applications;
- Analyzed Oxford House data regarding accessibility completed in SFY 2021;
- Conducted training surveys regarding technical assistance needs;
- Completed statewide Certified Community Behavioral Health Centers (CCBHC) needs assessment in May of 2021 and ongoing review of claims data;
- Received technical assistance from multiple consultants;
- Completed strategic planning process for the Statewide Interagency Council (SIAC) created November 2020;
- Reviewed priorities and supporting research from federal experts and funders, including SAMHSA.
- Completed strategic planning process for the Department and multiple branches, including key stakeholder interviews and staffing focus groups;
- Implemented needs assessment process for primary prevention in 1/3 of Kentucky counties; remainder of counties will be assessed to include review of data and trends, key stakeholder interviews, readiness reviews, and focus groups of youth and other focus populations;
- Conducted Bootcamp Translation project related to marketing of 988; included focus group discussions with individuals who identify as LGBTQ or people of color to ensure that marketing messages can be heard by individuals in historically underserved communities;
- Conducted correlational review of data related to suicidal behavior and self-harm with substance use and substance use disorders;
- Conducted correlational analysis of data related to suicides among those served by Community Mental Health Centers;
- Reviewed Kentucky's Point-In-Time Count of Homelessness to target services to reduce risk of individuals of houselessness.

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

- Impacts of the pandemic on behavioral health in Kentucky and changes in provision of behavioral health care across the state;
- Impacts of systemic social injustice and the resulting unrest resulting from the deaths of Breonna Taylor (in Louisville) and other individuals of color across the United States;
- Impacts of state and federal legislation related to treatment and prevention services for individuals who identify as LGBTQIA+;
- Implementation of 988 and the new crisis set aside;
- Addition of funding and allocation requirements for the Coronavirus Response and Relief Supplement Appropriations Act (CRRA), American Rescue Plan Act (ARPA), and Bipartisan Safer Communities Act (BSCA) funding from SAMHSA;
- Expanded regular Block Grant funding;
- Continued and increased federal funding for the Kentucky Opioid Response Effort (KORE) including the State Opioid Response Grant (SOR-II), which resulted in reorganization efforts within DBHDID;
- Completion of the Second Amended Settlement Agreement (signed October 2019) and negotiation of the Third Amended Settlement Agreement (effective July 2023) between the Cabinet for Health and Family Services and Kentucky Protection and Advocacy, requiring the transition of adults with SMI from Personal Care Homes into community settings of their choice;
- Continued workforce challenges with recruitment and retention, which has always been a barrier for the delivery of prevention, treatment and recovery services for rural Kentucky, but which has increased statewide since the pandemic;
- 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.;
- Continued implementation of full performance-based contracting by DBHDID;
- 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;
- Continued promulgation of new/amended regulations, in collaboration with various state agencies, as well as continued new legislative actions, sometimes unfunded mandates;
- 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;
- Underfunded state pension system and the increased retirement contributions required by the majority of the CMHCs;
- Service Members, Veterans, and their Families (SMVF) with behavioral health needs; and
- The recent welcomed addition of priorities identified by the Kentucky Behavioral Health Planning and Advisory Council (BHPAC), which include the following, as discussed at the Finance and Data Committee meeting of the BHPAC in May of 2022:

- Housing, Jail Triage, and Reentry Services for offenders with behavioral health issues
- Emergency Behavioral Health Clinics
- Workforce development
- Services for older adults
- Coordinated prevention efforts
- Health promotion (include medication education)
- Enhanced warmline services
- Specialized services for LGBTQIA+
- Eating Disorder Services
- Peer Support
- State-run inpatient adolescent psychiatric hospital
- CMHC staff training

The following DBHDID key priorities were identified by DBHDID leadership in 2022:

- Increase access to behavioral health and intellectual disability services and supports, especially for Kentucky residents in acute crisis situations.
- Improve quality of care in the behavioral health and intellectual disability service delivery system.
- Reinforce a resilient, inclusive, and equitable organizational culture.

In addition, the following DBHDID goals were identified by DBHDID leadership in 2022:

- Assist in the modernization of Medicaid services to increase the quality of benefit services.
- Develop an infrastructure that ensures the use of research-based knowledge, both internally and externally, to enhance the continuum of care through evidence-based programs, practices, and policies.
- Empower Kentuckians regardless of disability, age, race, sexual orientation, or gender to lead lives of dignity and hope in accordance with their individual choices.
- Ensure responsible fiscal and programmatic oversight and accountability.
- Promote quality outcomes through best practices and data-driven decisions.
- Promote resilience, recovery, and inclusion in community living.
- Provide education and resources to all stakeholders to create and sustain an infrastructure base for evidence-based practices.
- Provide mental health and substance use prevention services across the lifespan.

**Kentucky Priority Populations**

As required in the above instructions, the following provides the information for each of the priority populations: Prevalence Data; Unmet Needs and Critical Service Gaps; Addressing the Need; and Data Sources. Additional detail about the available programs and activities to address identified needs of the various populations is located in other areas of this application as required by the block grant application instructions, particularly in the *Environmental Factors and Plan* where the federal criterion for both block grants are addressed fully in narrative numbers 8, 9 and 10.

## Adults with SMI

***Prevalence Data for this population:***
Using 2020 census data and the state's prevalence rate estimate of 2.6 percent, CMHCs are aware of the number of adults with SMI in potential need of services. The CMHCs 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 Population in Kentucky. Census (2020) – 3,045,985
Estimated Number of Adults with SMI (2.6% of Kentucky's adult population) – 79,196
Kentucky SMI Adults Served by CMHCs in SFY 2022 – 44,178 or 56% (of the 2.6% estimated SMI population)

Trend data shows that the CMHCs served more adults with SMI in SFY 2022 than prior to the pandemic. The total adults with SMI served in SFY 2019 was 43,660. The COVID 19 pandemic appeared to increase the need for community-based mental health services for individuals with high acuity, including those with SMI.

***Unmet Needs and Critical Service Gaps:***
Several unmet needs exist for individuals with SMI living in Kentucky. Housing needs are paramount for this population, and multi-faceted. There is a lack of safe, affordable housing in the community for individuals with SMI, especially in rural areas. In addition, there is a need for greater availability of differing levels of community housing support.

Kentucky owns/operates four (4) state psychiatric hospitals across the state. There are also many personal care homes in the state, with eligibility criteria that are less than nursing home level of care, but much more restrictive than community housing. An additional level of community residential housing care was created, for individuals with SMI who did not need personal care home level of care but needed more intense supports and supervision to live in the community. This level of housing allows for up to three (3) adults with SMI to have their own space in a community house or apartment, but there is 24/7 staffed supervision and available behavioral health services around the clock. There remains limited availability of these community residential support services to assist individuals with SMI with complex and intensive service needs. In addition, although CMHCs are required to have housing specialists and provide supportive housing services, the needs continue to outweigh the amount of available support. DBHDID does also contract with additional housing providers for adults with SMI, in the most populated areas. In addition, utilization of available crisis stabilization units and other crisis support services needs to be enhanced as alternatives to psychiatric hospitalization.

The Cabinet for Health and Family Services (CHFS) has been involved in a Settlement Agreement with Kentucky Protection and Advocacy since 2013, focusing on transitioning adults with SMI living in personal care homes to communities of their choice. As a result of this agreement, additional funding enhanced the community-based continuum of care for adults with SMI, added such services as Assertive Community Treatment (ACT), Individual Placement and Support (IPS) Supported Employment, Permanent Supportive Housing and Peer Support, as well as Permanent Supportive Housing. Every CMHC, which is the safety net provider for this population, has at

least one (1) ACT team, and is able to provide each of these evidence-based practices to those in their communities. However, the fidelity to these models and access to these services is not consistent across the state. In addition, although each CMHC has this service, this service is not always available in all counties within a region.

The table below outline service data over the last three (3) fiscal years. These numbers represent only adults with SMI served and only served through the CMHCs.

| Service | SFY 2022 | SFY 2021 | SFY 2020 |
|---|---|---|---|
| **Peer Support** | 3,372 (7.6%) | 3,656 (8.4%) | 3,216 (7.4%) |
| **Supported Employment** | 448 (1%) | 509 (1.1%) | 666 (1.5%) |

This data demonstrates that access rates are not optimal as 44,178 adults with SMI, representing 56% of the estimated SMI population were served by the CMHCs, but only a small percentage of these individuals received these evidence-based practices. The pandemic made access more difficult and, in some cases, impossible.

The table below outlines CMHC service data for the number of adults with SMI receiving targeted case management services per fiscal year.

| Service | SFY 2022 | | SFY 2021 | | SFY 2020 | |
|---|---|---|---|---|---|---|
| **Targeted Case Management** | 5,847 | 7.38% | 5,795 | 7.32% | 5,950 | 6.9% |

The number of individuals with SMI who received targeted case management (TCM) services per fiscal year shows a steady increase of the last three (3) years. However, access remains an issue since 56% of total estimated number of adults with SMI were served by CMHCs but only 7.38% of them received TCM in SFY 2022. TCM services are regarded as critical for this population and sometimes necessary in order to assist with identification of and linkage to other needed services and supports such as ACT, supported employment, peer support and other treatment services.

For Assertive Community Treatment (ACT), 602 or 1.3% of individuals with SMI were served during SFY 2022.

Kentucky Division of Mental Health (DMH) contracts with the National Alliance on Mental Illness, Lexington (NAMI-Lex) to implement the evidence-based Consumer Operated Services Program (COSP) peer support programming across the state. NAMI Lex provides annual fidelity reviews for each COSP and gathers information regarding the six (6) primary areas for consultation and coaching needs.

- Structure
- Environment
- Belief Systems

- Peer Support
- Education
- Advocacy

Some needs identified for this programming include staff turnover and retention, understanding the purpose of each fidelity domain and how it translates into evidence-based practice, and knowledge of recovery principles and how to operationalize recovery principles into program practices. The pandemic drastically affected staffing in these programs, as each program is staffed with adult peer support specialists. In addition, Kentucky experienced a national disaster during December of 2021 when a tornado destroyed much of western Kentucky. One of the COSP programs in that area, although not physically destroyed, never recovered from this disaster, and was closed.

***Addressing the Need:***
DBHDID continues work toward full implementation of community-based, evidence-based practices for adults with SMI in Kentucky. DBHDID works collaboratively with Managed Care Organizations (MCOs) and Kentucky Department for Medicaid Services on many issues, including a legislatively driven 1915i waiver for some previously non-reimbursed services for adults with SMI.

The Division of Mental Health (DMH) continues to provide training and technical assistance around ACT, including team building and engagement, in addition to fidelity monitoring. A DMH program administrator is assigned to work solely on ACT services. A separate implementation team, consisting of the DMH IPS program administrator, Kentucky Office of Vocational Rehabilitation, and specific fidelity reviewers/ trainers/coaches contracted through the University of Kentucky, oversees and guides all aspects of the delivery of IPS Supported Employment services. The fidelity scores for ACT and IPS Supported Employment have ranged from exemplary to fair, with some areas of the state doing very well and others needing much support. The pandemic interrupted DBHDID fidelity processes, and with staff attrition in the field, implementation efforts suffered a setback. Some fidelity teams did adapt to a virtual method of review and coaching during the pandemic. DBHDID also had staff attrition during the pandemic. Most vacant staff positions have been filled and others are in the process of being filled, and fidelity processes are now back on track. DMH also recently hired a program administrator to focus on targeted case management services for adults with SMI. Work will continue to support and enhance evidence-based service provision for adults with SMI.

In an attempt to address some of the issues identified related to housing, DBHDID has consistently supported, through statewide funding, housing vouchers for individuals identified as having SMI and either institutionalized or at risk of institutionalization and in need or transitioning to community housing. This program is called the Olmstead Housing Initiative (OHI) and allows state general funds to create more flexible options to assist with identified housing costs for these individuals.

DMH, through a partnership with NAMI Lex, created a training and technical assistance center, Kentucky System Transformation Advocating Recovery Supports (KYSTARS), several years ago. This group, via contract, provides an annual KYSTARS statewide conference, focusing on support for peer support specialists, targeted case managers, community support associates and the agencies and individuals who supervise and support these individuals. As fidelity reviews of the COSPs are provided by NAMI Lex, identified needs are utilized to create beneficial workshops offered at this annual conference. A special designated conference track for peer support specialists working in COSPs is offered. This conference is also important in furthering education

and understanding of recovery for the broader provider community. There is an additional specific conference track for those professionals who supervise peer support specialists in their agencies.

In an additional effort to enhance support for peer support services, DMH also partnered with Bridgehaven, a nationally recognized therapeutic rehabilitation program for adults with SMI, to establish the Center for Peer Excellency. This group is managed mostly by experienced peer support specialists who provide statewide support for peer support specialists across the state including ongoing training events, consultation calls, newsletters, and other vital support.

CMHCs are required to provide person centered recovery planning processes for all adults with SMI who receive services. This initiative was implemented with much support a few years ago and includes the best practices of shared decision making and person centered planning in a stagewise format that meets the criteria for medical necessity.

***Data Sources:***

Kentucky DBHDID Management Information System (MIS) Client/Event Data Set – University of Kentucky Institute for Biomedical Informatics (IBI) – SFY 2022, SFY 2021, SFY 2020 Certified Data

University of Kentucky IBI Data Source - American Community Survey Data – 2020 Census – https://www.census-charts.com/ASC/Kentucky.html

DBHDID Form 172, Assertive Community Treatment – Project Report Form – SFY 2022

University of Kentucky, Human Development Institute (HDI) Individual Placement and Support (IPS) Supported Employment site data

KYSTARS COSP fidelity data reports

**Older Adults with SMI**

***Prevalence Data:***
According to the Centers for Disease Control and Prevention (CDC), as of 2019, 54.1 million adults in the United States are 65 years old or older, representing 16% of the population. By the year 2040, the number of older adults is expected to reach 80.8 million.

Approximately 20% of people aged 55 and older will experience a mental health concern, such as a mood disorder, that is not a normal part of the aging process. (2008 – American Association for Geriatric Psychiatry).

Kentucky DBHDID captures data on older adults based on age 60 and above who have SMI. Utilizing 2020 Census data, the total aged 60 and above population in Kentucky estimated to have SMI is 26,493. (2.6% of the age 60 and above population). Of this identified population, the CMHCs served 6,935 older adults with SMI (26%) during SFY 2022. Some of the CMHCs that serve the most rural populations in both the eastern and western sections of the state serve a very large portion of these individuals. This is possibly due to there being more available services for this population in larger populated areas.

***Unmet Needs and Critical Services Gaps:***
There are several unmet needs in Kentucky within this population. A lack of housing that meets physical needs in addition to behavioral health needs is one area that needs attention. Additionally, the need for understanding and expertise regarding the aging population, especially the aging population and mental health needs, among service providers is a critical gap.

More collaboration between agencies that serve this fragile and expanding population group is needed.

***Addressing the needs:***
Beginning in October of 1999, The Kentucky Mental Health and Aging Coalition (MHAC) was created to assist in supporting the needs of the aging population. The Coalition contains broad stakeholder involvement including the DBHDID, Department for Aging and Independent Living, Area Agencies on Aging, local Mental Health and Aging Coalition representation from across the state, state universities, older adults, and other local public and private organizations.

Traditionally, the statewide MHAC met quarterly and utilized small funding opportunities through mini grants to support local MHACs in providing educational events, technical assistance, and implementing evidence-based practices for this population in their area. DBHDID staff attrition as well as the pandemic led to a loss of coordination and activity of this group. DMH has a program administrator dedicated to this population and work is beginning to reinvigorate this group and reestablish connections to local CMHCs. In addition, the Division of Substance Use Disorder (DSUD) also has a program administrator dedicated to older adults with SUD. The DMH program administrator will work with DSUD to collaborate in meeting the needs of older adults with SMI/SUD in Kentucky.

***Data Sources:***

Centers for Disease Control and Infection (CDC) 2019. Accessed via: https://www.cdc.gov/chronicdisease/resources/publications/factsheets/promoting-health-for-older-adults.htm

American Association for Geriatric Psychiatry. Geriatrics and Mental Health – the facts. 2008. Accessed via https://www.cdc.gov/aging/pdf/cib_mental_health.pdf

Kentucky DBHDID Management Information System (MIS) Client/Event Data Set – University of Kentucky Institute for Biomedical Informatics (IBI) – SFY 2022 Certified Data

**Adults with SMI who live in rural areas**

***Prevalence Data:***
The 2020 Census data show 66,300,254 individuals in the United States living in rural areas. This represents 20% of the total population. The US Census delineates rural and urban geographical areas. An urban area is designated as being comprised of densely settled population that meet minimum housing unit density and/or population density requirements. The “rural” designation indicates the areas not identified as urban.

Kentucky 2020 Census data shows 1,860,980 individuals, or 41.3% of the total population living in rural areas.

DBHDID monitors individuals with SMI who live in areas designated as rural in Kentucky. The total estimated of adults with SMI living in rural Kentucky counties, based on 2020 Census numbers is 26,993. (2.6% of the total adult rural population). During SFY 2022, the CMHCs served 18,627 of these individuals, or 69%. Much of this population are receiving services in Kentucky.

***Unmet Needs and Critical Service Gaps:***
Kentucky is a very rural state. Most of the issues listed under general adults with SMI unmet needs will apply to those living in rural areas. Housing is scarce in rural areas and transportation is a much larger barrier, considering there are few public transportation options for rural Kentucky, and travel is generally considerable and sometimes treacherous.

***Addressing the Needs:***
The increasing use of telehealth services during the pandemic has been useful in serving these individuals in rural areas. Individuals without transportation options were able to connect with mental health treatment services in a virtual manner. Kentucky has had telehealth options for several years prior to the pandemic, but only for prescribers and a few types of licensed clinicians. During the pandemic, regulatory changes were made that now allow Medicaid reimbursement for most mental health services via telehealth. There are still access barriers in rural Kentucky, due to inconsistent internet connections and poverty, but the telehealth changes assisted with treatment access for many individuals.

The Department for Medicaid Services provides for medical transportation via contracts with numerous vendors in all areas of the state. Kentucky Department for Transportation also oversees a program called the Non-Emergency Transportation Network (NETN) and provides additional vendors for medical transportation needs. The NETN can assist with a broader scope of transportation needs, but they still must be related to a health need. (e.g., transportation to a doctor's appointment and then also to pick up a prescription is allowed, but transportation to the grocery story is not allowed). There continues to be many needs in the area of rural transportation.

***Data Sources:***

2020 Census Data
https://www.census.gov/programs-surveys/geography/guidance/geo-areas/urban-rural/2020-ua-facts.html

Kentucky DBHDID Management Information System (MIS) Client/Event Data Set – University of Kentucky Institute for Biomedical Informatics (IBI) – SFY 2022 Certified Data

Non-Emergency Medical Transportation (NEMP) Workbook. Accessed via
NEMT-Workbook.pdf (hdiuky.org)

**Adults with SMI experiencing homelessness:**

***Prevalence Data:***
According to Housing and Urban Development: The 2022 Annual Homelessness Assessment Report to Congress, on one single night in January of 2022 there were 582,462 individuals experiencing homelessness across the nation, or 18 in every 10,000 people. Of those, 60% were located in sheltered locations and 40% were in unsheltered locations (on the street, in abandoned building or other uninhabitable locations).

DBHDID monitors the number of adults with SMI who are experiencing homelessness in Kentucky. During SFY 2022, CMHCs served 3,632 adults with SMI experiencing homelessness, which is 4.6% of the state's estimated SMI population.

The preliminary annual point in time street count in Kentucky (known as the K-Count) for 2023 has shown unsheltered individuals experiencing homelessness has more than doubled in the Louisville Metro area over the last year to more than 500 individuals. The Louisville Metro area is Kentucky's most densely populated urban area.

***Unmet Needs and Critical Service Gaps:***
The Housing and Urban Development (HUD) housing programs and other low-income housing programs supported nationally have not met the needs of the SMI population experiencing homelessness. Many housing programs having waiting lists of one year or more before being accepted into housing slots. In addition, all of the noted housing issues related to all adults with SMI apply to this population as well. There is a lack of shelter bed capacity for this population, and most congregate settings do not work well for adults with SMI as they need smaller sheltered housing to meet their mental health needs.

There are workforce issues and a lack of adequately trained community-based staff for this population. Transportation is also a critical need for this population, as access to necessary services is extremely challenging.

***Addressing the Needs:***
DMH has a program administrator that focuses on housing issues for individuals with SMI, including working with several statewide groups that address homelessness. DMH also provides funding (state general and block grant) for several agencies across the state, in addition to the CMHCs, to assist with work with this population, including two agencies in Louisville, a homeless shelter in Lexington, a drop in center in western Kentucky and others.

The CMHC based in Louisville also has a Homeless Outreach Team that works in the community to identify and provide services to this population, including transition age individuals. This outreach team also partners with the University of Louisville in identifying people who need assistance. Some emergency COVID 19 funding assisted with providing additional suicide screening and peer support for these individuals in the Louisville area.

In addition, the DSUD also has a program administrator that focuses on recovery housing for individuals with SUD and is working to grow the housing options for that population.

DBHDID maintains funds in the four (4) state Catchment Areas (encompasses the entire 120 counties) to address needs of people who meet the criteria for Olmstead funding and need assistance to gain and sustain community housing. These funds are wraparound funds designed for the CMHCs who exist in each of the four (4) Catchment Areas to be able to assist with specialized needs, that generally include housing support. This is in addition to the OHI voucher program mentioned under the adults with SMI section.

DMH has applied for the Treatment for Individuals Experiencing Homelessness Grant from SAMSHA with the project name of TEAM SOAR (Treatment Enhanced Assertive Mechanics for SSI/SSDI Outreach Access Recovery). This grant would provide increased housing assistance, therapeutic supports, and street outreach for individuals in areas of Kentucky that are experiencing the highest rates of homelessness.

***Data Sources Used:***

Kentucky DBHDID Management Information System (MIS) Client/Event Data Set – University of Kentucky Institute for Biomedical Informatics (IBI) – SFY 2022 Certified Data

Housing and Urban Development: The 2022 Annual Homelessness Assessment Report to Congress. Accessed via https://www.huduser.gov/portal/sites/default/files/pdf/2022-AHAR-Part-1.pdf

KHC K-Count (2022) https://www.kyhousing.org/Programs/Homeless-Programs/Pages/K-Count.aspx

Louisville Coalition for the Homeless Street Count (2023) accessed via https://louhomeless.org/

**Children with SED and Their Families**

***Prevalence Data for this population:***
Using 2020 census data and the state's agreed upon SED prevalence estimate of five (5) percent, Community Mental Health Centers (CMHCs) are aware of the potential number of children with a severe emotional disability (SED) who are in need of services. The CMHCs also rely heavily on indicators and recommendations from the local communities, parent networks, and Regional Interagency Planning Councils (RIACs). Kentucky Kids Count, the annual report distributed by Kentucky Youth Advocates is also helpful for program planning (www.kyyouth.org). Results of Kentucky's Youth Risk Behavior Surveillance Survey (YRBSS) and Kentucky Incentives for Prevention (KIP) are also critical drivers of regional and state planning.

According to the 2020 Census, there are 1,013,813 children ages 0-18 in Kentucky. Applying a 5% prevalence estimate, there are 50,691 Kentucky children who meet criteria for having a severe emotional disability (SED). According to the Kentucky MIS Client and Event data set, the CMHCs served 20,802 children with SED in SFY 21 and 21,441 in SFY 22 (42% and 43% of Kentucky's children who meet criteria for having a SED, respectively.

| CMHCs | Child Census 2020 | Estimated Prevalence (5% of the Child Census) | Kentucky Children with SED Served in SFY 2021 | Percentage of Children with SED Served in SFY 2021 | Kentucky Children with SED Served in SFY 2022 | Percentage of Children with SED Served in SFY 2022 |
|---|---|---|---|---|---|---|
| Four Rivers | 45,800 | 2,290 | 1,321 | 58% | 1,614 | 70% |
| Pennyroyal | 51,360 | 2,568 | 761 | 30% | 882 | 34% |
| RiverValley | 52,360 | 2,618 | 675 | 26% | 555 | 21% |
| LifeSkills | 62,100 | 3,105 | 915 | 29% | 979 | 32% |
| Communicare | 65,440 | 3272 | 1,532 | 47% | 1,575 | 48% |
| Seven Counties Services | 215,400 | 10,770 | 3,469 | 32% | 3,605 | 33% |

| | | | | | | |
|---|---|---|---|---|---|---|
| NorthKey | 105,220 | 5,261 | 2,582 | 49% | 3,119 | 59% |
| Comprehend | 13,760 | 688 | 495 | 72% | 495 | 72% |
| Pathways | 49,340 | 2,467 | 1,938 | 79% | 2,206 | 89% |
| Mountain | 39,040 | 1,952 | 2,232 | 114% | 2,243 | 115% |
| Kentucky River | 29,460 | 1,473 | 574 | 39% | 595 | 40% |
| Cumberland River | 60,420 | 3,021 | 1,718 | 57% | 1,672 | 55% |
| Adanta | 46,280 | 2,314 | 786 | 34% | 695 | 30% |
| New Vista | 159,140 | 7,957 | 1,804 | 23% | 1,206 | 15% |
| **TOTAL** | **995,120** | **49,756** | **20,802** | **42%** | **21,441** | **43%** |

**Children with SED who experience homelessness**

For the 2021-2022 school year, the Kentucky Department of Education reported that 21,062 unduplicated children and youth from age 3-21 enrolled in public schools met the definition of being homeless. Using a prevalence rate of 5% suggests that approximately 1,052 children and youth who experienced homelessness and were served by Kentucky public schools met criteria for having an SED, however this is an underestimate, given the increased mental health risk factors that impact children with unstable housing. Further limitations of these data are that only children enrolled in public school are included. Children under age 5 who do not qualify for public preschool and youth who drop out of school (who may be at higher risk for mental health challenges), are not included. The Kentucky MIS Client/Event data show that in SFY 21 the CMHCs served 198 youth with SED who experienced homelessness and 187 in SFY 22, indicating that approximately 1% of youth with SED that were served by the CMHCs reported experiencing homelessness. This is likely an underestimate, as information about housing stability is updated infrequently and may be underreported by families.

**Children with SED who live in rural areas**

A primarily rural state, 102 of Kentucky's 120 counties are considered *Rural or Designated Eligible Census Tracts in Metropolitan Counties* by the Health Resource Service Administration - HRSA). Rural counties are disproportionately impacted by poverty; according to the Annie E. Casey Foundation Kids Count data, 22% of Kentucky's children are living in poverty and 12% in extreme poverty. Transportation in rural areas is a considerable challenge as families often do not have access to reliable transportation, and with few exceptions, public transportation is non-existent. As a result, many children are not able to travel to service providers, and service reimbursement rates do not include travel time, so home-based services are not consistently available across the state. Finally, the majority of counties, and all rural counties, in KY are designated as Mental Health Provider Shortage Areas by the HRSA, thus creating further barriers to families seeking mental health services for their children.

**Kentucky Families**

A primarily rural state, Kentucky's population is 4.5 million, according to the 2020 Census numbers, and ranks 48$^{th}$ for overall poverty rate. The table below provides additional data from the 2020 Census; Center for American Progress; Center for Disease Control; and Spotlight on Poverty & Opportunity that indicate challenges faced by Kentucky families. Each of the indicators below increase the risk for mental health challenges among families and their children. This highlights the importance of focusing on the whole family to improve health and well-being and mitigate risk factors.

| | Percentage |
|---|---|
| Families living below 200% of poverty level | 35% |
| All Kentuckians in poverty | 16% |
| Jobs that are low wage | 24% |
| Income for women compared to men | 80% |
| Kentuckians with food insecurity | 14% |
| KY children living in households with food insecurity | 16% |
| Kentuckians with high rental cost burden | 43% |
| Adult Kentuckians with disabilities | 33% |
| Children in poverty (2020) | 22% |
| Children in extreme poverty (2020) | 12% |
| Kentucky working-aged women in poverty | 17% |
| KY children in single-parent homes | 36% |
| KY Teen birth rate per 1,000 females age 15-19 | 25 |
| KY births to mothers without a high school degree | 13% |
| KY rate per 1,000 children ages 0-17 in foster care | 54 |

***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. Williams, Scott, and Aarons more recently (2017) conducted a systematic review and meta-analysis of SED prevalence studies conducted in the United States. Results of this work indicate that the percentage of youth experiencing SED is higher than previously estimated (*"10.06% of youths experience SED with substantial impairment in one or more functional domains and that 6.36% of youths experience SED with substantial impairment in two or more domains"* p. 36), Kentucky has not yet applied this rate to estimate SED prevalence.

Based on 2020 Census numbers and certified 2022 Kentucky's MIS Client/Event data, approximately 43% of children with SED were served by Regional Boards statewide and approximately 8% of them received targeted case management services in SFY 22. Far fewer children with SED received High Fidelity Wraparound (HFW); SFY 22 KY MIS Client/Event data indicate that 394 children received this more intensive approach to care coordination (less than 1% of Kentucky's SED population). According to the National Wraparound Initiative's review of multiple studies, when wraparound is implemented with fidelity (i.e., HFW), *"young people with complex needs are more likely to be able to stay in their homes and communities, or, should a crisis occur, to be in out-of-home placements only for short periods of time."* 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, including HFW. While DBHDID has supported HFW implementation within the CMHCs, funding has been insufficient for consistent implementation; expansion; or to scale or to achieve sustainability.

Additional service gaps, as reported by CMHCs children's services directors as part of the annual Plan and Budget process, include intensive in-home therapy services; respite; a continuum of crisis services for children (i.e., mobile response; crisis stabilization units; respite), and effective clinical interventions for very young children (birth through age 5) and their families. Additionally, availability of and access to services for children and youth with very high acuity behavioral health needs, including those with co-occurring substance use disorder and/or intellectual or developmental disabilities; high levels of aggression, and sexually reactive behaviors have been identified by multiple system of care partners (CMHCs; child welfare; juvenile justice; education; families) have been identified as gaps.

All of the noted service gaps are further impacted by the severe behavioral workforce shortage that has been exacerbated since the onset of the COVID 19 pandemic.

***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 Targeted Case Management (TCM) supervisors; HFW staff; children's crisis program directors; and other regional leaders to provide technical assistance and support in transitioning to virtual and telehealth platforms as well as workforce recruitment and retention.

DBHDID met regularly with Department for Medicaid Services (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 were awarded in SFY 2021. DBHDID and DMS staff has reinstituted quarterly meetings with MCOs with the intent of increased communication, data review, and collaborative guidance toward continuous quality improvement. Furthermore, DBHDID worked closely with DMS to identify services that will be added to upcoming Medicaid State Plan Amendments and waiver applications in an effort to meet the increasingly high acuity behavioral health needs of Kentucky's children, youth, and families.

The DBHDID collaborates closely with the Kentucky Partnership for Families and Children, Inc. (KPFC). A statewide family-run organization for children and youth with or at risk of developing behavioral health challenges, KPFC is a SAMHSA Statewide Family Network Grantee and includes Kentucky chapters of both Federation of Families, and Youth MOVE. Since its inception in 1999, KPFC has partnered with DBHDID to implement activities aimed at supporting children, youth, and families via multiple federal grant sources, including but not limited to several SAMHSA grants (mental health and substance use block grants; Children's Mental Health Initiative (System of Care); Healthy Transitions; Adolescent Substance Use; Youth Suicide Prevention; State Opioid Response, and other federal and state grant opportunities. When peer support was under development in Kentucky, KPFC recruited and supported parents and youth to participate on the stakeholder groups that developed the training curricula and regulations for Family and Youth Peer Support. It offers regular peer support training events and provides ongoing leadership development for youth and families and connects them with opportunities to drive Kentucky's system of care. Currently, KPFC employs certified Family and Youth Peer Support Specialists in six (6) of the nine (9) child welfare service regions. These staff are not employed by behavioral health provider agencies so are able to engage in outreach and engagement to families who may be reluctant to participate in treatment services, as they are not reliant on billing to sustain their positions. KPFC peer specialists have filled a gap by connecting many previously unserved youth and families to treatment and other community resources. Further, they have built partnerships with local child welfare, court, education, and treatment partners.

Several state-level interagency workgroups were established to facilitate access to appropriate services for children with the highest acuity behavioral health needs, including efforts focused on individual children and youth as well as those aimed at systemic changes to the infrastructure an service/support delivery system within the system of care.

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## Early Serious Mental Illness/First Episode Psychosis

***Prevalence Data:***
The following table shows some targeted demographics for youth and young adults in Kentucky aged 15 – 30 years old, including race and ethnicity.

| 2021 Census Estimates (Kentucky State Data Center) * | KY 2021 |
|---|---|
| Total population in Kentucky | 4,506,589 |
| Total population between 15 -30 years old | 887,949 |
| % of population between 15-30 years old | 20% |
| **Race/Ethnicity for 15 -30 years old** | |
| Black | 91,376<br>10% |
| Asian | 16,783<br>2% |
| White (non-Hispanic) | 704,122<br>79% |
| Hispanic | 46,790<br>5% |
| Other | 28,878<br>3% |
| **By Gender 15 - 30 years old** | |
| Female | 49% |
| Male | 51% |

**2021 Population Estimates used due to 2020 Census data not including breakouts for race/ethnicity by age groups.*

Research shows that three out of 100 people experience psychosis at some point in their lives. (McGrath, J. et.al. 2008). Seventy-five percent of these serious mental health conditions begin by age 24. (NAMI 2017).

The National Institute for Mental Health (NIMH) RAISE study concluded that compared to typical care, people with early psychosis who received the evidence-based practice of Coordinated Specialty Care (CSC) experience greater improvement in symptoms, relationships, and quality of life, are more involved in work or school, and stay in treatment longer. This research also shows that the sooner people get CSC the great the improvements.

Using the formula for estimating the state incidence rate of First Episode Psychosis (FEP), derived from the OnTrack NY FEP study (Humensky, et. al. September 2013) the estimated incidence rate of FEP in Kentucky is approximately 1,352 per year. Kentucky is divided into fourteen (14) CMHC geographical regions. Please see the chart below for estimated incidence rate of FEP per CMHC region.

| Kentucky<br>Community Mental Health Centers<br>2020 Census Population Chart<br>Kentucky State Data Center<br>Per Year Estimated Incidence Rates for First Episode Psychosis | | |
|---|---|---|
| **CMHC** | **Total Pop** | **.03% national per year incidence estimate for FEP** |
| **Four Rivers** | 196,876 | 59 |
| **Pennyroyal Center** | 214,610 | 64 |
| **River Valley** | 216,809 | 65 |
| **Lifeskills** | 312,062 | 94 |
| **Communicare** | 280,770 | 84 |
| **Seven Counties** | 1,024,500 | 307 |
| **NorthKey** | 468,471 | 141 |
| **Comprehend** | 55,875 | 17 |
| **Pathways** | 219,862 | 66 |
| **Mountain** | 140,215 | 42 |
| **Kentucky River** | 106,511 | 32 |
| **Cumberland River** | 229,783 | 69 |
| **Adanta** | 206,583 | 62 |
| **New Vista** | 832,909 | 250 |
| **Kentucky** | 4,505,836 | 1,352 |

The Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) 2017 report to Congress indicated that in 2016, 5.9% of individuals between ages 15 and 25, had a serious mental illness (SMI) and for children with serious emotional disturbance (SED) this prevalence varied between 6.8% - 11%.

During SFY 2022, Kentucky CMHCs served 749 young people between the ages of 13 and 20 who were identified as having an SMI. This is a 1.7% penetration rate (44,178 total SMI served). During SFY 2022, Kentucky CMHCs served 5,081 young people between the ages of 13 and 20 who were identified as having an SED. This is a 24% penetration rate (21,441 total SED served). During SFY 2022, Kentucky CMHCs served 302 young people between the ages of 13 and 20 with a substance use disorder (SUD). This is a 1.8% penetration rate (total SUD served 16,345). This Kentucky SFY 2022 data only includes ages 13 – 20 due to difficulties with age grouping of available data reports. Looking at this data alone shows that Kentucky serves many more individuals in the transition age group with SED than identified in the ISMICC report. However, it appears Kentucky serves fewer young people with SMI than identified in the ISMICC report. The addition of the penetration rate for young people with SUD shows room to grow in that area as well.

***Unmet Needs and Critical Gaps:***
Several areas of unmet needs and critical gaps exist regarding behavioral health services for youth and young adults with early serious mental illness, including First Episode Psychosis (FEP).

Behavioral health services have traditionally been siloed separately into adult and children's services, and into mental health or substance use disorder treatment services. Most individuals with First Episode Psychosis fall into a transition age group that may span both MH/SUD program areas. While there are pockets of specialized supports that break these silos in various areas of the state, substantial service gaps still exist through the transition from child to adult service options. There is also a need for statewide coordination of specialized support for this age group across all the providers in Kentucky. Few of these young people are receiving the full array of needed services, including substance use disorder treatment, and creating infrastructure to address these needs has been a necessary component of work with this age group, including those with First Episode Psychosis.

An additional complication is that a large portion of this age group utilizes private insurance through their parents and many of the services captured in Coordinated Specialty Care (CSC) are not billable through traditional insurance. (i.e., case management, peer support, supported employment/education). Kentucky Medicaid does not cover some CSC services as well (i.e., supported employment/education), or may not cover for the length of time needed for this population (e.g., targeted case management). CSC is a fairly expensive service to provide, and the national average for caseload on each CSC team is 30 – 40 individuals. Though these services are effective and vital, federal block grant funds have been needed to ensure sustainability for this very important service.

The COVID 19 pandemic led to increased isolation and disconnect with available community supports for this age group. The pandemic also led to workforce issues across the Commonwealth. Some of Kentucky's CSC teams had multiple staff turnover. Workforce issues have been improving across the state but are still deficient in some areas and some teams have had some issues with filling vacancies. The Division of Mental Health (DMH) state FEP team has worked to support and assist these local teams in strengthening staffing and enhancing staff competency and having capacity to identify and serve these young people in their areas. Alternatively, a few of the CSC teams have retained staff and have been serving so many young people they were outgrowing their original team and needed to expand to multiple CSC teams.

Kentucky's state FEP team maintains regular consultation and technical assistance with all CSC teams across the state. In meeting with teams, several additional areas were identified needing additional focus:

- Support for implementation of multi-family group therapy (MFG), the evidence-based family psychoeducation/therapy model embedded in Kentucky's CSC programs;
- Additional support and empowerment for CSC team leaders;
- Support in making occupational therapy available for CSC participants who needed it;
- Enhancing clinical expertise on CSC teams;
- Guidance in hiring and retaining youth peer specialists on the CSC teams; and
- Flexibility in length of program time and additional programming based on changing and identified individual needs.

***Addressing the Need:***

1) A cross branch implementation team for transition aged youth was created within DBHDID that included the following branches via Memorandums of Understanding (MOU): The Adult Mental Health and Recovery Services Branch; The Children's Behavioral Health and Recovery Services Branch; the Adult Substance Use Treatment and Recovery Services Branch; the Mental Health Prevention, Promotion and Preparedness Branch; and the Substance Use Prevention and Promotion Branch. This team crosses both Mental Health and Substance Use Disorder Divisions and include the Division of Mental Health (DMH) state FEP team. This team is charged with enhancing the seamless coordination of transition age youth behavioral health services across child and adult services as well as substance use prevention and treatment.
2) Each CMHC is required to identify two (2) Key Contacts, one from adult services and one from children's services, to attend statewide FEP meetings and assist with implementation of FEP programming. Even CMHCs without CSC teams are required to provide these Key Contacts and attend training events designed to build capacity for identifying and treating these young people in their communities.
3) COVID 19 supplement block grant funds were utilized to bolster funding for all CSC programs during the pandemic. In addition, COVID 19 supplement block grant funds were utilized for all CMHCs without CSC teams, to assist with additional required training and education activities. COVID 19 supplement funds were also allocated to develop a second CSC team in one region.
4) Each CMHC now has a Youth Substance Use Disorder Treatment Coordinator position, that is located within their children's services but is charged with coordinating other programs and services for this age group who have or are at risk of having substance use disorders or co-occurring MH/SUD.
5) Each CMHC also now has a Transition Age Youth Coordinator who is responsible for collaborating across local programming to enhance supports that are developmentally appropriate and evidence informed for youth, young adults, and their families, who are affected by serious behavioral health issues. These staff are charged with providing consultation, referral, education, training, technical assistance, coaching, outreach, and system development within their CMHC. These positions are funded through blending of mental health and substance use disorder block grant funds.
6) The DMH FEP team, in partnership with the Early Assessment and Support Alliance (EASA), host a monthly MFG consultation call to assist with implementation barriers and provide ongoing support for all CSC teams.
7) DMH FEP state program administrator hosts a monthly meeting with all CSC team leaders to build competencies, address implementation barriers, provide statewide information

sharing regarding infrastructure support as well as evidence-based components of CSC, and to provide an additional feedback loop for communication from the field.

8) DMH state FEP team developed a relationship with the Kentucky Occupational Therapy Association (KOTA) to provide training opportunities and meet on a monthly basis to address barriers to local engagement and implementation of occupational therapy services for CSC participants.
9) Beginning in SFY 24, CMHC contracts have an added requirement of at least .50 FTE therapist on their CSC team, in addition to having the team leader required to be a clinical person.
10) Beginning in SFY 24, CMHC contracts clarified the language to require a youth peer specialist on the CSC team and DMH FEP team will continue to work with CSC teams to address barriers related to hiring, training, supporting and thus retaining these young people.
11) Kentucky has provided more structure and additional training opportunities regarding engagement and treatment needs for young people with early psychosis. The Stepped Care Model (Sale, Tamara, et.al. 2018) is in development in Kentucky, and in partnership with the Yale University Prime Clinic, DMH provided a training on the Stepped Care Model for all CSC teams with ongoing consultation. This will assist with development of additional levels of care for these young people, and better meet needs that have been identified. In addition, The Prime Clinic provides regular training and consultation to support the Structured Interview for Psychosis Risk Syndromes (SIPS) proficiency within the CSC teams.
12) Beginning with a directive from Kentucky legislators, the Kentucky Department for Medicaid Services is currently working on a 1915i Waiver proposal for CMS that would include reimbursement for supportive housing services and supported employment services for individuals with SMI. DBHDID is involved in this endeavor.
13) Beginning in late SFY 2023, DMH partnered with Mental Health America of Kentucky to provide a foundational First Episode Psychosis learning series to help generate awareness and educate around basic components of CSC. The scope and audience for this learning series is broad, in an effort to build capacity. This series was funded through Bipartisan Safer Communities Act (BSCA) funding.

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## Behavioral Health Crisis Services

### Individuals in need of behavioral health crisis services

***Prevalence data*:**

Kentucky Total Population: 4,461,952

Kentucky Adult Population: 3,045,985

Adult SMI Estimate (2.6%): 79,196

Kentucky Child Population: 995,111 (22% of state population)

Child SED Estimate (5%): 49,756

### Adults Served by CMHC Crisis Programs

According to the 2020 census, there are over 3 million adults in Kentucky. In 2022, almost nineteen thousand adults, or approximately 1 in every 185 adults in the state, were provided a crisis service by a Kentucky Community Mental Health Center (CMHC). These services include walk-in crisis services at a local CMHC office, mobile crisis services, or a residential stay in a crisis stabilization unit. Approximately 1 in every 740 adults received a mobile crisis service. Public funds are also used to provide additional crisis services in partnership with Wellspring Kentucky (residential crisis services), University of Louisville and Seven Counties Services (crisis evaluation and 23-hour observation), Baptist Health Hardin and Communicare (psychiatric consultation), but are not included in this data. Table 1 provides 2020-2022 data for adults served by CMHC crisis programs.

| Table 1. Total Number and Percentage of Adults Served by CMHC Crisis Programs SFY 2020-2022 | | | | |
|---|---|---|---|---|
| **A** | **B** | **C** | **D** | **E** |
| | Adults Age 18+ Served<br><br>CMHC Mobile Crisis | % of KY Adults Served<br><br>CMHC Mobile Crisis | Adults Age 18+ Served<br><br>CMHC Mobile, Walk-In, or Residential Crisis Service | % of KY Adults Served<br><br>CMHC Mobile, Walk-In, or Residential Crisis Service |
| **Source or Formula** | CMHC Service Mix Utilization Adults Report | Col B/2020 State Adult Census | CMHC Service Mix Utilization Adults Report | Col D/2020 State Adult Census |
| **2022** | 4702 | 0.13% | 18,629 | 0.53% |
| **2021** | 4,570 | 0.13% | 18,728 | 0.54% |
| **2020** | 5,393 | 0.15% | 21,274 | 0.61% |

**Adults with SMI Served by a CMHC Crisis Program**

Approximately 2.6% (almost eighty thousand) of Kentucky's adults are estimated to have a serious mental illness (SMI). In 2022, CMHCs provided a crisis services to 6494 adults with SMI (approximately 7.2%) and mobile crisis services to 1857 adults with SMI (2.1%). Over 1 in 3 adults who were provided a CMHC crisis service in 2022 had SMI. Table 2 provides 2020-2022 data for adults with SMI served by CMHC crisis programs.

| Table 2. Total Number and Percentage of Adults with Serious Mental Illness Served by CMHC Crisis Programs SFY 2020-2022 | | | | | | |
|---|---|---|---|---|---|---|
| **A** | **B** | **C** | **D** | **E** | **F** | **G** |
| | Adults Age 18+ with SMI Served<br><br>CMHC Mobile Crisis | % of Adults Served by CMHC Mobile Crisis Teams Who Had SMI Marker | % of Adults with SMI Served by CMHC Mobile Crisis | Adults Age 18+ with SMI Served<br><br>CMHC Mobile, Walk-In, or Residential Crisis Service | % of Adults Served by CMHC Mobile, Walk-In, or Residential Crisis Service Who Had SMI Marker | % of Kentucky's Adults Served by CMHC Mobile, Walk-In, or Residential Crisis Service and Had SMI Marker |
| **Source or Formula** | Crisis Service Mix Utilization SMI Report | Table 1, Col B/Table 2, Col B | Col B/2020 State SMI Estimate | Crisis Service Mix Utilization SMI Report | Table 1, Col D/Table 2, Col E | Col E/2020 State Adult Census |
| **2022** | 1857 | 39.5% | 2.1% | 6494 | 34.9% | 7.2% |
| **2021** | 1727 | 37.8% | 1.9% | 6803 | 36.3% | 7.5% |
| **2020** | 1875 | 34.8% | 2.1% | 7140 | 33.6% | 7.9% |

**Children Served by CMHC Crisis Programs**

Kentucky is home to almost a million children and teens. In 2022, CMHCs provided a crisis service to 5,865 of them, or approximately 1 of every 175 children. These services included mobile crisis services, walk-in crisis services at a CMHC office, or residential care in a crisis stabilization unit. A little more than 1,000 of those services were mobile crisis services. Table 3 provides 2020-2022 data for children served by CMHC Crisis Programs.

| Table 3. Total Number of Children Served by CMHC Crisis Programs SFY 2020-2022 | | | | |
|---|---|---|---|---|
| **A** | **B** | **C** | **D** | **E** |
| | Children Age 0-17 Served<br><br>CMHC Mobile Crisis | % of KY Children Served<br><br>CMHC Mobile Crisis | Children Age 0-17 Served<br><br>CMHC Mobile, Walk-In, or Residential Crisis Service | % of KY Children Served<br><br>CMHC Mobile, Walk-In, or Residential Crisis Services |
| **Source or Formula** | CMHC Service Mix Utilization Children Report | Col B/2020 State Child Census | CMHC Service Mix Utilization Children Report | Col D/2020 State Child Census |
| **2022** | 1016 | 0.10% | 5865 | 0.57% |
| **2021** | 479 | 0.05% | 3493 | 0.34% |
| **2020** | 442 | 0.04% | 4498 | 0.44% |

**Children with SED Served by CMHC Crisis Programs**

Approximately 5% (almost 50,000) of Kentucky children have a serious emotional disturbance (SED). In 2022, CMHCs provided a crisis services to 3,404 children with SED (approximately 6.7%) and mobile crisis services to 656 children with SED (2%). Fifty-eight percent of children provided a crisis service had SED. Table 4 provides 2020-2022 data for children with SED served by CMHC crisis programs.

| Table 4. Total Number and Percentage of Children with Serious Emotional Disturbance Served by CMHC Crisis Programs SFY 2020-2022 | | | | | | |
|---|---|---|---|---|---|---|
| **A** | **B** | **C** | **D** | **E** | **F** | **G** |
| | Children with SED Served<br><br>CMHC Mobile Crisis Service | % of KY Children with SED Served a CMHC Mobile Crisis Service | % of Children Served a CMHC Mobile Crisis Service Who Had SED Marker | Children Age 0-17 with SED Served a CMHC Mobile, Walk-In, or Residential Crisis Service | % of Kentucky's Children with SED Served a CMHC Mobile, Walk-In, or Residential Crisis Service | % of Children Served a CMHC Mobile, Walk-In, or Residential Crisis Service Who Had SED Marker |
| Source or Formula | Crisis Service Mix/Utilization SED Report | Col B/2020 State SED Estimate | Table 3, Col B/Table 4, Col B | Crisis Service Mix/Utilization SED Report | Col E/2020 State SED Estimate | Col E/Table 3, Col D |
| 2022 | 656 | 2.0% | 65% | 3404 | 6.7% | 58% |
| 2021 | 321 | 0.9% | 67% | 2464 | 4.8% | 71% |
| 2020 | 395 | 0.8% | 89% | 3960 | 7.7% | 88% |

**Individuals with a Substance Use Disorder Served by CMHC Crisis Programs**

In 2022, 6573 adolescents and adults with a substance use disorder (SUD) were provided a crisis service by a CMHC crisis program. These services include walk-in crisis services at a local office, mobile crisis services, and residential care in a crisis stabilization unit. Over one in four individuals provided a crisis service by a CMHC crisis program had a substance use disorder diagnosis. Mobile crisis services were provided to 1504 individuals. Table 5 provides 2020-2022 data for adolescents and adults with SUD served by CMHC crisis programs.

| Table 5. Total Number and Percentage of Individuals with Substance Use Disorder Served by CMHC Crisis Programs SFY 2020-2022 | | | | | | | |
|---|---|---|---|---|---|---|---|
| **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** |
| | Total Individuals Served by CMHC Mobile, Walk-In, or Residential Crisis Services | Total Individuals with SUD Served by CMHC Mobile Crisis Services | % of Individuals Served by CMHC Mobile Crisis Services Who Had an SUD Diagnosis | % of Kentuckians Served a CMHC Mobile Crisis Service and Had an SUD Diagnosis | Total Individuals with SUD Served by CMHC Mobile, Walk-In, or Residential Crisis Service | % of Individuals Served by CMHC Mobile, Walk-In, or Residential Crisis Service Who Had an SUD Diagnosis | % of Kentuckians Served a CMHC Mobile, Walk-In, or Residential Crisis Service and Had an SUD Diagnosis |
| **Source or Formula** | CMHC Service Mix Utilization Report | CMHC Service Mix Utilization SUD Report | Col C/Col B | Col C/State Census | CMHC Service Mix Utilization SUD Report | Col F/Col B | Col F/2020 State Adult and Child Census |
| **2022** | 24,682 | 1504 | 6.1% | 0.03% | 6573 | 26.6% | 0.15% |
| **2021** | 22,718 | 1460 | 6.4% | 0.03% | 6751 | 29.7% | 0.15% |
| **2020** | 26,472 | 2050 | 7.7% | 0.05% | 7413 | 28.0% | 0.16% |

**CMHC 988 and Call Center Services**

CMHC call centers provide a variety of services to individuals in crisis, such as responding to callers/texters/chatters on regional crisis lines, warmlines, and the 988 Lifeline. They also coordinate services with jail triage teams, emergency evaluators, quick response teams, mobile crisis teams, and emergency services personnel. Thirteen CMHCs are members of the 988 Suicide and Crisis Lifeline. In 2022, CMHCs provided 294,652 responses to callers, texters, and chatters. Table 6 provides 2021-2022 data on the number of responses provided by CMHC call centers.

| Table 6. Total Number of Call Center Responses Provided by CMHC Call Centers SFY 2021-2022 | | | | |
|---|---|---|---|---|
| | Regional Crisis Calls Addressed | Regional Crisis Texts, Chats, and Emails Addressed | Warmline Calls Addressed | *NSPL/988 Calls, Texts, and Chats Addressed |
| **2022** | 257,022 | 2620 | 17,753 | 17,257 |
| **2021** | 293,490 | 468 | 10,422 | 15,461 |

*National Suicide Prevention Lifeline (NSPL)

***Unmet service needs/critical gaps***

- Increase capacity to answer Kentucky calls in-state.
- Increase capacity to reduce the amount of time it takes calls to be answered in state.
- Increase capacity to reduce the number of calls that are abandoned by the caller before they access a call center staff member.
- Increase crisis capacity, especially for mobile crisis services.
- Increase capacity to serve Kentucky's youth with complex needs.
- Enhance crisis data reporting.

***Addressing the needs***

- Increase capacity to:
    - answer Kentucky 988 calls in-state.
    - to reduce the amount of time it takes 988 calls to be answered in state.
    - to reduce the number of 988 calls that are abandoned by the caller before they access a call center staff member.
        - DBHDID has received and completed a 988 implementation planning grant, applied for and received a 988 Capacity grant and Supplement, and is applying for the 2023 988 Follow-Up grant to ensure sufficient capacity of staffing to address the current and expected increasing volume of calls to Kentucky 988 centers.
        - DBHDID requested and received a $19 million two-year 988 State General Fund line item to support increased staffing and improved technology across the 13 Crisis Call Centers participating in 988. These funds are expected to remain in the behavioral health appropriation for subsequent biennia budgets.
        - DBHDID requested and received a Technology Transfer Initiative (TTI) grant from NASMHPD that focuses on developing a job architecture for crisis call centers, standardizing education and experience expectations for staffing the call centers, as well as identifying the quality of outcomes based

on levels of experience and education in order to devise a consistent model to be used across the state's 13 centers.
    - DBHDID is reviewing uniform platform models for a statewide Air Traffic Control model adoption that will allow 988 calls first to ring in the local region and then, as needed, bounce to the next available caller for a back-up system. This will reduce the number of callers needed across the entire system and leverage the existing staff to respond to current and expected call volumes.
    - DBHDID is providing technical assistance to centers to review existing technology platforms and identify next steps to reduce through technological advance the number of staff needed.
    - DBHDID is also negotiating a one to two-year contract with Crisis Text Line to support local call centers in focusing on increasing capacity to address Kentucky calls prior to adding demands of chats and texts.
    - DBHDID is supporting training to crisis call center staff to support cultural responsiveness for focus populations (people of color, LGBTQIA+, rural, farm family and military-connected).

- Increase crisis capacity, especially for mobile crisis services.
    - KY Department for Medicaid Services (DMS) completed a one-year CMS mobile crisis planning grant which included an assessment of need and recommendations. DBHDID will continue to collaborate with DMS to implement their plan for expansion of services.
    - Utilize DBHDID's workforce task force to increase crisis workforce.
    - Increase in-state training opportunities.
    - Continue to increase crisis telehealth opportunities.
    - Improve referral process between 988 call centers, 911, and crisis services.
    - One 988 call center is implementing a volunteer program and sharing lessons learned with other 988 call centers.
    - Investigate and increase technology supports.
    - Increase collaboration with substance use treatment providers and Quick Response Teams to better serve individuals experiencing a substance use crisis.
    - Support implementation of co-responder and alternative responder models in the state through technical assistance, training and, potentially, funding if available.

- Increase capacity to serve Kentucky's youth with complex needs.
    - Continue to participate in daily meetings with Department for Community Based Services, Kentucky's child protective services agency to ensure effective care and treatment for children with complex needs in the child protection system.
    - To increase treatment options, continue to review Kentucky's psychiatric residential treatment facilities statutes, regulations, and policies and implement improvements.

- Enhance crisis data reporting.
    - Develop reports of race and ethnicity data.
    - Improve SUD crisis reports.

- Work with providers to ensure SED and SMI markers are being utilized for clients accessing crisis services.

**Children's Crisis Data Sources**

- DBHDID Management Information System (MIS) Client/Event Data Set – University of Kentucky, Institute for Biomedical Informatics (IBI) - 2020 Census: 995,111 children ages 0-17, with estimate of 5% with SED = 49,756
- CMHC Service Mix/Utilization – Children (Service code 176)
- Crisis Service Mix/Utilization - SED (Service code 176)
- CMHC Service Mix/Utilization - Children (Service codes 139, 176, 200, 210, 211)
- Crisis Service Mix/Utilization - SED (Service codes 139, 176, 200, 210, 211)
- 988 Call Center monthly reports

**Adult Crisis Data Sources**

- DBHDID Management Information System (MIS) Client/Event Data Set – University of Kentucky, Institute for Biomedical Informatics (IBI) - 2020 Census: 3,045,985 adults age 18+, with estimate of 2.6% with SMI = 79,196
- CMHC Service Mix/Utilization -Adults (Service code 176)
- CMHC Service Mix/Utilization -SMI (Service code 176)
- CMHC Service Mix/Utilization - Adults (Service codes 138, 176, 200, 210, 211
- Crisis Service Mix/Utilization - SMI (Service codes 138, 176, 200, 210, 211)

**SUD Crisis Data Sources**

- DBHDID MIS Client/Event Data Set – University of Kentucky IBI - 2020 Census: 4,461,952 total population
- CMHC Service Mix/Utilization (Service code 176)
- CMHC Service Mix/Utilization (Service codes 138, 139, 176, 200, 210, 211)
- CMHC Service Mix/Utilization - SUD (Service code 176)
- CMHC Service Mix/Utilization - SUD (Service codes 138, 139, 176, 200, 210, 211)

**Call Center Data Sources**

- DBHDID Form 113D Crisis Services Planning & Implementation Report (Fiscal Years 2020, 2021, 2022)
- Kentucky Broad State Metric Report, Provided by Vibrant Emotional Health (National Administrator of NSPL/988)

**University of Kentucky IBI Data Source**

- American Community Survey Data – 2020 Census – https://www.census-charts.com/ASC/Kentucky.html

**Women who are pregnant and have a substance use disorder/co-occurring mental health disorder**

***Prevalence Data:***
Substance use is an increasing concern for women. According to the 2021 National Survey on Drug Use and Health (NSDUH), 28.6 million women (ages 12 and older) in the U.S. used illicit substances in the past year, and 17.7 million women (ages 12 and older) used an illicit substance in the past month (Center for Behavioral Health Statistics and Quality, 2022). In 2021, 4.4 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.

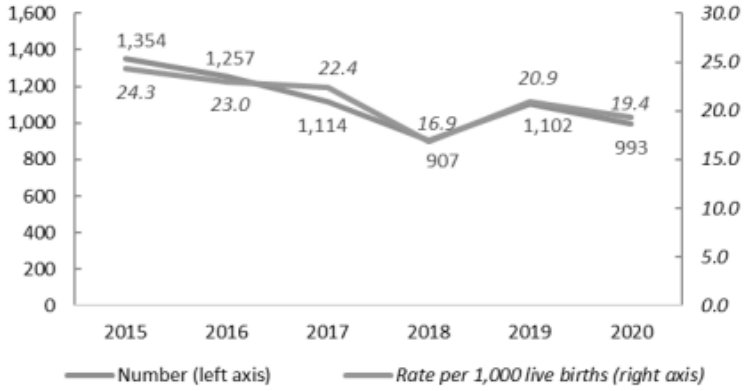
According to the 2021 National Survey on Drug Use and Health (NSDUH), 7.7% of pregnant women, aged 15-44 used illegal drugs, 9.8% reported using alcohol, and 10.1% smoked cigarettes in the past month (Center for Behavioral Health Statistics and Quality, 2022).

An analysis of geographic distributions of Neonatal Abstinence Syndrome (NAS) rates and opioid prescribing rates showed overlapping geographic patterns, suggesting an association between high opioid prescribing rates among women of childbearing age and NAS (Prescription Behavior Surveillance System, 2017).

In 2021, the rate of drug-induced deaths among women residents of Kentucky was 34.7 per 100,000 residents (Steel & Mirzaian, 2022a). Pregnant women who chronically misuse prescription medications also have a greater risk for medical complications.

Between 2000 to 2019, there was 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 (n = 907). In 2020, the Kentucky NAS Registry documented 993 unduplicated cases of NAS, which was a decrease from 2019 (KY CHFS, 2021). The most recent data available shows a 2020 rate of NAS/ Neonatal Opioid Withdrawal Syndrome (NOWS) in Kentucky as 19.4 cases per 1,000 hospital births (KY CHFS, 2021).

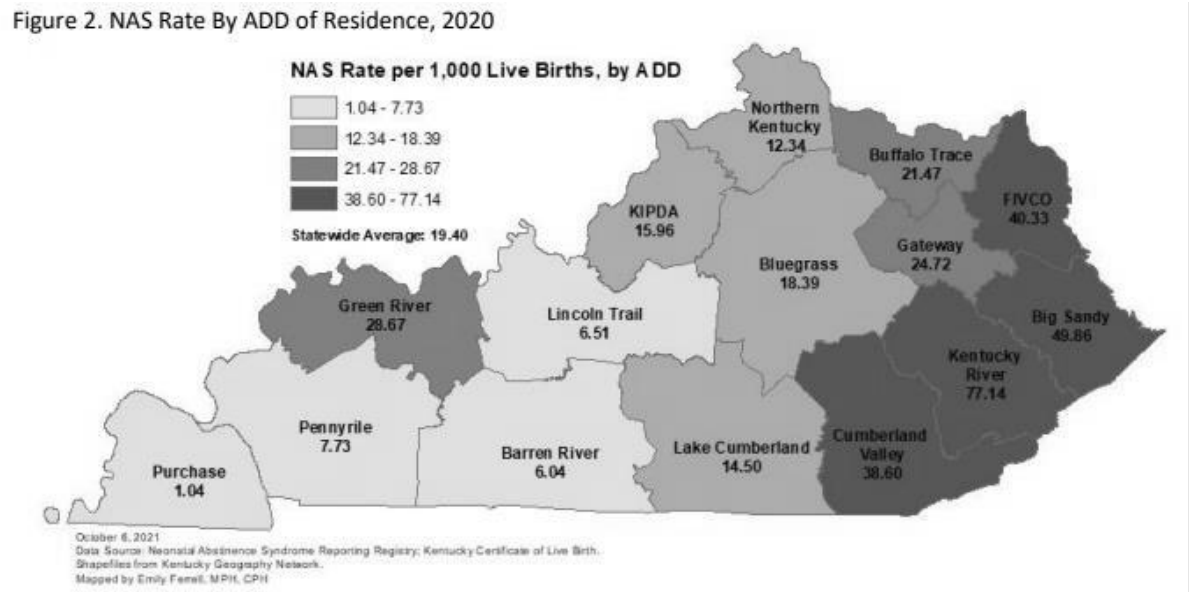
Figure 1. Kentucky Resident NAS Cases, 2015-2019




Source: Kentucky Cabinet for Health and Family Services (CHFS). (2021). *Neonatal Abstinence Syndrome in Kentucky: Annual Report on 2021 Public Health Neonatal Abstinence Syndrome (NAS) Reporting Registry*.

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. An example is 77.1 rate per 1,000 live births in 2020 in the Kentucky River Area Development District in southeastern Kentucky. (KCHFS, 2021).

Figure 2. NAS Rate By ADD of Residence, 2020




Source: Kentucky Cabinet for Health and Family Services (CHFS). (2021). *Neonatal Abstinence Syndrome in Kentucky: Annual Report on 2021 Public Health Neonatal Abstinence Syndrome (NAS) Reporting Registry*.

**Unmet Needs and Critical Service Gaps:**

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 aged twelve (12) and older.

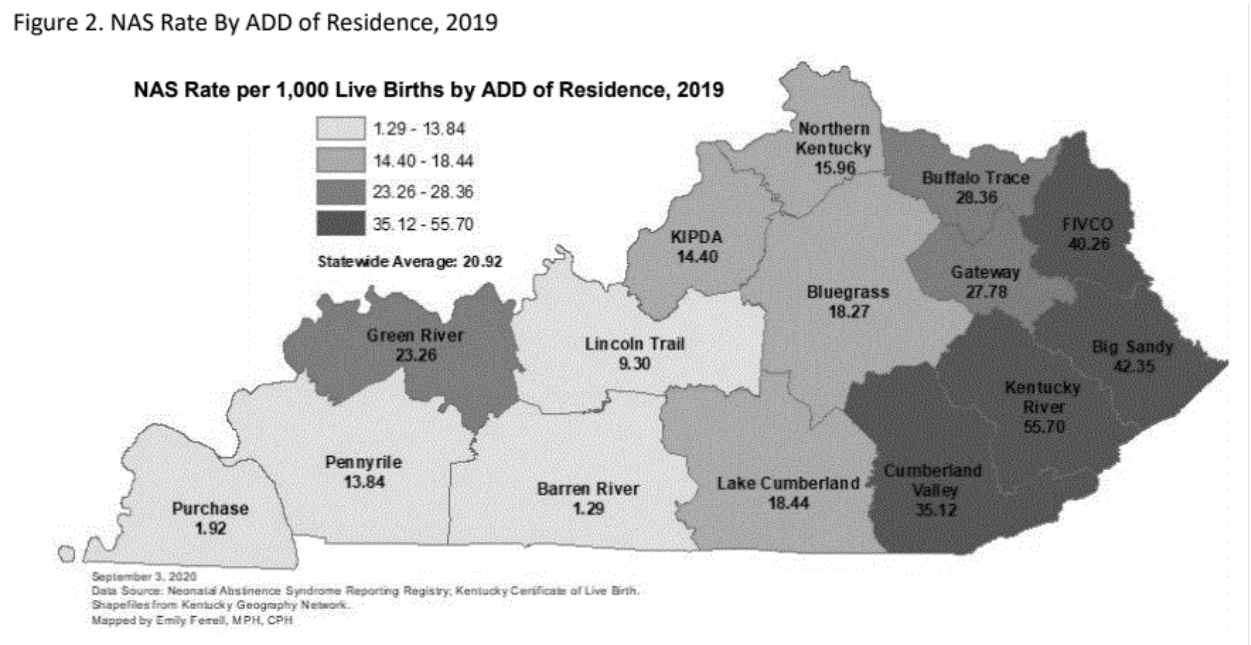
Stigma associated with pregnant women and substance use disorder continues to create barriers to identification and treatment of this population. To reduce stigma, ongoing training and consultation to professionals and community partners continues to be a crucial need.

Kentucky has struggled with development of comprehensive SUD treatment services in part due to the expansion of Medicaid enrollees and the subsequent growth of new behavioral health provider types across the state. While having substance use disorder treatment services newly included in the Medicaid State Plan Amendment in 2014 has been an important inclusion. the subsequent creation of new provider types in addition to CMHCs has been challenging. Behavioral Health Service Organizations (BHSOs) are private organizations (some non-profit) that are licensed to provide behavioral health services but may or may not have a relationship with DBHDID. In addition, most of the BHSOs that were created are serving mostly individuals with SUD.

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.

Figure 2. NAS Rate By ADD of Residence, 2019



***Addressing the Need:***
Kentucky implemented the Affordable Care Act (ACA) and expanded Medicaid coverage in 2014 to a larger population. Most critical to pregnant women with substance use/mental health disorders is the ACA parity requirement that ensures substance use disorder (SUD) and mental health disorder services are covered. Prior to this, Medicaid substance use disorder treatment 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 fourteen (14) Community Mental Health Centers (CMHCs) in Kentucky, 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.

Kentucky's statewide prevention and treatment infrastructure is growing. The statewide bed capacity of residential/transitional services for pregnant women is located within forty-seven (47) Alcohol and Other Drug Entity (AODE) licensed facilities, where eleven (11) of those programs also allow dependent children to live on-site with the mother during treatment and while transitioning through the continuum of care. There are 263 Intensive Outpatient Programs (IOP) for substance use disorder treatment and 492 outpatient programs have indicated that they are offering and providing substance use disorder treatment services to persons who are pregnant.

Kentucky has over 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 and 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 Toward Recovery (MATR)** engages pregnant and postpartum persons in universal, selective, and indicated substance use prevention education services, as well as identifies, assesses, and links pregnant and postpartum persons 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 enhance 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 Adult Substance Use Treatment & Recovery Services Branch in the Division of Substance Use Disorder has implemented a statewide effort in all 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 evidence-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, including 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 and Support (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 Houses that operate 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 Houses are 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 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. 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 through the specialized program, The Journey. This program has 25 available residential treatment beds for women, their infant and children under the age of two (2) as they move through the continuum of care, 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;

- 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;

- New Vista is a Community Mental Health Center located in Lexington KY. Through the Schwartz Center, pregnant women are provided specialized services. These services

include; 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; and

- The Appalachian Restoration Project located in Barbourville, KY provides residential services for twelve (12) pregnant and parenting women and their children under the age of two (2). Services include; residential substance use treatment, counseling services, medication-assisted treatment, and targeted case management services for women during pregnancy and post-partum.

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 10 (ten) DBHDID-funded POSC pilot sites led by the regional Community Mental Health Centers (CMHCs) in partnership with their local Department for Community Based Services

(DCBS), Child Protective Services, community partners and stakeholders. The 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. The Department is working to expand this project to all fourteen (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 serious mental illness die 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.

In 2017, Kentucky was awarded the Kentucky Care Integration (KCI) grant. This was 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 by the Substance Abuse and Mental Health Services Administration (SAMHSA). KCI was 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. The KCI sites provided co-located, integrated services, including evidence-based screening/assessment, diagnosis, prevention, and treatment according to a shared, individualized care plan. Preliminary data showed 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. Although the grant ended in 2022, the integrated care model continues at the two (2) grant sites and has influenced work across the state to move toward a broader application of this model.

In addition, the state of Kentucky currently has 33 Narcotic Treatment Programs/Opioid Treatment Programs and three (3) Medication Stations that accept pregnant persons. The Narcotic Treatment Program, and the New Vista Medication-Assisted Recovery Program in Lexington, receive block grant funding to assist in the treatment for this priority population. Pregnant women receive priority treatment at this program.

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), training specific to peer support specialists working with pregnant and parenting persons, 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. As of April 2023, Kentucky has 26 DBHDID approved SBIRT Instructors across the state;
- Continue the collaborative work of the 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 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 Toward 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, prior to, during, and after pregnancy through community engagement and outreach events. 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 preventioneducation and case management services for postpartum persons to six (6) months postbirth. This expansion would also provide services and supports to the individual during the most critical and important time in a new parent's life;
- Enhance training, data collection and reporting methods for community mental health center staff who work with pregnant and parenting persons;
- Continue to promote the development of a coordinated and collaborative system of care to address the needs of families affected by substance 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:***

Kentucky is working with many agencies and departments to collect data regularly 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 include:

Center for Behavioral Health Statistics and Quality. (2022). Results from the 2021 National Survey on Drug Use and Health: Detailed tables. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2021-nsduh-detailed-tables

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Halfon N, Mendonca A, and Berkowitz G, Health status of children in foster care. The experience of the Center for the Vulnerable Child. Arch Pediatr Adolesce Med, 1995. (149(4): 386-92.

Office of Drug Control Policy, Annual Report

CDAR: Center for Drug and Alcohol Research, KY-Moms Annual Report for 2017

Substance Abuse and Mental Health Services Administration, Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

National Institute on Drug Abuse, Advancing Addiction Science 2018

Produced by the Kentucky Injury Prevention and Research Center, May 2016. Kentucky Inpatient Hospitalization Claims Files, Frankfort, KY, [2000-2015]; Cabinet for Health and Family Services, Office of Health Policy.

**Parents with a substance use disorder who have 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. 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 misuse 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 child protective services 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 (KIPRC, 2022). Between 2000 to 2019, there was 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 (n = 907). In 2020, the KY NAS Registry documented 993 unduplicated cases of NAS, which was a decrease from 2019 (KY CHFS, 2021). The most recent data available shows a 2020 rate of NAS/ Neonatal Opioid Withdrawal Syndrome (NOWS) in Kentucky as 19.4 cases per 1,000 hospital births (KY CHFS, 2021).

After a decrease from 2017 to 2018, drug-involved fatal overdose rates have increased in Kentucky since 2019 through 2021: in 2019 (29.5), in 2020 (43.6), and in 2021 (50.1) per 100,000 population (Kentucky Injury Prevention and Research Center [KIPRC], 2022). The rate for non-heroin opioid-involved fatal overdoses has increased from 21.6 per 100,000 in 2019 to 39.8 per 100,000 in 2021 (KIPRC, 2022). However, the rate for heroin-involved fatal overdose has decreased since 2017 (5.4) to 2021 (1.2 per 100,000). The rate of non-cocaine stimulant-involved fatal overdose has increased from 7.0 in 2017 to 22.0 per 100,000 in 2021 (KIPRC, 2022).

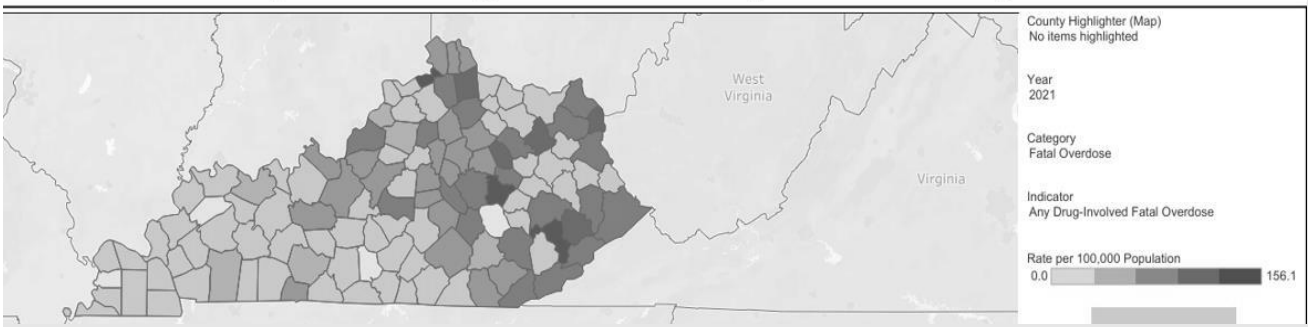
- Heroin use has not changed significantly in the general population of Kentucky residents from 2002-2004 and 2017-2019 (SAMHSA, 2020).
- Moreover, heroin-related overdose deaths declined by 90% from January 2017 through June 2021 among Kentucky residents (Kentucky Substance Use Research & Enforcement, 2022) and heroin-related emergency-related emergency department visits and inpatient hospitalizations also declined from January 2017 through June 2021 (by 55.2% and 45.4%, respectively).
- However, heroin-related emergency department visits and inpatient hospitalizations increased by 14.4% and 20.2% respectively from the first quarter of 2021 through the second quarter of 2021 (Kentucky Substance Use Research & Enforcement, 2022).

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 2021, 79.6% of drug overdose deaths (unintentional and undetermined intent) in Kentucky involved any opioids, with the most frequently reported opioid being illicitly manufactured fentanyl (Steel & Mirzaian, 2022). Fentanyl was the most frequently detected drug in toxicology testing for overdose deaths in 2021, found in 69.4% of overdose deaths (1,562), an increase of 15.4% over the 1,354 deaths in 2020 (Steel & Mirzaian, 2022).
- Opioid-related deaths among Kentucky residents increased by 59.3% from January 2017 through June 2021 (Kentucky Substance Use Research & Enforcement, 2022).
- Methamphetamine was involved in 858 (38.1%) drug overdose deaths in 2021, which was an increase of 48.2% over the 579 methamphetamine-involved overdose deaths in 2020 (Steel & Mirzaian, 2022). A 213.9% increase in methamphetamine-related overdose deaths was found among Kentucky residents from January 2017 through June 2021 (Kentucky Substance Use Research & Enforcement, 2021).
- The Centers for Disease Control and Prevention ranked Kentucky the 5th highest in rate for opioid prescribing in 2020, with a rate of 68.2 opioid painkiller prescriptions for every 100 people (CDC, 2021).
- 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).
- Opioid-related emergency department visits increased by 62.9% from January 2017 through June 2021 and by 18.0% from the first quarter of 2021 through the second quarter of 2021 (Kentucky Substance Use Research & Enforcement, 2021).

There is variability in the rate of drug overdose deaths by county and region of Kentucky (KIPRC, 2022). For example, in 2021, Estill County had the highest rate of fatal drug overdose, 156.1 per 100,000. The highest rates are found in Appalachian counties, the central Bluegrass Region, northern Kentucky and the counties around Jefferson (KIPRC, 2022).

**Kentucky Resident Drug Overdose Rates by State and County**




Source: Kentucky Injury Prevention and Research Center (KIPRC). (2022). Drug overdose and related comorbidity county profiles. Retrieved April 11, 2013 from https://kiprc.uky.edu/programs/overdose-data-action/county-profiles.

With regards to NAS in Kentucky, 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. An example is 77.1 rate per 1,000 live births in 2020 shown in the Kentucky River Area Development District in Southeastern 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 above the national average. Buprenorphine (64.3%), unspecified opioids (33.0%), heroin (18.9%), and methadone (10.5%) were the most frequently reported opioids. Other commonly used substances reported were amphetamines, including methamphetamine (35.6%), cannabinoids (28.3%), and benzodiazepines (11.1%) (KY CHFS, 2021). All other substances were used by less than 10% of women in the registry. A majority of cases (~61%) were exposed to more than one substance during pregnancy, with an average of being exposed to two (2) or more substances (KY CHFS, 2021). 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. Over half (54.3%) of women had a prescription for medications to treat substance use disorder (KY CHFS, 2021).

In addition, Infants with NAS are twice (2) as likely to have a low birth weight and three (3) times as likely to be admitted to a neonatal intensive care unit (KY CHFS, 2021). Tobacco use co-occurs with substance use at high rates, which could further affect the health and development of these infants. Kentucky Office of Vital Statistics data show that 14% of women whose babies did not have NAS reported they had smoked during pregnancy, which was significantly lower than the percent of women whose babies have NAS (68%) (KY CHFS, 2021). Infants with NAS are hospitalized approximately 3.5 times longer than infants without NAS at delivery (12.6 days versus 3.6 days, respectively). Infants with NAS who received pharmacological treatment (46%) had average hospital stays of 20.6 days compared to 5.9 days for infants who receive comfort care only (KY CHFS, 2021). Among infants who received pharmacological treatment in 2021, the most common pharmacological treatments were morphine (86.8%) and clonidine (27.6%), with approximately 28.5% of infants with NAS receiving multiple medications (KY CHFS, 2021).

***Unmet Needs and Service Gaps***:
As noted above, 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. The U.S. average is 8.9. Additionally, 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.

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 (KIPRC, 2022).

In Kentucky, the Department for Community Based Services (DCBS) is the child protective services authority and a sister Agency under the same Cabinet. Kentucky is currently struggling with significant workforce shortages within DCBS resulting in extremely high caseloads, challenging the ability to address the current needs of families affected by abuse and neglect. DCBS also experiences high staff turnover which results in less experienced and knowledgeable staff to address the significant risks caused by the rising use of substances and associated negative effects on families. Staff have limited training on SUD and are in need of assistance to provide quality services to address the needs of the families they serve.

Other areas of need include:

- Additional treatment programs that incorporate services for families with children.
- Support services specific to families with children including: childcare, parenting supports including parenting programs specific to families affected by SUD, supportive housing services, supported employment, peer support, transportation, and life skills development.
- 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 persons.

***Addressing the Need:***

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 (QRT) was established in one (1) CMHC region, seven (7) housing assistance programs were established, and five (5) reintegration programs were created to work collaboratively with the Justice System. 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 significantly 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 111 Oxford Houses that are equipped to provide a stable and supportive living environment for a person in SUD recovery and persons in SUD recovery with dependent children. Six (6) houses for women with dependent children and two (2) 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 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. KRHN has a total of fifty one (51) Certified Recovery Housing programs of those seven (7), certified residences to serve women with dependent children.

In order to increase access to recovery housing and increase the number of residences that support persons in recovery from substance use disorder (SUD), the Adult Substance Use Treatment and Recovery Services Branch offered five (5) recovery housing expansion grants to expand capacity or establish new recovery housing. The grants established new or expanded services for men, women, and pregnant and parenting women.

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.

DBHDID has partnered with the Pacific Institute for Research and Evaluation, (P.I.R.E.) and received one (1) of six (6) awards from the U.S. Office on Women's Health Violence Against Women and Substance Use Prevention Initiative bringing an additional 2.25 million dollars into the state of Kentucky to address intimate partner violence (Grant #ASTWH220123). The initiative, Focus on Integrating Response, Screening, and Training (FIRST) for Women in Kentucky, will create a community of practice connected to the KY Coalition Against Domestic Violence (KCADV) member programs and the KY Cabinet for Health and Family Services, Department for Behavioral Health, Developmental and Intellectual Disabilities, Branch of Adult Substance Use Treatment and Recovery Services that will implement intersectional, trauma-informed training for each of KYs' regional SUD treatment and Intimate Partner Violence (IPV) service providers. Specifically, the project engages KY's fourteen (14) regional Community Mental Health Centers as well as the fifteen (15) regional domestic violence shelters who are members of KCADV. The team is also working with the state Health Department and the KY Perinatal Quality Collaborative to address the intersection of IPV and SUD for local medical practitioners.

In addition, Kentucky plans to:

- 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 disorder 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 2024/2025 priorities.
- Increase the availability of crisis response including Quick Response Teams (QRT) and mobile response services

***Data Sources Used:***

- Department for Community Based Services (DCBS) TWIST (The Worker's Information System) Database

- TEDS (Treatment Episode Data Set)

- NOMS (National Outcome Measures) data set.

- Halfon N, Mendonca A, and Berkowitz G, Health status of children in foster care. The experience of the Center for the Vulnerable Child. Arch Pediatr Adolesce Med, 1995. (149(4): 386-92.

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- Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (2021, September 22). U.S. state opioid dispensing rates, 2020. Accessed on April 11, 2023 at https://www.cdc.gov/drugoverdose/rxrate-maps/state2020.html

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- Kentucky Substance Use Research & Enforcement. Six Major Overdose-Related Substances in Kentucky, January 1, 2017–June 30, 2021. K-SURE Brief (No.16), December 2021. Accessed April 10, 2023 at https://kiprc.uky.edu/sites/default/files/2022-01/K.SURE%20Product%2016%2C%202021-final.pdf.

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Syndrome (NAS) Reporting Registry. Retrieved from https://chfs.ky.gov/agencies/dph/dmch/Documents/NASReport.pdf

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- National Institute on Drug Abuse. (2019). Kentucky Opioid Summary. Retrieved from https://www.drugabuse.gov/opioid-summaries-by-state/kentucky-opioid-summary

- Norton Children's News (April 2021) https://nortonchildrens.com/news/kentucky-child-abuse-statistics

- Steel, M., & Mirzaian, M. (2022). Kentucky resident drug overdose deaths, 2017-2021: Annual report. Lexington, KY: University of Kentucky, Kentucky Injury Prevention and Research Center. Accessed on April 10, 2023 at https://kiprc.uky.edu/sites/default/files/2022-06/KY%20Drug%20Overdose%20Deaths%20Annual%20Report%202021.pdf.

- Substance Abuse and Mental Health Services Administration. (2020). Behavioral Health Barometer: Kentucky, Volume 6: Indicators as measured through the 2019 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services. HHS Publication No. SMA–20–Baro–19–KY. Rockville, MD: Substance Abuse and Mental Health Services Administration.

**Individuals with Substance Use Disorders**

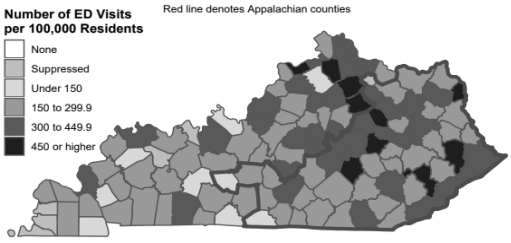
***Prevalence Data for this population:***

An estimated 15.3% of the population age 12 and older in the U.S. met diagnostic criteria for alcohol or drug use disorder in 2021 (Substance Abuse & Mental Health Data Archive, 2023). Based on the 2020 census data estimate for 2021, the state population age 12 and older was 3,851,676. Using this formula, 589,306 of Kentucky's population age 12 and older met criteria for an SUD. (U.S. Census Bureau, Kentucky State Data Center). During SFY 2021, Kentucky's fourteen (14) Community Mental Health Centers (CMHCs) provided substance use specific treatment for 17,373 unique individuals ages 12 and older, 175 of whom were under age 18 (Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set, 2022). The total number of unique individuals served across the CMHCs in state fiscal year 2022 was 154,873 and 27,592 were identified as having co-occurring mental health and substance use disorders.

Nationally, the Centers for Disease Control and Prevention (CDC) estimates that drug overdose deaths increased by 30% from October 2019 to October 2020. According to the CDC, drug overdose deaths in Kentucky increased by 14.2% from 2,104 in December 2020 to 2,403 in December 2021, but then decreased by 6.7% from 2,422 in October 2021 to 2,259 in October 2022 (Ahmad, Cisewski, Rossen, & Sutton, 2023). 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, fatal overdose rates began to rapidly increase beginning in mid-March

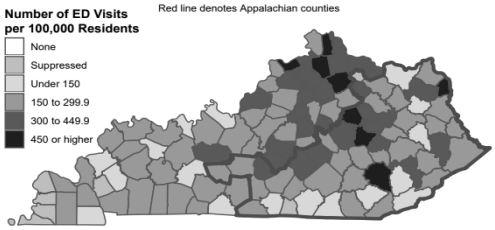
reaching their peak in October 2021 (Ahmad et al., 2023). In 2021, a total of 12,946 Kentucky residents visited an emergency department (ED) for a nonfatal drug overdose, which was an increase of 0.4% over the number of nonfatal drug overdose visits in 2020 (12,894) (Steel & Mirzaian, 2022b). From 2020 to 2021, the number of nonfatal overdoses involving a non-heroin opioid increased by 19.7%, while the number of nonfatal overdoses involving heroin decreased by 26.3%, and the number of nonfatal overdoses involving psychostimulants other than cocaine decreased by 5.9% (Steel & Mirzaian, 2022b). Beginning in 2020, the age-adjusted rate of ED visits for nonfatal drug overdoses involving any drug among Kentucky residents was higher for Black individuals than White individuals with this pattern continuing in 2021 (Steel & Mirzaian, 2022b).

**Figure 10.1.1: Age-Adjusted Rates of Emergency Department (ED) Visits for a Nonfatal Drug Overdose by Kentucky County of Residence, 2021**



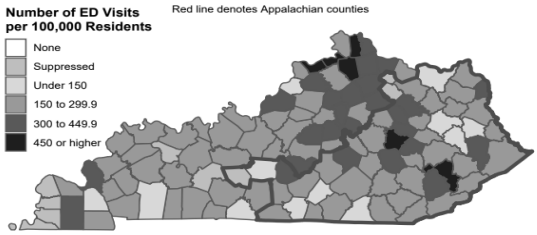

Produced by the Kentucky Injury Prevention and Research Center, as bona fide agent for the Kentucky Department for Public Health. Data source: Kentucky Outpatient Services Database Files, Office of Health Data and Analytics, Cabinet for Health and Family Services. Data extracted September 2022. Data are provisional and subject to change.

**Figure 10.1.4: Age-Adjusted Rates of Emergency Department (ED) Visits for a Nonfatal Drug Overdose by Kentucky County of Residence, 2018**



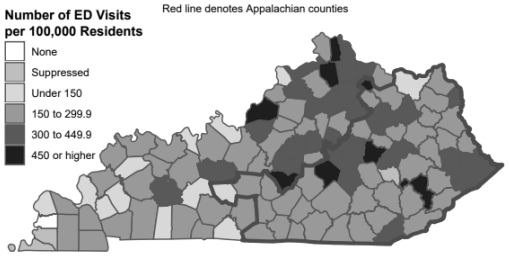

Produced by the Kentucky Injury Prevention and Research Center, as bona fide agent for the Kentucky Department for Public Health. Data source: Kentucky Outpatient Services Database Files, Office of Health Data and Analytics, Cabinet for Health and Family Services. Data extracted September 2022. Data are provisional and subject to change.

**Figure 10.1.3: Age-Adjusted Rates of Emergency Department (ED) Visits for a Nonfatal Drug Overdose by Kentucky County of Residence, 2019**




Produced by the Kentucky Injury Prevention and Research Center, as bona fide agent for the Kentucky Department for Public Health. Data source: Kentucky Outpatient Services Database Files, Office of Health Data and Analytics, Cabinet for Health and Family Services. Data extracted September 2022. Data are provisional and subject to change.

**Figure 10.1.2: Age-Adjusted Rates of Emergency Department (ED) Visits for a Nonfatal Drug Overdose by Kentucky County of Residence, 2020**

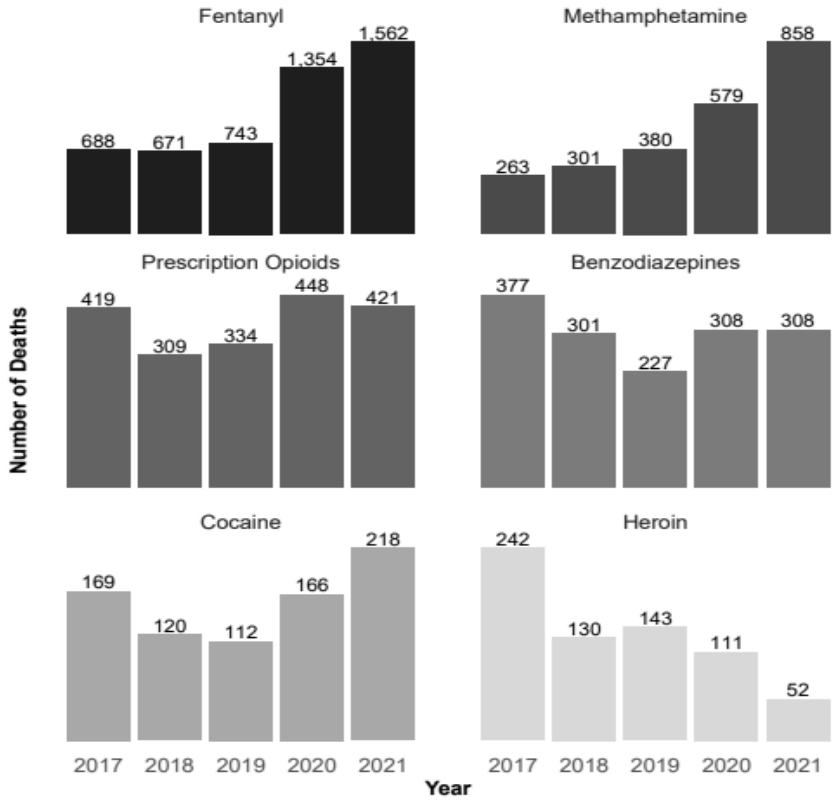



Produced by the Kentucky Injury Prevention and Research Center, as bona fide agent for the Kentucky Department for Public Health. Data source: Kentucky Outpatient Services Database Files, Office of Health Data and Analytics, Cabinet for Health and Family Services. Data extracted September 2022. Data are provisional and subject to change.

The majority of drug overdose deaths in Kentucky residents involve opioids: 79.6% in 2021 and 81.1% in 2020 (Steel & Mirzaian, 2022a). Opioid overdoses are primarily attributed to fentanyl and fentanyl analogs. Fentanyl was involved in 69.4% of drug overdose deaths in 2021, which was an increase of 15.4% over the fentanyl-involved deaths in 2020 (Steel & Mirzaian, 2022a). Methamphetamine was involved in 38.1% of the overdose deaths in 2021, which was an increase of 48.2% over the methamphetamine-involved overdose deaths in 2020 (Steel & Mirzaian, 2020a).

**Number of Deaths, by Drug Type**

**Numbers of Drug Overdose Deaths among Kentucky Residents by Drug Type, 2017–2021**




Produced by the Kentucky Injury Prevention and Research Center as bona fide agent for the Kentucky Department for Public Health. Data are provisional and subject to change. June 2022.

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Emergency medical services (EMS) for suspected drug overdose-related encounters increased 60.2% from January 2017 through June 2021 (Kentucky Substance Use Research & Enforcement, 2021). The second quarter of 2021 had the second highest number of EMS suspected overdose encounters (a little over 4,500) in Kentucky, with the second quarter of 2020 having the highest number (a little under 5,000) (Kentucky Substance Use Research & Enforcement, 2021). Drug overdose-related hospitalizations declined by 18.3% from 2017 through June 2021; however, they increased by 19.5% from the first quarter of 2021 through the second quarter of 2021 (Kentucky Substance Use Research & Enforcement, 2021).

According to the Kentucky Housing Corporation (KHC, 2021), of the 4,011 individuals experiencing homelessness 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 experience homelessness. Approximately 80% of those who experience chronic homelessness report lifetime substance use and more than one third (34.7%) of individuals experiencing homelessness report engaging in chronic substance use (SAMHSA, 2011). In a systematic review of 39 articles on homelessness of adults in high-income countries, the most common diagnostic category was alcohol use disorders (a random effects pooled prevalence of 36.7%), followed by drug use disorders (21.7% random effects pooled prevalence; Gutwinski, Schreiter, Deutscher, & Fazel, 2021).

According to the 2021 Neonatal Abstinence Syndrome (NAS) Reporting Registry Annual Report, there were 993 unduplicated cases of newborns with signs and symptoms of NAS in 2020, which was a decrease from 2019 (Kentucky Cabinet for Health and Family Services [KY CHFS], 2021). This represents 19.4 of every 1,000 live births among Kentucky residents. NAS prevalence rates are highest in Appalachian regions of the state, with the rate in Kentucky River ADD at 77.1 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 2.6 times above the national average. Buprenorphine (64.3%), unspecified opioids (33.0%), heroin (18.9%), and methadone (10.5%) were the most frequently reported opioids. Other commonly used substances reported were amphetamines, including methamphetamine (35.6%), cannabinoids (28.3%), and benzodiazepines (11.1%) (KY CHFS, 2021). All other substances were used by less than 10% of women in the registry. A majority of cases (61%) were exposed to more than one substance during pregnancy, with an average of being exposed to two (2) or more substances (KY CHFS, 2021). Although buprenorphine and methadone can produce NAS, these are FDA approved medications used under medical supervision for the treatment of OUD, which is preferable to untreated OUD during pregnancy that is associated with adverse health outcomes. Increased access to and utilization of MOUD may explain why these medications are two (2) of the most reported substances to the NAS registry. Over half (54.3%) of women had a prescription for medications to treat substance use disorder (KY CHFS, 2021).

In addition, infants with NAS are twice (2) as likely to have a low birth weight and three (3) times as likely to be admitted to a neonatal intensive care unit (KY CHFS, 2021). Tobacco use co-occurs with substance use at high rates, which could further affect the health and development of these infants. Kentucky Office of Vital Statistics data show that 14% of women whose babies did not have NAS reported they had smoked during pregnancy, which was significantly lower than the percent of women whose babies have NAS (68%) (KY CHFS, 2021). Infants with NAS are hospitalized approximately 3.5 times longer than infants without NAS at delivery (12.6 days versus 3.6 days, respectively). Infants with NAS who received pharmacological treatment (46%) had average hospital stays of 20.6 days compared to 5.9 days for infants who receive comfort care only (KY CHFS, 2021). Among infants who received pharmacological treatment in 2021, the most

common pharmacological treatments were morphine (86.8%) and clonidine (27.6%), with approximately 28.5% of infants with NAS receiving multiple medications (KY CHFS, 2021).

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.

***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;
- Recovery Housing;
- Services directed at addressing SUD services for individuals experiencing homelessness;
- In reach services and programs targeting justice involved individuals;
- Transportation to access substance use disorder treatment services in rural areas;
- Systematic screening of pregnant persons for SUD
- Residential housing for pregnant and parenting persons;
- 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;
- Harm reduction resources and outreach;
- Crisis response services
- Access to naloxone among stimulant users, and
- Limited access to Wi-Fi services.

As noted earlier**,** approximately 80% of those who experience chronic homelessness report lifetime substance use and more than one third (34.7%) of individuals experiencing homelessness report engaging in chronic substance use. Services to identify and engaged this population remain limited. For those individuals who enter into treatment there remains a need for housing supports both during and after treatment 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 appropriate and available treatment and recovery housing for 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 reentry. During SFY 2022, COVID restrictions were eased and in reach services were restored. However, due to workforce issues, staffing these programs remain a challenge and available services for those experiencing reentry remain limited. The goal for DBHDID is to provide an array of services and supports for justice involved individuals returning to their communities. Program case managers assess and identify individual needs prior to release from custody. Appropriate wraparound services including substance use, mental and physical health treatment as well as harm reduction and peer support are coordinated.

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. In Kentucky, methamphetamine was involved in 858 overdose deaths in 2021, which was 38.1% of overdose deaths, and an increase from 2020 (n = 578, 29.4%) (Steel & Mirzaian, 2022a). 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.

***Addressing the Need:***

During SFY 2022, the Adult Substance Abuse Treatment and Recovery Services Branch of DBHDID operated the Kentucky Recovery Housing Network (KRHN), implementing best-practice standards for recovery housing. KRHN provided technical assistance to recovery housing operators, community partners, provided an open forum for training and community building with a monthly open call, and created a directory of certified recovery housing. In order to increase access to recovery housing and increase the number of residences that support persons in recovery from substance use disorder (SUD), the Adult Substance Abuse Treatment and Recovery Services Branch offered five (5) recovery housing expansion grants to expand capacity or establish new recovery housing. The grants established new or expanded services for men, women, and pregnant and parenting women. Kentucky currently has a total of 51 Certified Recovery Housing programs with over 700 beds. The program continues to grow at a constant rate.

Additionally, the SUD Treatment Branch, created supportive infrastructure and provided technical assistance to the Kentucky Oxford House Outreach staff and began to implement a strategic planning process to enhance equitable access to community-based recovery housing. In an effort to facilitate referrals for housing requests and to maximize a cooperative approach to services for at-risk populations, linkages were created with health care providers, substance use treatment and recovery programs, and criminal justice agencies. Kentucky Oxford House has opened houses throughout the state for men, women, men with children, and women with children. There are currently 111 houses across the state.

During SFY 2022, DBHDID provided grants to increase access to crisis and treatment services. Those grants supported innovative projects designed to identify and engage underserved populations experiencing a crisis, including individuals experiencing homelessness, justice involved individuals and individuals discharged from emergency rooms.

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 peer 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 the gold standard for opioid use disorder treatment through the thirty three (33) state-certified Narcotic Treatment Programs that dispense methadone or buprenorphine in tandem with treatment services. Kentucky also maintains comprehensive legislative regulations to support access to all buprenorphine formulations.. For example, Kentucky has removed prior authorization requirements for extended-release buprenorphine, Sublocade. Additionally, Kentucky has established an online treatment locator platform called FindHelpNowky.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. FindHelpNowky.org also contains a multidisciplinary information center to help answer questions about substance use, treatment, recovery and harm reduction resources. FindHelpNowky.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 continue to work on the following:

- Increase access to quality prenatal care;
- Increase access to MOUD for pregnant and parenting persons;
- Implementing a plan of safe care initiative to enhance, at the community level, a coordinated system of care for pregnant and parenting persons, their infants and families affected by SUD;
- 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.

In response to the ongoing opioid crisis DBHDID has worked to expand access to MOUD and increase the number of Kentuckian’s linked to treatment, harm reduction, and recovery services. Key interventions include education & technical support, identifying and addressing MOUD access gaps, and expanding the MOUD delivery system. Targeted implementation areas will include clinical and nonclinical settings: OBOT & OTP’s, general healthcare, prehospital and hospital, mobile treatment units, correctional settings, and other community-based programs. Local interdisciplinary teams will be identified and assembled to carry out interventions at the

community level. Kentucky currently has 33 full service Narcotic Treatment Programs (NTP) and three (3) medication stations.

Through federal funding from the Substance Abuse and Mental Health Services Administration (SAMHSA), from the Kentucky State Opioid Response (SOR) grants and guided by the Recovery-Oriented System-of-Care framework, the Kentucky Opioid Response Effort (KORE) implements a robust array of evidence-based prevention, harm reduction, treatment, and recovery support services for individuals with opioid and/or stimulant use disorder (OUD/StimUD). Priority populations include: 1) Overdose survivors; 2) Justice-involved individuals; 3) Pregnant/parenting women; and 4) Black, Indigenous, and People of Color. Goals and annual objectives are driven by a needs assessment and strategic plan. From September 30th, 2021, to September 29, 2022, the number of unduplicated clients that received OUD treatment services through KORE was 13,150. This includes 3,991 that received services that included the use of a federally approved medication for the treatment of opioid use disorder. During the same time period, 13,149 unduplicated clients received recovery support services that included access to recovery housing, coaching or peer support, and employment supports.

Work to address the needs of individuals with substance use disorder in Kentucky continues. This includes concerted efforts to mitigate complications stemming from the COVID-19 pandemic, ensure equity in service access and availability 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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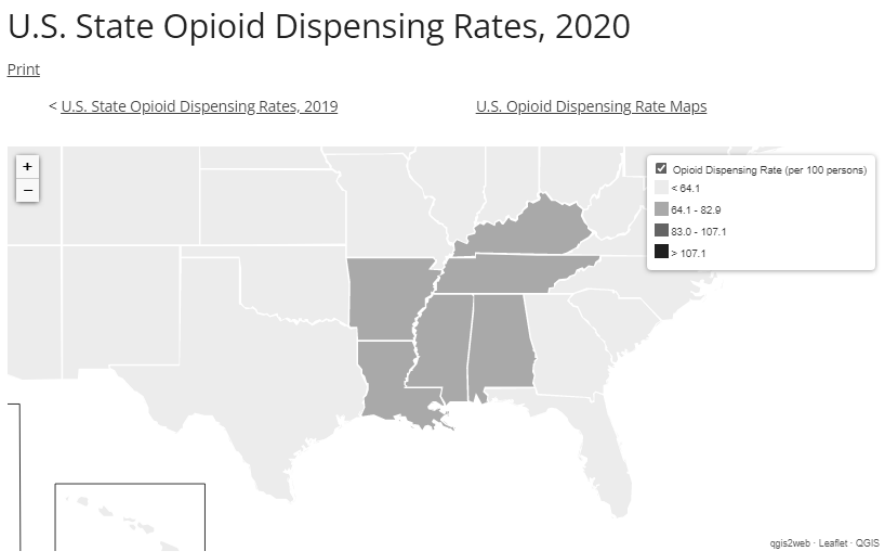
**Persons who inject drugs (PWID):**

***Prevalence Data:***

A 2014 Cabinet policy change included an expansion in the types of providers that could be reimbursed for Substance Use Disorder (SUD) treatment services through the Kentucky Department for Medicaid Services. The full impact of this policy remains unseen; yet, the DBHDID is noticing a shift in substance use disorder service provision by its contracted CMHCs. 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 SUD. The DBHDID data reflects this by showing a decline in the number of persons having SUD served by CMHCs. In that same time frame, there was a decrease of 0.277% (5,806) in the overall number of persons having SUD that were served by CMHCs. Two (2) important subsets of that include persons who inject drugs 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 DBHDID 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. In 2021, a total of 2,251 Kentucky residents died from drug overdose, which was an increase of 14.6% over the 1,965 drug overdose deaths in 2020 (Steel & Mirzaian, 2022). The Centers for Disease Control and Prevention ranked Kentucky the 5th highest in rate of opioid prescribing in 2020, with a rate of 68.2 opioid painkiller prescriptions for every 100 people (CDC, 2021).




Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (2021, September 22). *U.S. state opioid dispensing rates, 2020*. Accessed on April 11, 2023 at https://www.cdc.gov/drugoverdose/rxrate-maps/state2020.html

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, 2021, 2022). Kentucky had the fifth highest rate of opioid prescribing in the US in 2020 at 68.2 opioid painkiller prescriptions for every 100 people (CDC, 2021). In 2020, 51 Kentucky counties had opioid dispensing rates that were higher than the U.S. average rate of 43.3 prescriptions per 100 persons (CDC, 2022). Opioids continued to drive the increase in drug overdose deaths:

- In 2021, 79.6% of drug overdose deaths (unintentional and undetermined intent) in Kentucky involved any opioids, with the most frequently reported opioid being illicitly manufactured fentanyl (Steel & Mirzaian, 2022).
- Kentucky ranked third in the U.S. for drug overdose deaths (unintentional, intentional, undetermined) in 2020 at 49.2 per 100,000 (age-adjusted) and fifth in the U.S. at 55.6 (age-adjusted) drug overdose deaths per 100,000 in 2021 (CDC, 2023).
- 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). Drug overdose deaths among Kentucky residents increased 14.6% from 2020 to 2021 (Steel & Mirzaian, 2022).

- For the first time from 2017, in 2021, the age-adjusted rate of drug overdose deaths among Black Kentucky residents was higher than the age-adjusted rate for White Kentucky residents (Steel & Mirzaian, 2022).
- Fentanyl was the most frequently detected drug in toxicology testing for overdose deaths in 2021, found in 69.4% of overdose deaths (1,562), an increase of 15.4% over the 1,354 deaths in 2020 (Steel & Mirzaian, 2022).
- Methamphetamine was involved in 858 (38.1%) drug overdose deaths in 2021, which was an increase of 48.2% over the 579 methamphetamine-involved overdose deaths in 2020 (Steel & Mirzaian, 2022). A 213.9% increase in methamphetamine-related overdose deaths was found among Kentucky residents from January 2017 through June 2021 (Kentucky Substance Use Research & Enforcement, 2021).
- Fentanyl and fentanyl analog-related deaths increased by 97.5% from the beginning of 2017 through June 2021 (Kentucky Substance Use Research & Enforcement, 2021).
- Heroin-related emergency department visits and inpatient hospitalizations declined from January 2017 through June 2021 (by 55.2% and 45.4%, respectively). Nonetheless, from the first quarter of 2021 through the second quarter of 2021, heroin-related emergency department visits and inpatient hospitalizations increased (by 14.4% and 20.2%, respectively) (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 regarding the use of medications to treat substance use disorder. This has limited some client's access to person-centered services and a complete continuum of evidence-based 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 barriers and location of services.

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

***Addressing the Need:***
DBHDID will continue to ensure that all CMHCs screen for intravenous 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 Services Programs (SSP). And to enhance harm reduction efforts statewide. (no block grant funds will be used to purchase syringes). In addition, DBHDID will work to enhance access to peer support services for these individuals as well as evidence-based OUD services, including MOUD.

DBHDID has established a goal to expand access to MOUD and increase the number of Kentuckian's linked to treatment, harm reduction, and recovery services. Key interventions include education & technical support, identifying and addressing MOUD access gaps, and

expanding the MOUD delivery system. Implementation areas of focus include clinical and nonclinical settings such as: Office Based Opioid Treatment (OBOT) & Opioid Treatment Programs(OTPs), general healthcare, prehospital and hospital, mobile treatment units, correctional settings, and other community-based programs. Local interdisciplinary teams will be identified and assembled to carry out interventions at the community level. Kentucky currently has 33 full-service Narcotic Treatment Programs (NTP) and 3 medication stations.

As of April 2023, there were 83 Syringe Services Program (SSP) sites in 64 counties in KY. Community-based SSPs provide access to sterile needles and syringes free of cost, facilitate safe disposal of used needles and syringes and offer safer injection education. SSPs in Kentucky also provide participants with access to critical services and programs, including substance use disorder treatment programs, overdose prevention education, screening, care and treatment for HIV and viral hepatitis, prevention of mother-to-child transmission, hepatitis A and hepatitis B vaccination, screening for other sexually transmitted diseases and tuberculosis, partner services, and other medical, social and mental health services.

In addition the Kentucky Opioid Response Effort (KORE) has instituted the KORE Effort Overdose Education and Naloxone Distribution (OEND) program to provide naloxone at no cost to Kentucky agencies serving individuals at risk for opioid overdose or who may be in a position to reverse an overdose. Guided by the Recovery-Oriented System of Care Framework, the purpose of the Kentucky Opioid Response Effort (KORE) is to implement a comprehensive targeted response to Kentucky's opioid crisis by expanding equitable access to a full continuum of high quality, evidence-based opioid prevention, harm reduction, treatment, and recovery supports. The Kentucky Opioid Response Effort (KORE) is supported through a Substance Abuse and Mental Health Services Administration (SAMHSA) Grant H79TI083283.

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**Persons with or at risk for HIV/AIDS and who are in treatment or in need of treatment for substance use disorders**

***Prevalence data:***
In 2021, the estimated rate of Acquired Immune Deficiency Syndrome (AIDS) for Kentucky was 3.8 out of 100,000. (CSC, 2023)

In 2019, the estimated HIV prevalence (undiagnosed and diagnosed) in Kentucky was 242.8 cases per 100,000 and there were 328 cases of HIV diagnoses (CDC, 2023), 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).

In 2019, the estimated HIV prevalence (undiagnosed and diagnosed) in Kentucky was 242.8 cases and there were 328 cases of HIV diagnoses (CDC, 2023), 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).

Despite the fact that Kentucky is not a designated HIV state, Kentucky continues to monitor this issue and work with providers to meet all the needs of individuals in treatment or in need of treatment for substance use disorders.

**Hepatitis C (HCV)**
Kentucky has relatively low rates of HIV/AIDS, but a much higher rate of Hepatitis C. Kentucky is one of nine (9) states with the highest incidence rates of reported cases of acute Hepatitis C virus infection in 2020. In 2020, Kentucky had the eighth highest rate at 3.2 per 100,000 (CDC, 2022a). Moreover, in 2020, Kentucky had the sixth highest rate of deaths with hepatitis C listed as a cause of death, 6.17 per 100,000 (CDC, 2022b). 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.).

Injection drug use (IDU) is the most common means of HCV transmission in the U.S. (CDC, 2020). 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 (Schillie et al., 2020).

From 2013-2016, Kentucky had the second highest estimated prevalence of hepatitis C among pregnant women per National Health and Nutrition Examination Survey (NHANES); Schillie et al., 2020).

**Unmet Needs and Critical Gaps:**
HIV has been found across Appalachia, though known rates so far are lower than in urban Kentucky, where testing is more common. April Young, a University of Kentucky assistant professor of epidemiology, said less HIV testing in Eastern Kentucky means the disease could be spreading silently.

Many Kentuckians with HIV do not get tested before they become sick. As of June 30, 2017, 10,244 HIV infections had been diagnosed among Kentuckians and 63 percent of those cases had progressed to AIDS. Of the 3,600 AIDS cases diagnosed in the last 10 years, 24 percent were unaware of their HIV infection until 30 days or fewer before their AIDS diagnosis. This means many had been infected and infectious for 10 or more years before ever testing.
Researchers point to an explosion of HIV's widely accepted harbinger: the potentially deadly liver disease hepatitis C. Kentucky is one of nine (9) states with the highest incidence rates of reported cases of acute Hepatitis C virus infection in 2020. Like HIV, "hep C" can be spread by sharing needles. And it's easier to contract, so it's not uncommon to have both diseases. From 2008-2015, Kentucky had the nation's highest rate of new, acute hep C infections, with 1,089 cases. Another 38,000 Kentuckians live with chronic hep C.

**Addressing the Need**:
DBHDID works collaboratively with the Kentucky Department for Public Health to address HIV/AIDS.

The Kentucky Department for Public Health (DPH) HIV/AIDS Section assesses the current and future impact of HIV in Kentucky. This unit is composed of surveillance, prevention, and services programs. The HIV/AIDS Section is committed to:

1. Ensuring that HIV/AIDS surveillance is a quality, secure system;
2. Ensuring that all people at risk for HIV infection know their sero-status;
3. Ensuring that persons not infected with HIV remain uninfected;
4. Ensuring that persons infected with HIV do not transmit HIV to others;
5. Ensuring that persons infected with HIV have access to the most effective therapies possible;
6. Ensuring a quality professional education program includes the most current HIV/AIDS information.

Every county health department in Kentucky and many community based organizations offer free anonymous or confidential HIV tests.

To combat growing concern over HIV and Hepatitis C outbreaks, Kentucky law allows county health departments to provide syringe exchange programs also known as Syringe Service Programs. These programs have proven effective in reducing the spread of infections without

increasing drug use. There are currently 83 syringe services programs in 64 counties across the state.

The Kentucky HIV/AIDS Planning and Advisory Council (KHPAC) is responsible for planning priority interventions for target populations across the state, advising the Cabinet for Health and Family Services regarding HIV/AIDS activity in the commonwealth and providing guidance to the Title II Services Program. Much effort is made to assure the membership of KHPAC reflects the epidemic in our state with representation from all targeted populations.

The Viral Hepatitis Program (VHP) is responsible for prevention efforts and enhanced surveillance for adult hepatitis B, adult hepatitis C and perinatal hepatitis C. VHP works collaboratively with the Reportable Disease Section and the Immunization Branch at KDPH on other hepatitis activities. The program emphasizes the role of harm reduction and drug user health and strives to center the voices of those with lived experience.

Specifically, VHP aims to achieve the following:

- Develop, implement, and maintain a plan to rapidly detect and respond to outbreaks of acute hepatitis B and acute hepatitis C
- Systematically collect, analyze, interpret and disseminate data to characterize trends and implement public health interventions for acute hepatitis B and acute and chronic hepatitis C
- Support viral hepatitis elimination planning and surveillance and help maximize access to testing, treatment and prevention
- Improve access to services for people who inject drugs in areas disproportionately affected by drug use

The Division of Substance Use Disorder 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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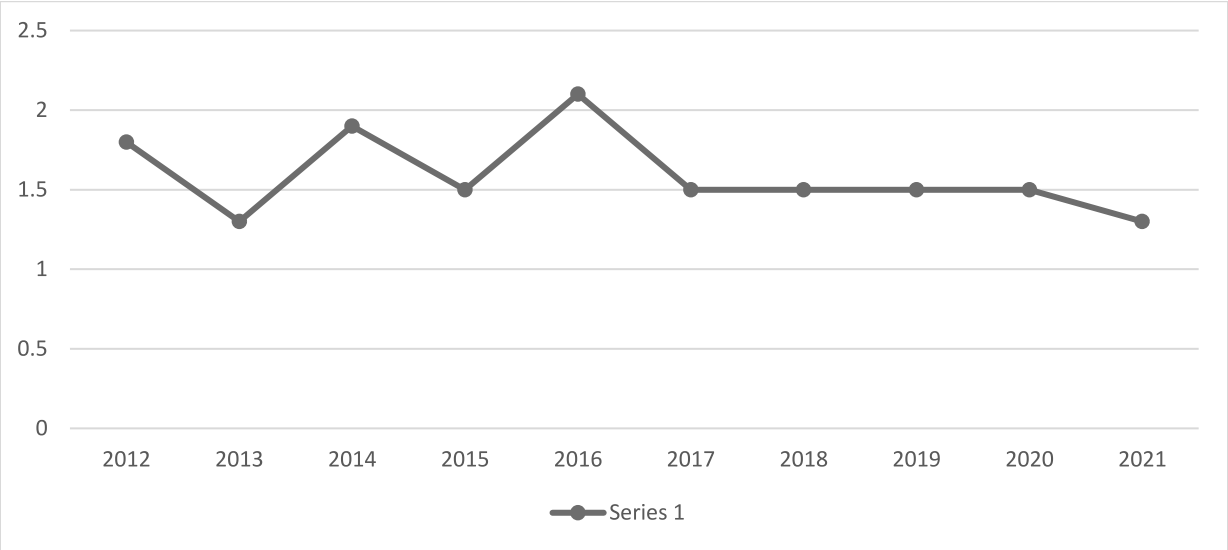
**Individuals with or at risk of tuberculosis**

***Prevalence Rate:***

Overall, rates of tuberculosis decreased gradually from 1993 to 2020 (2.2 cases per 100,000 persons in the U.S. (CDC, 2022a, 2022b). In 2021, there was a rebound in the incidence rate to pre-pandemic levels, 2.4 cases per 100,000 (CDC, 2022a). Kentucky is considered a low-incidence state for tuberculosis, ranking 34$^{th}$ out of the 50 U.S. states for highest incidence, per the Centers for Disease Control & Prevention (CDC, 2022b). As reported by the Kentucky Department for Public Health (DPH), a total of 67 cases of tuberculosis were reported statewide for 2021, which is a rate of 1.3 per 100,000 (Kentucky total population per 2020 Census, 4,505,836). This is below the national incidence rate for the U.S. in 2021 of 2.4 per 100,000, based on the total national population of 331,501,080. (Kentucky Cabinet for Health and Family Services, 2022). Kentucky has seen a nearly continual reduction of cases of tuberculosis since 2000, when the rate was 3.7 per 100,000. Within the last 10 years, incidence rates 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*

**Figure 1. Kentucky's annual incidence rates (per 100,000 population) of tuberculosis, 2012-2021**




**Source: Kentucky Cabinet for Health and Family Services, Department for Public Health, Division of Epidemiology and Health Planning, Infectious Disease Branch. (2022). *Kentucky's 10-year tuberculosis confirmed case counts and incidence rates, 2012-2021*. Frankfort, KY: Kentucky Tuberculosis Prevention and Control Program. April 11, 2023 https://www.chfs.ky.gov/agencies/dph/dehp/idb/Documents/201221ConfirmedTBCased.pdf**

Information obtained from the Kentucky Department Of Public Health (DPH) - **https://chfs.ky.gov/agencies/dph/dehp/idb/Pages/tbdata.aspx**

***Unmet Needs and Critical Service Gaps:***
Despite the relatively low rates of tuberculosis in Kentucky, CDC (2022c) advises that persons with weakened immune systems are at a higher risk of contracting tuberculosis. This includes individuals experiencing SUD. Kentucky ranks among the highest U.S. states for prevalence of substance misuse. Moreover, individuals who live in congregate settings, including correctional facilities, detention centers, residential facilities, and homeless shelters have an increased risk of becoming infected with tuberculosis due to shared airspaces (CDC, 2022c).

***Addressing the Need:***
DBHDID works with the fourteen (14) Community Mental Health Centers (CMHCs) to ensure that individuals who receive SUD services and have or are at risk of contracting tuberculosis, 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 tuberculosis, ensuring that CMHCs are systematically screening for tuberculosis among individuals receiving services for SUD, and offering CMHCs technical assistance in updating and improving their policies and procedures regarding tuberculosis screening and referral.

The Division of Substance Use Disorder 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.

The Division of Substance Use Disorder 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 have been submitting their specific written procedures, training processes, and training curriculum to DBHDID as part of the annual reporting process. These written procedures include the CMHC's training curriculum designed to ensure staff receive adequate instruction on effective and consistent implementation of the CMHC's tuberculosis protocols.

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 tuberculosis as a public health problem. The program works to achieve that objective by focusing its efforts on rendering and maintaining all individuals who have tuberculosis disease, as non-infectious, ensuring non-infected persons do not become infected, and ensuring that individuals who are infected but who do not have tuberculosis 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. DBHDID continues to work with the DPH to obtain the most current data on Kentucky's rates of newly diagnosed cases of tuberculosis so the most appropriate services may be coordinated.

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

***Prevalence Data/Unmet Needs and Service Gaps:***

Analysis of 2021 Youth Behavior Risk Surveillance Survey (YRBSS) data, substance use among Kentucky's middle and high school students trended downward from 2019 to 2021, with the exception of heroin use, which remained the same. Kentucky students reported the following:

| Table 1 | KY Middle School 2019 | KY Middle School 2021 | KY High School 2019 | KY High School 2021 | US High School 2019 | US High School 2021 |
|---|---|---|---|---|---|---|
| Ever use an electronic vapor product | 31% | 24% | 54% | 45% | 50% | 36% |
| Currently smoking cigarettes or cigars or using smokeless tobacco or electronic vapor products | 18% | 12% | 27% | 22% | 33% | 19% |

| | | | | | | |
|---|---|---|---|---|---|---|
| Ever drank alcohol | 23% | 19% | -- | -- | -- | -- |
| Current alcohol use | -- | -- | 23% | 17% | 29% | 23% |
| Alcohol use prior to age 11 | 12% | 10% | -- | -- | -- | -- |
| Alcohol use prior to age 13 | -- | -- | 15% | 14% | 15% | 15% |
| Ever use marijuana | 10% | 6% | 32% | 23% | 37% | 28% |
| Marijuana use prior to age 11 | 3% | 2% | -- | -- | -- | -- |
| Marijuana use prior to age 13 | -- | -- | 7% | 6% | 6% | 5% |
| Ever taken prescription pain medicine without a doctor's prescription or differently than prescribed | 9% | 9% | 11% | 11% | 14% | 12% |
| Ever use heroin | -- | -- | 2% | 2% | 2% | 1% |

It is important to note that opioids have now become one of the most lethal and sought out substances for many individuals across the nation and Kentucky. Although alcohol, marijuana, and nicotine are still the top three substances used by adolescents, results from the 2019 and 2021 YRBSS show that 2% of Kentucky high school students has tried heroin; 9% of middle students has taken prescription pain medicine without a prescription or differently than prescribed, as well as 11% of high school students. 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 using 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. Tobacco/nicotine use remains higher in Kentucky than nationally; vaping is especially becoming more problematic in Kentucky schools.

Nationally, the Centers for Disease Control and Prevention (CDC, 2021) estimates a 30 percent increase in drug overdose deaths from October 2019 to October 2020; in 2021 overdose deaths increased at a slower rate, but still increased by an additional 15%. 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).

Results of the 2021 National Survey on Drug Use and Health (NSDUH) reveal further distressing statistics for Kentucky's youth. As noted in Table 2, past month marijuana and alcohol use are slightly lower than national averages, as well as occurrence of a major depressive disorder. However, both cigarette smoking and use of tobacco products by Kentucky's youth are elevated compared to national averages.

| Table 2. 2021 National Survey on Drug Use and Health - Kentucky vs. US | | |
|---|---|---|
| ITEM | 12- 17 KY | 12-17 US |
| Past Month Marijuana Use | 5.52% | 5.76% |
| Past Month Alcohol Use | 6.42% | 6.99% |
| Past Month Cigarette Use | 1.87% | 1.51% |
| Past Month Tobacco Product Use | 3.69% | 2.63% |
| Had at least one major depressive episode in the past year | 19.19% | 20.10% |

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

The Kentucky Incentives for Prevention (KIP, 2021) survey, a school-administered survey that assesses the extent of alcohol, drug, and tobacco use among those who are 11 to 18 years old across Kentucky, added questions about military connectedness in 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 drug use and mental health correlates among 10th graders from military-connected families for any drug use as well as prescription drugs. 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, BHDID will work with regional youth treatment coordinators to implement outreach and engagement strategies specific to this population.

| Table 3. Prevalence of Prescription Drug Use and Mental Health Correlates among 10th Graders from Military-Connected Families (KIP, 2021) | | | |
|---|---|---|---|
| **Family Member on Active Duty or Veteran** | | | |
| | No/Don't Know<br>62% | Yes, Grandparent or Other Relative<br>32% | Yes, Immediate Family Member<br>16% |
| **30-Day Drug Use** | **No/Don't Know** | **1 military connected family member** | **2 or more Military connected family members** |
| Cigarettes | 10% | 10% | 14% |
| Alcohol | 15% | 16% | 21% |
| Marijuana | 10% | 10% | 12% |
| Prescription Drugs | 4% | 4% | 6% |
| **Mental Health** | **No/Don't Know** | **1 military connected family member** | **2 or more military connected family members** |

| | | | |
|---|---|---|---|
| Serious Psychological Distress (past 30 days) | 20% | 22% | 23% |
| Self-harm (ever in lifetime) | 18% | 21% | 24% |
| Self-harm (ever in lifetime) | 18% | 21% | 24% |
| Suicide plan (past year) | 11% | 13% | 15% |
| Suicide ideation (past year) | 13% | 17% | 18% |

In addition to the impact of military connectedness on youth mental health and substance use, 2020 saw the onset of the COVID 19 pandemic and a rise in protests aimed at racial injustice as well as ongoing political discord. Consequences are emerging, yet it will be some time before the full impact of these issues are realized. When asked via the KIP survey how often their mental health was 'not good' during COVID 19, 38% of 10th graders and 40% of 12th graders responded 'most of the time' or 'always'. Additionally, 12% of 12th graders and 8% of 10th graders reported their substance use increased during the pandemic compared to before the onset, and 18% of 12th graders and 14% of 10th graders reported their tobacco use, including vape and e-cigarette devices, increased. When asked if they feared for their safety due to their race or culture, 11% of 12th graders and 10% of 10th graders responded 'yes'; 12% of 12th graders and 11% of 10th graders reported fear for their friends/family members because of their race.

These data along with reports from regional youth treatment coordinators indicate that substance use among Kentucky youth is on the rise and remains higher national averages. Further, given previous workforce shortages exacerbated during the COVID 19 pandemic, already-limited service capacity has decreased. Data from the CMHC plan and budget documents indicate that the primary service available for youth with substance use and co-occurring substance use and mental health concerns is outpatient therapy, with very few programs offering higher levels of care such as intensive outpatient, partial hospitalization, and residential services. Many of the programs put into place in the last decade have been unable to sustain to lack of community referrals, workforce shortages, and Medicaid reimbursement rates that do not cover costs.

Kentucky has historically allocated the majority of substance use block grant funds to support services for adults with substance use disorder (SUD). Likewise, Early and Periodic Screening Diagnostic and Treatment (EPSDT) has been available for residential SUD services for eligible adolescents, but these funds have been difficult to access. With a Medicaid state plan amendment in January 2014 and the implementation of the Affordable Care Act, Kentucky's Medicaid expanded to reimburse providers for substance use treatment with eligible recipients of all ages, thereby allowing young people to obtain substance use treatment services without having to utilize EPSDT, thus making it easier for adolescents 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 to new provider types, making a wider variety of geographically accessible treatment options available. The above changes coupled with Kentucky having been the recipient of several SAMHSA 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. However, activities supported with these discretionary grants have been difficult to sustain. 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.

As funds specific to adolescent substance use treatment have become available, Kentucky prioritized supporting workforce development in 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 School for Alcohol and Other Drug Studies and the System of Care Academy. Clinicians and other youth-serving staff have been offered professional development 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, trauma-informed care, and brain development.

Identified barriers in Kentucky to improving adolescent substance use services include a lack of state funds, a lack of service options, a lack of community awareness and understanding about youth SUD, and a decline in the workforce capacity. 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 decreases in 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 led to a gap in services for youth.

***Infrastructure Needs and Plans to Address:***

Starting with a SAMHSA Children's Mental Health Initiative (System of Care) 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 high quality services for youth has been a focus of the state. However, as mentioned, many of the activities of these grants have not sustained. Through grant-supported professional development and collaboration 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.

To support growth and sustainability planning, the Division of Mental Health recently filled a full-time position within the Children's Behavioral Health and Recovery Services Branch for a staff member that serves as the Youth Co-Occurring Program Administrator that had been vacant for several years. This position is charged with educating and re-energizing treatment providers; child-serving agencies; community partners and the general public around creating developmentally appropriate, evidence-based approaches to screening, referral, assessment, treatment, and recovery for youth with SUD and their families. Likewise, at the regional level BHDID began providing funds to support a full-time Youth Substance Use Treatment Coordinator staff position within each of the Community Mental Health Centers. The BHDID Program Administrator is responsible for supporting this statewide peer group of youth treatment coordinators. The coordinators are located within the CMHC's children's services division and are charged with serving as the regional subject matter expert in youth substance use and co-occurring substance use and mental health disorder treatment. The coordinators collaborate and

coordinate with other CMHC programs that have contact with individuals (children, adolescents, and adults) with or at-risk of developing SUD, and are also responsible for providing community outreach and education. 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. In SFY 24, the coordinators will implement training for CMHC staff, both clinical and nonclinical, and trainings for their communities. The coordinators will also keep an inventory of clinicians within their agency that are trained to serve youth with substance use disorders and will coordinate training as necessary. Results from a recent survey of CMHC children's directors and substance use directors show that across the fourteen (14) CMHCs, there are currently 235 clinicians who are trained to and routinely serve youth with substance use disorders, down from 541 in the previous year's report. This further supports the need for community education and engagement around identifying, screening, and appropriately referring youth with substance use issues.

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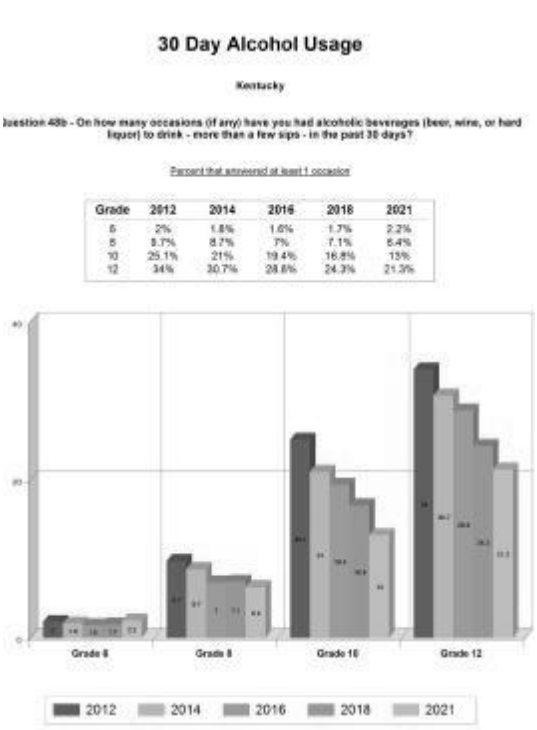
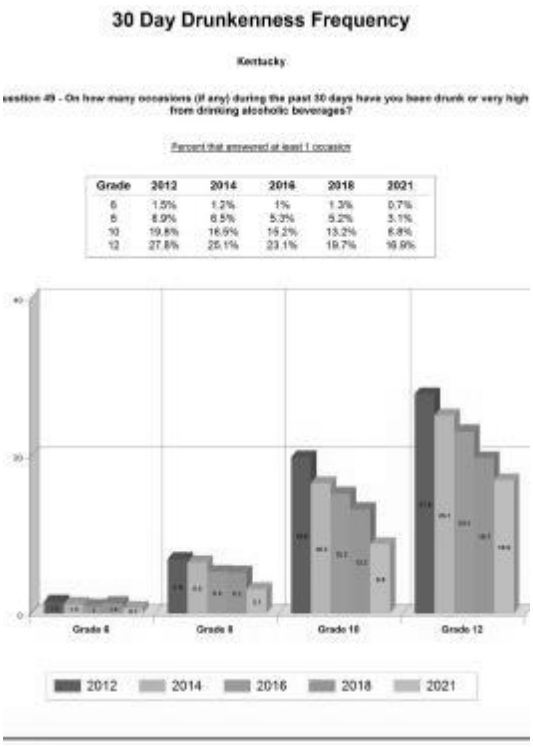
**Substance Use Primary Prevention**

***Prevalence Data for Kentucky's Selected Substances:***

SUBSTANCE 1: ALCOHOL The Kentucky prevention system has made substantial gains in reducing underage drinking over time. Tenth grade past 30-day alcohol use dropped 48% (25.1% to 13%) and twelfth grade use dropped 37% (34% to 21.3%) from 2012 to 2020, but 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 from 2020 to 2021 because of COVID-19 and school closings. Previously students in grades 6, 8, 10, and 12 took the survey every two years. The delay in administration means that the 2021 results are for a completely new group of students.

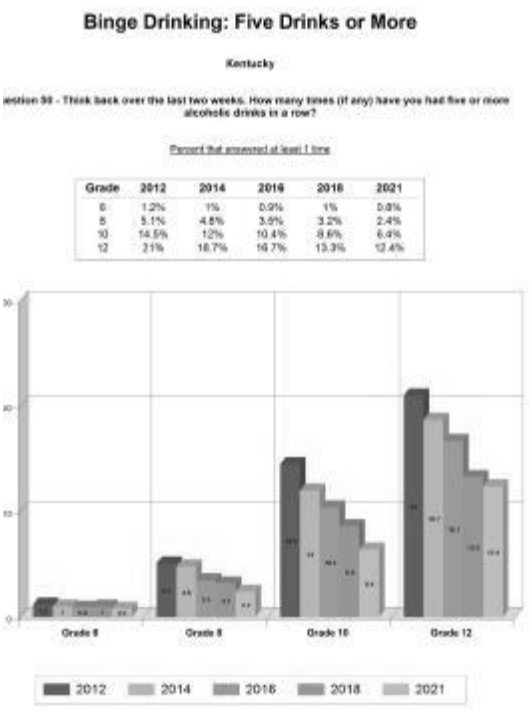
The 2021 Kentucky Incentives for Prevention (KIP) survey data reveals that 13% of 10th graders drank alcohol in the past 30 days, and 8.8% also report they have been drunk on at least one occasion in the past 30 days. Youth are not just drinking to drink but drinking to get drunk. Furthermore, 6.4% of 10$^{th}$ 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 sixteen 10$^{th}$ graders surveyed, or 1,512 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 6.4% in 2021) 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 2023, 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.The 2021 National Survey on Drug Use and Health (NSDUH) survey showed that Kentucky's alcohol use is below the national average in every age category. 39.01% of Kentucky adults reported past 30-day use of alcohol, compared to a national rate of 47.55%. That rate climbs to nearly 46% for those ages 18-25, compared to 50.13% nationwide. About 42% percent of adults over the age of 26 reported using alcohol in the past 30 days, compared to about 52% nationwide. Past 30-day alcohol use in the U.S. decreased from 51.37% in 2017-18 to 47.55% in 2021. (NSDUH) while it remained steady in Kentucky, 39.97% vs. 39.01%.

As was the case for alcohol use in 2021, binge drinking in Kentucky is lower than the national rate in every category except those 12-17 years of age. Across all populations, 19.04% of Kentuckians over the age of 12 reported binge drinking in the past month, according to the 2021 NSDUH Preliminary Report. Comparatively, the rate was 21.45% nationally. Kentucky youth binged at a rate of 3.06%, compared to 3.82% nationally. And among those over the age of 26, 19.47% of Kentuckians reported binge drinking in the past 30-days, compared to 22.37% nationwide. Across all age groups, binge drinking decreased from 2017-18 to 2021: US 24.49% to 21.45% and Kentucky 20.47% to 19.04%. (NSDUH)



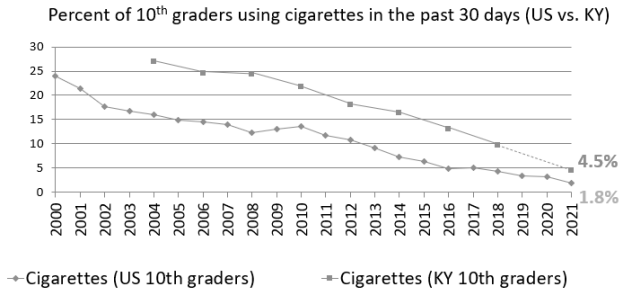

The cost of excessive alcohol use has been well documented. A 2010 study found that binge drinking is responsible for 77% of the total excessive drinking costs in all states and responsible for some of the serious health problems including alcohol poisoning, fetal alcohol spectrum disorder, sexually 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 M, 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 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 2021 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 79% from 21.7% in 2010 to 4.5% in 2021.

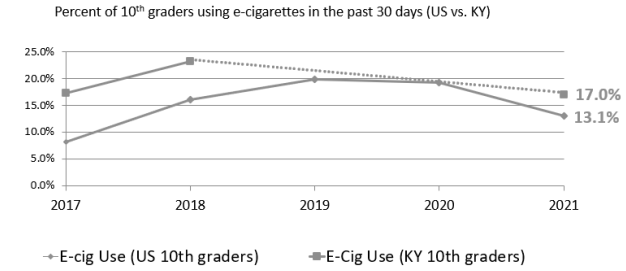
## Trends in Youth Smoking




DATA SOURCE: KIP Survey (2004 - 2021) & Monitoring the Future (2000 - 2021)

However, vaping remains at epidemic levels among Kentucky youth (See graph below). In 2021, 17% of Kentucky 10th grade youth reported current use of vapor products (KIP). This is down from the peak level of 23.2% of 10th graders in 2018. However, the current use rate remains significantly higher than the national average of 13% (MTF, 2021). In fact, use of e-cigarettes in Kentucky across all grades is roughly equivalent to combustible cigarette rates 10 years ago. Since 2018, e-cigarettes have surpassed alcohol as the most widely used substance among young people in Kentucky. Ten out of 14 regions report usage rates above the statewide average. At 24.1%, the Pennyroyal region is at the high end, followed closely by several regions in the 22-23% range. 2021 figures in the NorthKey region – seven percentage points below the state average - are the lowest at 9.9%

## Trends in Youth E-Cigarette Use (Nicotine)

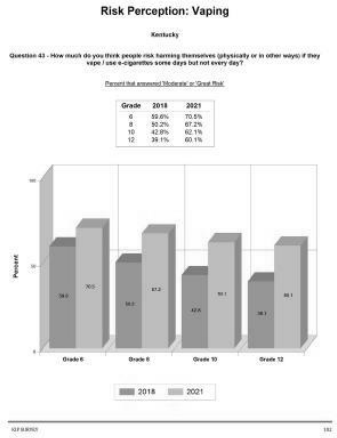



DATA SOURCE: KIP Survey (2017 - 2021) & Monitoring the Future (2017 - 2021)

Furthermore, reflecting national trends, Kentucky youth who are current users are using vapor products frequently. Among current 10th grade vapor product users, 45% used vapor products near daily (20-39 occasions) or daily (40+ occasions) in 2021.

Regulatory loopholes related to flavor restrictions are driving youth product selection. In early 2020, the Federal Drug Administration (FDA) passed a ban on flavored cartridges and pods. The primary target of the ban was the pod-based product JUUL, which ignited the youth e-cigarette epidemic. The ban did not include pre-filled disposable e-cigarette devices which operate similarly and mimic the appearance of pod-based devices. Disposable e-cigarette use increased 1,000% among high school e-cigarette users from 2019 to 2020 (Centers for Disease Control and Prevention). This loophole was closed in March of 2022, but history suggests regulatory processes will be slow to eliminate all of these flavored products. (Public Health Law Center). Kentucky's convenience store shelves and online vapor stores remain stocked with disposable devices available in a wide array of flavors. (Environmental Scans by Kentucky's Nicotine Prevention Enhancement Specialist)

Across all grades, levels of perceived risk for vaping were the lowest of all substances addressed on the KIP Survey. The perceved risk level increased substantially in 2021 – 38% of 10th graders perceived no risk or slight risk in 2021, compared to 57% in 2018. However, although improved, the rates remain notably low, indicating that Kentucky students continue to perceive vaping as a relatively low risk behavior. As a national comparison, among all middle and high school students participating in the 2021 National Youth Tobacco Survey, perceiving “no” or “little” harm from intermittent tobacco product use was highest for e-cigarettes (16.6%) (and lowest for cigarettes (9.6%).




Additionally, focus group data collected by Kentucky’s 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.

In 2021, the KIP survey added the item, “During the past 30 days, how did you get your own electronic vapor products?” to address how youth obtain their e-cigarettes. The largest percentage of Kentucky 10th grade youth, 48.5%, reported obtaining e-cigarettes through “borrowing” the products. 20.8% of Kentucky 10th grade youth reported buying them in a store such as a convenience store, supermarket, discount store, gas station, or vape store.

In relation to adult use, while there has been a significant decrease in the use of cigarettes in Kentucky, Kentucky has the fourth highest smoking rate (19.6%; Behavioral Risk Factor Surveillance System – BRFSS - 2021) and the highest rate of lung cancer in the nation (State of Lung Cancer report, 2021). Kentuckians report higher levels of tobacco use than the national average across products. In 2021, 9.3% of Kentucky adults reported using e-cigarettes (BRFSS, 2021). Nationally, the rate was 6.7% (BRFSS, 2021). Kentucky adults use smokeless tobacco at a rate (5.9%, 2021 BRFSS) that is greater than 2x higher than the national average (3.4%, 2021 BRFSS).

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

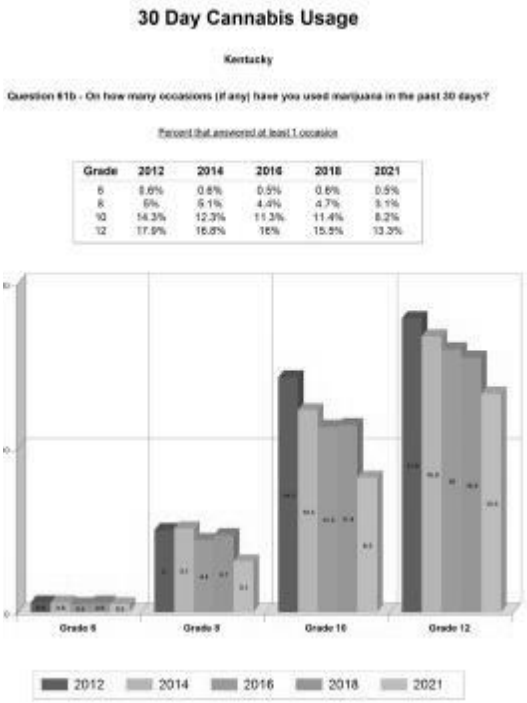
administered on a biannual basis to 6th, 8th, 10th, and 12th graders. Among those students, 49% of 10th graders report that drug use is a problem in their school and about 3% of 10th and 12th graders report that dealing drugs is a problem at school. (KIP 2021) Identified illicit drug use of concern include 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. (Kentucky will have legal medical cannabis beginning in January of 2025.) Since the 2015-2016 NSDUH report, Kentucky's past 30-day marijuana use among those over the age of 12 has climbed 41%, from 7.02% to 9.93%. (2021 NSDUH Preliminary Report) The majority of those increases are among Kentucky residents over the age of 26. In 2021 the past 30-day use rate among that age group was 31% higher than in 2015, from 6.8% to 8.9%. It did drop from 9.39% in 2019 to 8.9% in 2021 but remains significantly higher than in 2015. Residents aged 18-25 use marijuana at significantly greater rates than other age groups, with nearly 20% reporting past 30-day use in 2021. (2021 NSDUH Preliminary Report).

Overall, nearly 10% of Kentuckians report 30-day use of marijuana. 1.76% 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 to 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, 2021) despite the fact that 30-day use of marijuana by 12-17 year olds in Kentucky (5.52%, 2021 NSDUH) is slightly lower than the national rate (5.76%) for this age group. 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, increased sharply between 2016 and 2019 and fell slightly in 2021. Kentucky has not mirrored these trends, with usage rates among Kentucky 10th graders falling steadily from 2010 through 2021. (2021 KIP KY Trend Data)




Regionally, 10th graders in the Four Rivers CMHC region (at 12.5%) reported the highest rates of 10th grade marijuana use in 2021. Regions with the lowest rate of marijuana use in 2021 were Mountain, NorthKey, and Seven Counties.

Past year marijuana use rates, as measured on the (KIP survey), steadily increase from 6th through 12th grades, with 0.8% of 6th graders reporting use within the last year compared to 17.7% of 12th graders. For this age group, however, use rates have been declining since 2010, falling from a high of 30.3%. For 8th and 10th graders in Kentucky, 4.2% report they first smoked marijuana by the age of 12. Followed by 12th graders at 3.5% and 6th graders at 1.6%. Interestingly, the age of first use has declined for 10th and 12th graders but increased among 6th between 2016 and 2021. (2021 KIP)

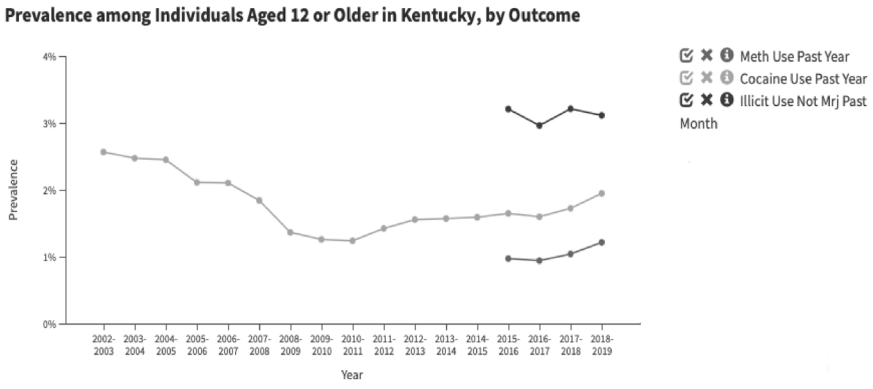
While the percentage of students reporting that access to marijuana has been decreasing since 2004, 46.7% of 12th graders and nearly 35% of 10th graders reported that it would be “sort of easy” or “very easy” for them to access the illicit substance. Personal disapproval of marijuana use decreases significantly from the 6th grader, where 97.1% of students said it was “wrong” or “very wrong” for someone to smoke marijuana to 12th graders where only 59.7% answered in the same manner. Generally, personal disapproval of marijuana use is decreasing in Kentucky. Personal disapproval ratings decreased between 2010 and 2018 among 10th and 12th graders and rose slightly in 2021. Overall, this indicates that they are perceiving it to be more acceptable for them to smoke marijuana. Perception of parental disapproval of smoking marijuana has also been decreasing over the same time frame with 17% of 12th graders perceive their parents would not disapprove of marijuana use. 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 and held steady in 2021. Only 51% of 12th graders reported that their friends would say it was “wrong” or “very wrong” for them to smoke

marijuana. (2021 KIP). 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 32.4% for 10th graders to 42.8% of 12th graders who report that at least one of their four best friends have used marijuana in the past year. The percentage of 6th and 8th graders who report that their friends have used in the last year is much lower (5%, and 16.4% respectively) than for older students, and has remained relatively unchanged from 2012-2021. During that same time period, the percentage of 10th and 12th grade students perceiving that their friends are using has decreased substantially by 27% and 20% respectively. Just as disapproval ratings for marijuana use have fallen over the past decade, so have risk perceptions. Only 42.1% of 10th graders reported that the risk of harm was moderate or great if they tried marijuana once or twice, down from 43.9% in 2004. The perception of harm also decreases significantly from the 6th grade to the 12th. The perception of harm among 6th graders was nearly 70%, compared to less than 33% 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 35.37%. Data from the Treatment Episode Date Set (TEDS) shows that admissions for marijuana use decreased 8.3% in Kentucky between 2015 and 2020, 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)



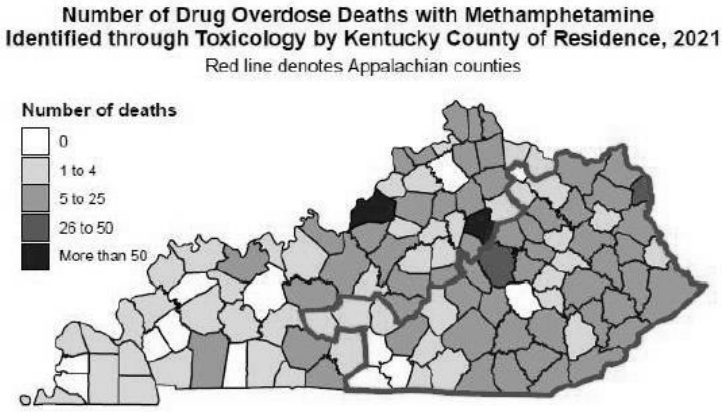

As Kentucky continued to address the opioid crisis, a fourth wave in the nation's substance use disorder epidemic began – stimulant use. Use of prescription drugs - such as Adderall, Ritalin and Adipex - and illicit substances - including methamphetamine and cocaine – began increasing around 2015. Meth use rates are higher in KY than in the U.S. as a whole. (1.32 % AND .91% respectively). Rates are highest for those 26 and older at 1.58%. Use of methamphetamine in Kentucky is above the national averages and use of cocaine is below it. Among youth in Kentucky, cocaine, methamphetamine, and stimulant use is small, compared to use of alcohol, tobacco, and marijuana. According to the 2021 KIP survey, 30-day cocaine use among 10th graders is about 0.5%. 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 (Kentucky Office of Drug Control Policy - 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.

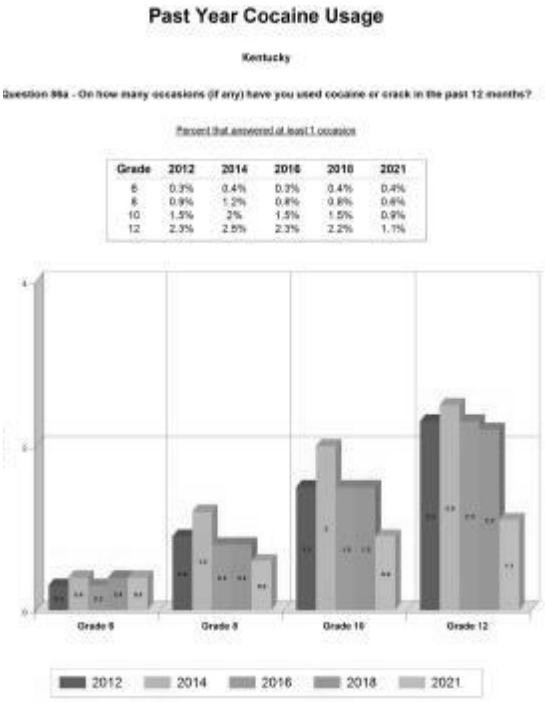
**Methamphetamines**

According to the KIP Survey, past year methamphetamine use has declined among 10th and 12th graders since 2012 from an average of 1% of youth to approximately 0.5%. Personal disapproval of methamphetamine use is high across the grades, ranging from 98% among seniors to approximately 99% among sixth graders. Perception of parental disapproval of meth use is also high at approximately 99% across all grades. Tenth graders who report at least one of their four best friends used methamphetamine in the last year has fallen from 6% in 2012 to 2.5% in 2021. The drop is similar in other grades. The Comprehend region in northeastern Kentucky has the highest rates of 10th grade methamphetamines use at 1.8% (compared with a statewide 10th-grade rate of .7%). The number of overdose deaths involving meth rose 226% from 2017 to 2021.The top five counties for methamphetamine related overdose deaths were Jefferson (250), Fayette (53), Madison (46), Boyd (32), and Kenton (24).




**Cocaine**

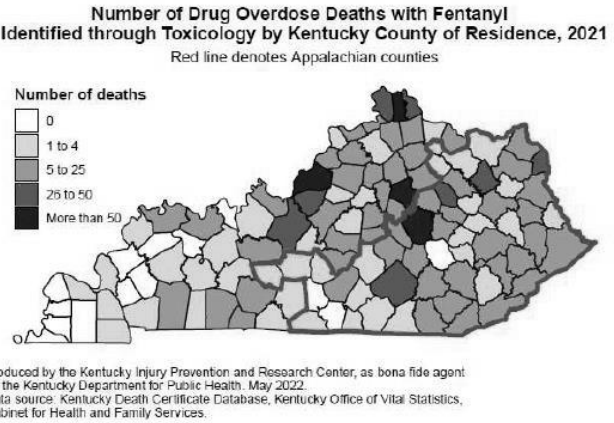
Over the last 12 years, cocaine use has been steady or decreasing among middle and high school students, with a gradual increase by grade level as measured by the KIP. KIP data shows that about 1.1% of 12th graders report past year cocaine use. NSDUH data shows that 2.57% of 18-25-year old's in Kentucky reported cocaine use in 2021, 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 96.5% for 12th graders to 98.6% to 6th graders. The percentage of parental disapproval of cocaine use ranged from 98.4% for 12th graders to 99.4% for 6th graders. Four percent of 12th graders said at least one of their four best friends had used cocaine in the last years. That percentage was 3.6% for 10th graders; 3.6% for 8th graders and 2.2% for 6th graders. The Four Rivers region in far western Kentucky had the highest rate of 10th graders reporting cocaine use (1.6%) in the past 30 days while Communicare in central Kentucky had the lowest at 0.1%. The overall 10th grade rate was .5%. NSDUH data indicates that cocaine use rose slowly across all ag groups from 2010 to 2018/19 and fell slightly in 2021.,



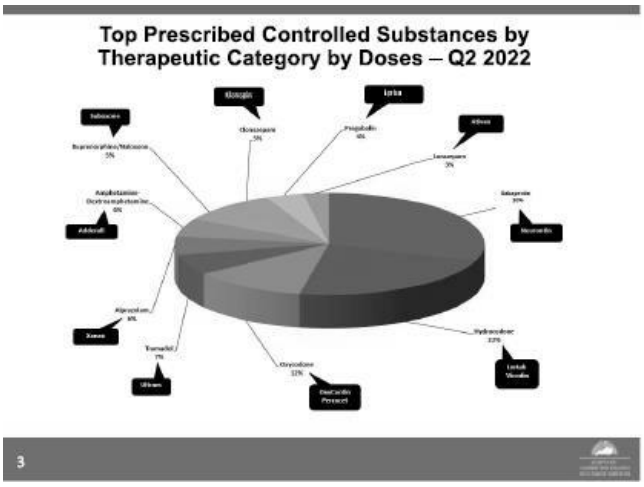

**Opioids/Heroin/Non-Medical Use of Prescription Drugs**

Substance use/misuse, particularly the use of prescription drugs along with heroin and illicit fentanyl, continues to be a major public health concern for Kentucky. According to the Overdose Fatality Report released by the Kentucky Office of Drug Control Policy, there were 1,316 overdose deaths in Kentucky in 2019 which increased to 2,250 in 2021 and fell approximately 5% to 2,217 in 2022. The largest number of overdose deaths in Kentucky in 2021 were among those aged 35-44. (Latest data disaggregated by age group.) At least 139 youth under the age of 25 died by overdose (all drugs) in 2021. The top five counties for opioid involved overdose deaths per 100,000 population in 2021 were Gallatin (114), Perry (107.4), Knott (106.7, and Fleming and Rowan (each at 100.6).

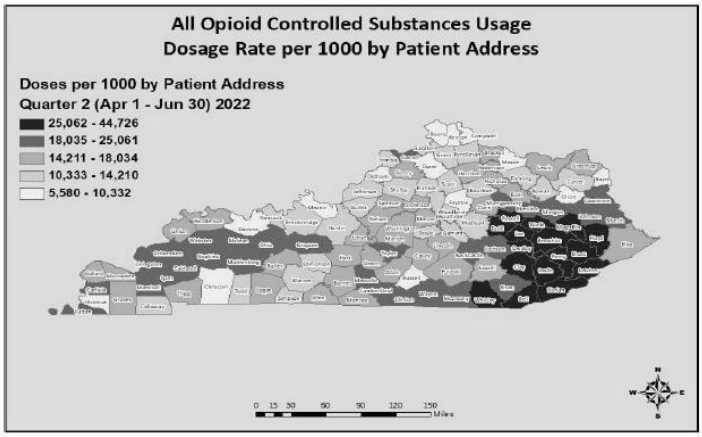
In 2021 heroin was present in approximately 93 overdose deaths in which autopsy and toxicology reports are available which was a 51.8% decrease from the 193 heroin involved overdose deaths in 2020. Additionally, the report shows that fentanyl was involved in 72.8% percent of overdose deaths in 2021, up 16% from 2020. Acetylfentanyl was involved in 11% of all overdose deaths for the year as well. This was a decrease of 49.6% from 2020. Jefferson (477) and Fayette (135) also represented the top five counties for fentanyl-related deaths, along with, Kenton (73), Madison (69), and Boyd (36).




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 4,379,144 opioid prescriptions given in Kentucky according to KASPER data, which is approximately .97 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 30% of all controlled substances dispensed in the state for Quarter 2 of 2022. Gabapentin, or Neurontin, is followed by hydrocodone (Lortab, Vicodin) at 22% and Oxycodone (OxyContin and Percocet) at 12%. Additional prescribed controlled substances include Tramadol (7%), Alprazolam (6%), Amphetamine/Dextroamphetamine (6%), Buprenorphine/Naloxone (5%), Clonazepam, (5%), Pregabalin (4%) 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 sixteen counties in southeastern Kentucky each with between 25,062-44,726 doses per 1,000 residents.



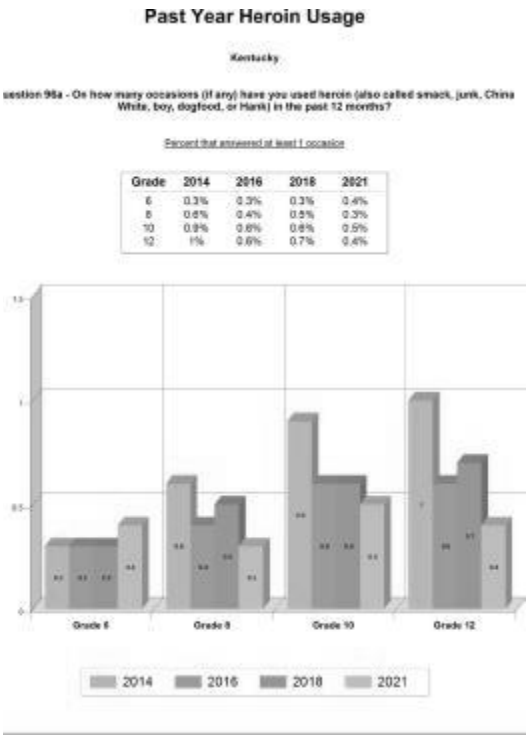
**Opioid Usage**
**Q2 2022**




Fifteen counties spread across Kentucky had the highest opioid morphine equivalent doses per 1,000 residents at 3-5 doses. Use of Benzodiazepines and Opioids are especially problematic in the state, with four of 120 counties reporting a rate of 21-22 per 1,000 residents of seven-day overlap by patient addresses. All of those counties were in southeastern Kentucky.

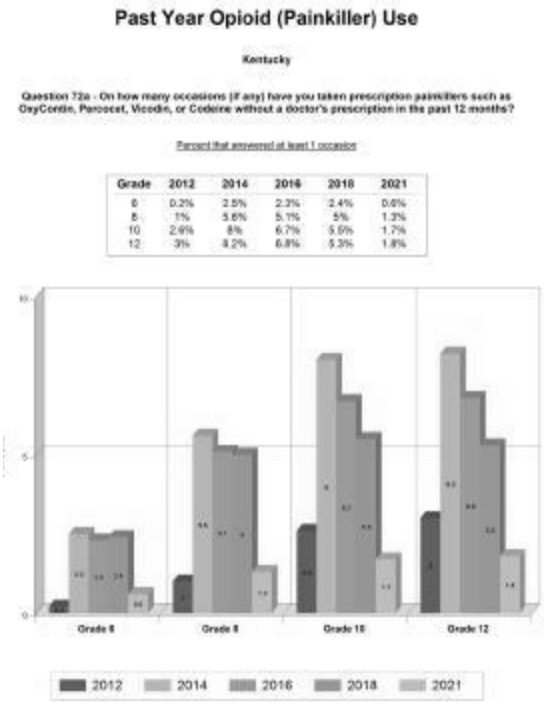
The Kentucky opioid overdose emergency department visit rate was 324 visits/100,000 population in year 2021. Individuals aged 25-34 comprised the largest percentage of individuals treated for opioid overdoses in Kentucky emergency departments (EDs). TEDS data shows a steady downward trend, from a high of 4,872 in 2016 to 3,177 in 2020, highlighting the work that has been done across Kentucky to stop access and use to heroin. Admissions for other opioids decreased as well, falling from 6,245 admissions in 2010 to 2,352 in 2020. Males are more likely to be admitted for both heroin and other opioid use than females. Those aged 30-34 are most likely to be admitted for heroin use as well as 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 (11.4% admitted, 8.6% percent of population).

Heroin use in youth has declined for most age groups. 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 2021 according to KIP. Most recent numbers indicate that 6$^{th}$ graders had a .4% prevalence and 8$^{th}$ graders had a .3% prevalence, maintaining similar numbers to those reported in 2014 and 2016. 10$^{th}$ graders improved by having a decrease from .9% in 2014 to .5% in 2021 and 12$^{th}$ graders improved by decreasing from 1% in 2014 to .4% in 2021.




2021 KIP results also show that 2.8% 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 is the highest rate 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% It rose to 1.7% again in 2021 However, this same question has shown significant increases for 6th and 8th graders in that time frame, rising from 2% to 4.7% for 8th graders (135% increase) and from 1.3% to 3.9% for 6th graders (200% increase).

Past year prescription pain killer use, as reported on the KIP, has shown a slight increase for 6th (.2% to .6%) and 8th (1% to 1.3%) graders from 2012 to 2021. There was a decrease of 2.6% to 1.7 % for 10th graders, and 3% to 1.8% for 12th graders. Thirty-day use of prescription pain killers has risen slightly from 0.5% to 0.7% for 6th graders and fallen for the other grades- 1.6% to 1.2% for 8th graders, 4.1% to 1.3% for 10th graders, and 4.8% to 1.4% 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.




Personal disapproval of prescription drug use without a doctor's prescription was high across the grades, with 96.1% of 6th graders and 94.3 of 12th graders reporting they felt it was "wrong" or "very wrong" to use prescription drugs without a doctor's orders. This rate has remained steady since 2012 when the question was added to the KIP survey. Perception of parental disapproval of prescription drug use without a doctor's prescription is similarly high with percentages ranging from 97% 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 97.7% of 6th graders. Perception of peer disapproval rose from 2012 to 2012, for 12th graders (78.8% to 91.2%), 10th graders (81.8% to 90.5%), and 8th graders (89.7% to 91.2%) who reported they felt their friends would think it "wrong" or "very wrong" to use prescription drugs without a doctor's order. It fell slightly for 6th graders from 96.4% to 94.9%. 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 55% between 2012 and 2021 and the percentage of 12th graders answering the same way dropped 65%. Risk perception increased among all students in the 2012-2021 timeframe. Sixth graders reporting they felt that using a prescription drug without a doctor's orders was a "moderate" or "great risk" climbed 16.3%, and 6% for 8th graders. At the same time, the percentage of 10th and 12th graders who reported moderate or great risk remained relatively unchanged.

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 .4% in 2021. Among 10th graders, .9% reported heroin use in 2014 and .5% in 2021. Thirty-day heroin usage is even lower with .3% of 6th, 10th, and 12th graders and just .2% of 8th graders reporting heroin use. Risk perception regarding heroin use has remained relatively steady across the grade levels between 2014 and 2021, with between 79.1% (6th graders) and 83.5% (12th) reporting moderate or great risk in using heroin.

***Unmet Service Needs and Critical Gaps:***

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 focus on educating youth, parents, and educators about the harmful effects of electronic vaping products, providing training and technical assistance to schools and community organizations to update school and community smoke-free policies to address electronic vaping devices, providing retailers of vaping products with information on the Tobacco Retailer Underage Sales Training (TRUST) for retailers to reduce sales to minors, and providing training and technical assistance to schools to support and enhance early prevention, screening, and assessment of adolescents. 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.

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.

ILLICIT DRUGS

The needs assessment process conducted for prevention services 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/fentanyl/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. As medical marijuana becomes legal, emphasis on reducing access to youth or others without a prescription will also be an area of focus.

Efforts focused on **cocaine** must address the significant increase of use by those in the 18-25-age-group and should include continuing to decrease 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.

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 was devoted to building the providers' (Regional Prevention Centers – RPCs) capacity regarding operationalizing the Strategic Prevention Framework (SPF) in their communities. Additionally, funding through discretionary grants, specifically the State Opioid Response grant, has allowed for expansion of prevention providers both in the community and at the state level. As a result of these additional funds, new staff – two positions at each of the 14 RPCs -were hired. The Substance Use Disorder Prevention and Promotion 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 seven years, all 14 have lost prevention staff, with turnover being close to 40%, and eight of the 14 have new directors.

Additionally, salaries for prevention specialists are relatively low 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 statutorily 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 a 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 often face 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 the promise of sustained employment. Unable to succinctly articulate the role that prevention plays within their host agency, RPC staff report feeling isolated within their corporate structure. Part of the technical assistance targeted over the next two (2) years involves training and support as the RPCs and all the prevention partner's work to create a consistent message of the work being done and the long-term benefits of prevention.

***Addressing the Need:***

To address underage drinking and binge drinking, each Regional Prevention Center will 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 State Epidemiology Outcomes Workgroup (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), marijuana use and the increasing prevalence of fentanyl. Currently there is no data beyond state level data that identifies local need for those over the age of 18.

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 the 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 which now includes the provision of data related to incidence and prevalence through a dashboard that will guide county-level assessments. The dashboard provides easy access to information on 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. RPC staff will share this information 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. The plans will include evaluation measures to understand the impact of those strategies and help refine the county-level work.

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 administrators 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 training and other skill-building opportunities for the RPCs.

In 2022 the state launched 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 allows learning opportunities to be layered over the new hires first year of employment, helps to facilitate the Certified Prevention Specialist certification process, and creates 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) 2021** - Since 1999, the KIP Survey has been administered in Kentucky through the Substance Use Prevention and Promotion 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 most recent administration was in the fall of 2021. The survey includes 6th, 8th, 10th, and 12th graders attending school in Kentucky communities. In 2021 the total sample size for 6th, 8th, 10th, and 12th grades was more than 93,000 students. The sample includes 127 out of 173 public school districts.

**Treatment Episode Data Set (TEDS) 2015-2020** – The Treatment Episode Data Set is a national census data system of annual admissions to substance use disorder treatment facilities. TEDS provides annual data on the number and characteristics of persons admitted to public and private substance use disorder treatment programs that receive public funding. TEDS consists of data reported to state substance use disorder 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 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 2021** – The Kentucky Overdose Fatality Report 2021 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, and 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, selective, and indicated methodologies. It is through the PDS that the Prevention Branch 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, 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.

**Kentucky Office of Drug Control Policy (KY-ODCP)** – The KY-ODCP is an organization within Kentucky's Justice and Public Safety Cabinet that was formed in 2004. This group advocates for

the enhancement of resources for substance misuse initiatives, assists in developing policy and legislation, coordinates overall research and evaluation of effectiveness of programs and services, and serves as a repository of information on best practices and standards of practice for prevention, treatment, education, and law enforcement, as related to substance misuse.

**Behavioral Risk Factor Surveillance System (BRFSS)** – The BRFSS is the nation's premier system of health-related telephone surveys that collect state data about residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. It was established in 1984 and is managed through the Centers for Disease Control and Prevention (CDC). In Kentucky, the Department for Public Health manages the BRFSS survey and data are analyzed by Kentucky's Area Development Districts and demographic variables such as gender, race, age, income, and education level. National medians for each risk factor and health behavior are also presented.

**State Lung Cancer Report 2021** – A report created by the American Lung Association that provides a state-specific understanding of the burden of lung cancer and opportunities to address this deadly disease.

**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 7.8% of the 4.477 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) 2020, Fiscal Year reports 282,767 military Veterans reside in Kentucky, of which 25,748 are female and 257,019 are male. According to the report, the total number of women Veterans in Kentucky, increased by 1,333. 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 57,462 Department of Defense personnel assigned to Kentucky (47,753 military personnel and 9,709 DOD civilians), 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 35,215 active duty military personnel stationed in the Commonwealth, and sixteenth in the number of total military personnel (including civilian workers, reservists, and National Guard). Kentucky 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 eighteen (18) VHA Community Based Outpatient Clinics (CBOCs) and one VHA Outpatient Clinic in Kentucky that provide mental health services, in addition to our four (4) VHA Medical Centers. These clinics suffer from workforce shortages at times since COVID-19 and there are fewer qualified clinicians to fill the positions. 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 7.8% of Kentucky's 4.477 million residents have served in the military
- Kentucky currently has a Veteran population of 282,767
- Kentucky ranks 8$^{th}$ nationally in defense spending by state GDP and 14$^{th}$ in direct defense spending
- In the Commonwealth, there are:
    - 25,748 Female Veterans
    - 257,019 Male Veterans
    - 35,215 Active Duty Military Personnel
    - ~8,000 Soldiers & Airmen in the Army National Guard & the Air National Guard

- 47,753 Total Military Personnel
- 57,462 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 2022 (July 1, 2021 - June 30 2022) | | | | | | | | | | | | |
| CMHC | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
| 01 - Four Rivers Behavioral Health | 248 | 233 | 188 | 283 | 311 | 335 | 338 | 307 | 321 | 269 | 205 | 226 |
| 02 - Pennyroyal Regional Center | 326 | 412 | 525 | 519 | 526 | 378 | 419 | 253 | 350 | 336 | 325 | 356 |
| 03 - River Valley Behavioral Health | 86 | 104 | 82 | 69 | 58 | 51 | 51 | 45 | 56 | 84 | 71 | 63 |
| 04 - LifeSkills | 280 | 103 | 188 | 212 | 125 | 159 | 170 | 115 | 61 | 59 | 77 | 49 |
| 05 - Communicare | 155 | 159 | 144 | 323 | 353 | 272 | 283 | 257 | 305 | 291 | 235 | 220 |
| 06 - Seven Counties Services | 356 | 387 | 311 | 337 | 354 | 363 | 396 | 389 | 384 | 352 | 301 | 276 |
| 07 - NorthKey | 210 | 179 | 158 | 194 | 225 | 194 | 116 | 136 | 134 | 139 | 181 | 193 |
| 08 - Comprehend, Inc. | 106 | 133 | 166 | 125 | 108 | 116 | 95 | 78 | 64 | 56 | 33 | 33 |
| 10 - Pathways, Inc. | 330 | 355 | 331 | 313 | 297 | 320 | 287 | 261 | 250 | 188 | 192 | 193 |
| 11 - Mountain Comprehensive Care | 155 | 135 | 170 | 145 | 162 | 219 | 244 | 256 | 260 | 302 | 300 | 336 |
| 12 - Kentucky River Community Care | 72 | 181 | 212 | 218 | 202 | 152 | 70 | 97 | 45 | 45 | 41 | 37 |
| 13 - Cumberland River | 175 | 179 | 19 | 15 | 37 | 117 | 160 | 191 | 157 | 114 | 99 | 106 |
| 14 - Adanta | 252 | 206 | 173 | 186 | 213 | 254 | 203 | 297 | 192 | 169 | 154 | 130 |
| 15 - New Vista | 456 | 398 | 380 | 330 | 338 | 208 | 180 | 160 | 165 | 137 | 141 | 154 |
| Total Undupicated Count | 3,380 | 3,191 | 3,055 | 3,301 | 3,327 | 3,124 | 2,893 | 2,737 | 2,744 | 2,541 | 2,355 | 2,372 |

| Active Duty Personnel Served by CMHC's | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Fiscal Year 2022 (July 1, 2021 - June 30 2022) | | | | | | | | | | | | |
| CMHC | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
| 01 - Four Rivers Behavioral Health | 58 | 51 | 37 | 39 | 33 | 53 | 42 | 45 | 51 | 47 | 35 | 40 |
| 02 - Pennyroyal Regional Center | 104 | 100 | 105 | 116 | 132 | 81 | 131 | 65 | 63 | 64 | 51 | 82 |
| 03 - River Valley Behavioral Health | 47 | 54 | 30 | 35 | 32 | 29 | 25 | 27 | 13 | 16 | 15 | 12 |
| 04 - LifeSkills | 255 | 42 | 78 | 88 | 49 | 42 | 34 | 37 | 15 | 20 | 32 | 18 |
| 05 - Communicare | 14 | 18 | 15 | 85 | 97 | 80 | 76 | 69 | 95 | 96 | 70 | 67 |
| 06 - Seven Counties Services | 75 | 79 | 66 | 84 | 82 | 83 | 113 | 111 | 91 | 70 | 57 | 54 |
| 07 - NorthKey | 56 | 53 | 44 | 41 | 47 | 48 | 44 | 43 | 29 | 33 | 50 | 51 |
| 08 - Comprehend, Inc. | 47 | 52 | 47 | 39 | 46 | 42 | 44 | 26 | 13 | 17 | 16 | 7 |
| 10 - Pathways, Inc. | 49 | 63 | 54 | 48 | 62 | 49 | 61 | 51 | 38 | 39 | 35 | 38 |
| 11 - Mountain Comprehensive Care | 93 | 72 | 96 | 55 | 60 | 78 | 101 | 90 | 85 | 100 | 94 | 105 |
| 12 - Kentucky River Community Care | 32 | 105 | 121 | 114 | 110 | 71 | 35 | 34 | 17 | 15 | 14 | 4 |
| 13 - Cumberland River | 1 | 4 | 6 | 6 | 11 | 40 | 54 | 83 | 58 | 46 | 42 | 38 |
| 14 - Adanta | 51 | 37 | 30 | 39 | 48 | 58 | 58 | 81 | 59 | 52 | 43 | 31 |
| 15 - New Vista | 85 | 79 | 83 | 81 | 77 | 52 | 61 | 48 | 53 | 42 | 45 | 54 |
| Total Undupicated Count | 964 | 808 | 811 | 870 | 886 | 806 | 760 | 705 | 680 | 657 | 599 | 601 |

| Veteran Served by CMHC's | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Fiscal Year 2022 (July 1, 2021 - June 30 2022) | | | | | | | | | | | | |
| CMHC | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
| 01 - Four Rivers Behavioral Health | 192 | 183 | 151 | 247 | 278 | 286 | 296 | 262 | 270 | 222 | 170 | 186 |
| 02 - Pennyroyal Regional Center | 223 | 316 | 421 | 407 | 395 | 298 | 288 | 188 | 287 | 272 | 274 | 274 |
| 03 - River Valley Behavioral Health | 39 | 50 | 52 | 34 | 26 | 22 | 26 | 18 | 43 | 68 | 56 | 51 |
| 04 - LifeSkills | 186 | 61 | 112 | 130 | 77 | 117 | 136 | 78 | 46 | 39 | 45 | 31 |
| 05 - Communicare | 141 | 142 | 129 | 238 | 256 | 192 | 207 | 188 | 210 | 195 | 165 | 153 |
| 06 - Seven Counties Services | 287 | 319 | 250 | 259 | 282 | 280 | 283 | 278 | 293 | 282 | 244 | 222 |
| 07 - NorthKey | 160 | 130 | 117 | 158 | 182 | 149 | 72 | 93 | 105 | 106 | 131 | 142 |
| 08 - Comprehend, Inc. | 59 | 82 | 119 | 86 | 67 | 77 | 51 | 52 | 51 | 39 | 17 | 26 |
| 10 - Pathways, Inc. | 283 | 292 | 279 | 265 | 236 | 271 | 226 | 210 | 212 | 149 | 157 | 155 |
| 11 - Mountain Comprehensive Care | 63 | 64 | 74 | 91 | 102 | 141 | 143 | 166 | 175 | 202 | 206 | 231 |
| 12 - Kentucky River Community Care | 40 | 76 | 91 | 105 | 92 | 81 | 35 | 63 | 28 | 30 | 27 | 33 |
| 13 - Cumberland River | 174 | 175 | 13 | 9 | 26 | 78 | 106 | 108 | 99 | 68 | 57 | 68 |
| 14 - Adanta | 204 | 172 | 143 | 149 | 168 | 197 | 145 | 216 | 133 | 117 | 111 | 99 |
| 15 - New Vista | 373 | 328 | 301 | 262 | 265 | 156 | 119 | 112 | 112 | 95 | 96 | 100 |
| Total Undupicated Count | 2,416 | 2,383 | 2,244 | 2,431 | 2,441 | 2,318 | 2,133 | 2,032 | 2,064 | 1,884 | 1,756 | 1,771 |

***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:***

***Kentucky Governor's SMVF Challenge Team***

DBHDID joined another Kentucky Governor's Challenge for Service Members, Veterans and their Families in 2019. Representatives from SAMHSA's SMVF Technical Assistance Center, Military, Federal, State, Veterans Service Organizations, public and private providers meet quarterly to focus on Lethal Means Safety relating to suicide prevention in 2023. The areas of focus were identified to include firearms safety training and safe storage of medication. The taskforce is currently working on action plans and strategies to address access to lethal means and advertisement to bring public awareness.

***Military Behavioral Health Coordinators***

DBH inserted language into the Community Mental Health Center (CMHC) contracts in 2013, 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.

***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.

**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 Specialists (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 paraprofessional 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, and Referral to 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 click on the state for totals https://www.va.gov/vetdata/Veteran_Population.asp
- Military OneSource, Military Community Demographics click on the year for the report https://www.militaryonesource.mil/data-research-and-statistics/military-community-demographics/
- DoD Personnel, Workforce Reports & Publications https://dwp.dmdc.osd.mil/dwp/app/dod-data-reports/workforce-reports
- Statista - Geographic stationing of active duty United States Armed Forces personnel in 2021, by U.S. state
- https://www.statista.com/statistics/232722/geographic-stationing-of-active-duty-us-defense-force-personnel-by-state/
- The Kentucky National Guard http://kentuckyguard.dodlive.mil/about-us/
- The Kentucky Commission on Military Affairs https://kcma.ky.gov/resources/Pages/default.aspx
- Military Active-Duty Personnel, Civilians by State https://www.governing.com/now/2021-military-active-duty-personnel-civilians-by-state

# 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:**

To avoid an increase in the rate of adults, who did not already reside in personal care homes, being discharged to personal care homes from state operated psychiatric hospitals.

**Strategies to attain the goal:**

The electronic medical records system utilized by state operated psychiatric hospitals collects living arrangement at admission and discharge.
Maintain collaborative partnerships between the state operated 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.
Maintain related infrastructure including regular Olmstead meetings, transition committee meetings and other meetings that require state operated psychiatric hospitals, DBHDID and community partner involvement.
Provide technical assistance to the state operated psychiatric hospitals and the CMHCs to address barriers to supporting community living.

### Annual Performance Indicators to measure goal success

**Indicator #:** 1

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

**Baseline Measurement:** The SFY 2022 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 is 4.2% = 214/5,040.

**First-year target/outcome measurement:** By the end of SFY 2024, the 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 will be less than 8%. This number will be calculated annually.

**Second-year target/outcome measurement:** By the end of SFY 2024, the 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 will be 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 adults discharged to a personal care home where the living arrangement on admission was not personal care home, divided by the total number of adults discharged where the living arrangement on admission 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 needing the levels of care described in this indicator are experiencing SMI. However, the specific data sets for

both state-operated 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 two (2) years, and individuals must need assistance with daily living/personal care functioning.
This performance indicator is being continued due to the importance of monitoring the rate of persons being discharged to personal care homes, where the living arrangement on admission is not personal care home.

**Priority #:** 2

**Priority Area:** Children with SED

**Priority Type:** MHS

**Population(s):** SED

**Goal of the priority area:**

Maintain provider workforce identified that serve children, youth, and transition age youth, including those with SED.

**Strategies to attain the goal:**

CMHCs are required via contract to provide a full continuum of services for children, youth, transition age youth (age birth through 21) with or at risk of developing SED, and their families, as deemed appropriate.
Provide consultation and technical assistance to CMHC children's services staff in best practices for recruiting, supporting, and retaining a high quality workforce for children, youth, transition age youth and families.
Continue peer group meetings with Children's Service Directors and other peer groups to enhance consultation, technical assistance, and support around workforce strategies.
Provide technical assistance to CMHCs regarding accurate coding procedures for reporting comprehensive community support and peer support services, as these are more recently added services and provider types, with unique support needs.

## Annual Performance Indicators to measure goal success

**Indicator #:** 1

**Indicator:** Identified provider workforce that serve children, youth and transition age youth, including those with SED. (specifically targeted case managers, community support associates, clinicians, and peer specialists)

**Baseline Measurement:** Total number of identified providers for all CMHCs for this population for SFY 2024 is 941. (Includes TCMs, CSAs, clinicians, and PSS)

**First-year target/outcome measurement:** Maintain current identified provider workforce at no less than 85% of the SFY 2024 baseline. At the end of SFY 2024, the total identified provider workforce will be maintained at between 800 – 941 providers.

**Second-year target/outcome measurement:** Maintain current identified provider workforce at no less than 85% of the SFY 2024 baseline. At the end of SFY 2024, the total identified provider workforce will be maintained at between 800 – 941 providers.

**Data Source:**

Annual Plan and Budget Document Form 118, Children and Transition Age Youth System of Care Application.

**Description of Data:**

Form 118 is required at the beginning of each SFY, as part of the annual Plan and Budget process, for each CMHC. Form 118 describes current system of care per CMHC.
For this measure, page 3 of Form 118, which describes the current staffing for each CMHC for this population will be used, including the tallies of following staff positions: targeted case managers, including HiFi Wraparound facilitators; community support associates; clinicians who serve the early childhood population (birth through five); clinicians who serve the transition age youth population (16 – 21); and peer specialists (including family and youth peer support specialists).
Year One measurement will be taken from Page 3 of Form 118 that is submitted with SFY 2025 plan and budget process.
Year Two measurement will be taken from Page 3 of Form 118 that is submitted with SFY 2026 plan and budget process.

**Data issues/caveats that affect outcome measures:**

Workforce issues have been negatively impacted due to the pandemic. Much support has been provided to the CMHCs to address workforce issues, including staff recruitment and retention, but the issue persists.
Staff recruitment and retention remain a very challenging issue and any additional statewide or national events, such as the pandemic,

would negatively affect the outcome of this measure.
This measure is conservative but needed as adequate workforce for this population is especially important.

**Priority #:** 3

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

**Priority Type:** ESMI

**Population(s):** ESMI

**Goal of the priority area:**

Increase access to evidence-based practices for individuals with 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 quarterly meetings with all key contacts from CMHCs regarding this population to provide technical assistance/education regarding CSC and First Episode Psychosis.
Embed rapid access measures and rationale into CMHC contract deliverables for CSC outpatient funded sites.
Provide refresher training for CSC prescribers and create infrastructure to support CSC prescribers.

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1

**Indicator:** Young people will have access to available prescriber appointments within seven days of admission into 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:** Young people will have access to available prescriber appointments within seven days of admission into 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.

**First-year target/outcome measurement:** By the end of SFY 2024, the statewide total of new admissions into CSC programs seeing team prescribers within seven days of admission will be at least 67 percent.

**Second-year target/outcome measurement:** By the end of SFY 2025, the statewide total of new admissions into CSC programs seeing team prescribers within seven days of admission will be at least 67 percent.

**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 is required from each CSC team on a quarterly basis. Numbers of new admissions are gathered quarterly as well as the number of new admissions who choose to see a prescriber, and the number of those who are seen by a prescriber within seven (7) days of admission.

**Data issues/caveats that affect outcome measures:**

Young people being admitted into CSC programs are encouraged, but not required, to see a prescriber, whether or not they will be taking medication. Young people who choose not to see a prescriber will not negatively impact this measure.
Some young people being admitted into CSC programs already have a prescriber, and some of those want to continue seeing that provider. Young people who are admitted and choose to keep their own prescriber will not negatively impact this measure.

**Priority #:** 4

**Priority Area:** Behavioral Health Crisis Services

**Priority Type:** BHCS

**Population(s):** BHCS

**Goal of the priority area:**

Increase in-state crisis 988 calls, texts, and chat responses.

**Strategies to attain the goal:**

DBHDID will continue to provide training and technical assistance to 988 call centers.
DBHDID will continue to convene monthly peer group meetings of 988 call centers so that centers can share implementation strategies and best practices.
DBHDID will continue to develop collaborative relationships and processes with partner agencies.
DBHDID will continue to pursue funding and coverage opportunities to enhance 988 services.
DBHDID will continue to engage in regional and national training and technical assistance opportunities.
DBHDID will continue workforce initiatives to enhance 988 workforce development, recruitment, and retention.

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1

**Indicator:** Increase the number of 988 calls, texts, and chats answered in-state by one percent.

**Baseline Measurement:** In SFY 2023, Kentucky Call Centers responded to 21,301 calls, texts, and chats.

**First-year target/outcome measurement:** At the end of SFY 2024, Kentucky Call Centers will have responded to at least .50 percent more calls, texts, chats than baseline. (21,408 calls, texts, chats)

**Second-year target/outcome measurement:** At the end of SFY 2025, Kentucky Call Centers will have responded to an additional .50 percent more calls, texts, chats than baseline. (21,515 calls, texts, chats)

**Data Source:**

Kentucky Broad State Metric Report (a monthly report provided by Vibrant Emotional Health, the administrator of the 988 Suicide & Crisis Lifeline).

**Description of Data:**

Statewide total number of 988 calls, texts, and chats answered by Kentucky's thirteen (13) 988 call centers, as reported monthly by Vibrant Emotional Health via the 988 Broad State Metrics for Kentucky report.

**Data issues/caveats that affect outcome measures:**

Vibrant is continuously refining 988 telephone technology and reporting in real time and data is impacted periodically.
988 experienced a blackout this year that impacted all state and territory call centers for a day (national call centers were still operational). Although Vibrant addressed the issue and built in redundancies, something similar could happen again.
Vibrant is currently piloting a new Unified Platform and plans to implement it in phases nationally in the coming year. The in-state answer rate may be impacted. (Pennyroyal Center is one (1) of two national pilot sites, and they have seen a marked decrease in ability to respond to calls during the pilot testing.)
Kentucky is exploring the idea of developing its own state platform instead of using the Vibrant Unified Platform. If it does, answer rates could be impacted as it is implemented.

**Priority #:** 5

**Priority Area:** Primary Prevention

**Priority Type:** SUP

**Population(s):** PP

**Goal of the priority area:**

Increase awareness of the risks of using vaping products in youth.

**Strategies to attain the goal:**

Educate youth, parents, and school staff members about the harmful effects of electronic vaping products.

Provide training and technical assistance to schools and community organizations to update school and community smoke-free policies to address electronic vaping devices.
Provide retailers of vaping products with information on the Tobacco Retailer Underage Sales Training (TRUST) for retailers to reduce sales to minors.
Provide training and technical assistance to schools to support and enhance early prevention screening and assessment of adolescents.

**Annual Performance Indicators to measure goal success**

| | |
|---|---|
| **Indicator #:** | 1 |
| **Indicator:** | The number of Kentucky youth served by non-media related prevention services targeting vaping. |
| **Baseline Measurement:** | 2,833 Kentucky youth received non-media related prevention services targeting tobacco use in SFY 2022. (Kentucky Prevention Data System reports vaping and traditional tobacco use under the same category) |
| **First-year target/outcome measurement:** | At the end of SFY 2024, at least .50% more young people (2,847) will have received non-media related prevention services targeting vaping. |
| **Second-year target/outcome measurement:** | At the end of SFY 2025, at least .50% more young people (2,861) will have received non-media related prevention services targeting vaping. |

**Data Source:**

Kentucky's Prevention Data System.

**Description of Data:**

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:**

Accuracy of data depends on contracted providers entering activities accurately in a timely manner.

**Priority #:** 6

**Priority Area:** Pregnant Women and women with dependent children who have Substance Use Disorder

**Priority Type:** SUT

**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 specific needs and/or risk factors that affect pregnant women and women with dependent children, their children and families in the POSC initiative regions.
Identify barriers to resources and services to address those needs and/or risk factors.
Develop and implement a written strategic plan in collaboration with the POSC workgroups to reduce identified barriers and provide services and/or resources.

**Annual Performance Indicators to measure goal success**

| | |
|---|---|
| **Indicator #:** | 1 |
| **Indicator:** | Implementation of Plan of Safe Care (POSC) strategic plans. |
| **Baseline Measurement:** | At the end of SFY 2022, there are 10 POSC sites to serve PWWDC with SUD. There are 0 completed POSC strategic plans. |
| **First-year target/outcome measurement:** | At the end of SFY 2024, two POSC sites will have developed and submitted to DBHDID a written strategic plan and provided documentation of implementation. |
| **Second-year target/outcome measurement:** | At the end of SFY 2025, two additional POSC sites will have developed and submitted to |

DBHDID a written strategic plan and provided documentation of implementation.

**Data Source:**

CMHC contract reporting requirement. CMHC.ContrRepReq@ky.gov ; monthly POSC meetings

**Description of Data:**

The CMHCs with POSC sites will be required to submit strategic plans that outline identified barriers to resources and services for this population and implementation steps to address identified needs. The strategic reports will be submitted via the data source.
DSUD program staff will attend all monthly POSC meetings and assist with plan development.
DSUD program staff will review all summaries from monthly meetings to monitor implementation activities.

**Data issues/caveats that affect outcome measures:**

**Priority #:** 7

**Priority Area:** Persons who inject drugs

**Priority Type:** SUT

**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:** Increase the number of Syringe Services Programs (SSPs) in place across the state.

**Baseline Measurement:** At the end of SFY 2023 there are 83 SSPs across the state.

**First-year target/outcome measurement:** At the end of SFY 2024, there will be one additional SSP in the state. (84)

**Second-year target/outcome measurement:** At the end of SFY 2025, there will be one additional SSP in the state. (85)

**Data Source:**

The Kentucky Department for Public Health Surveillance data, Kentucky Office of Drug Control Policy (ODCP), Kentucky Harm Reduction Coalition, the 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 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.

**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 offer 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 hepatitis B vaccination; screening for other sexually transmitted diseases and tuberculosis; partner services and other medical, social, and mental health services.
In direct response to Senate Bill 192, enacted during the 2015 regular legislative session, the Department for Public Health has published guidelines for local health departments implementing harm reduction and syringe services programs.

**Priority #:** 8

**Priority Area:** Persons with or at risk of tuberculosis

**Priority Type:** SUT

**Population(s):** TB

**Goal of the priority area:**

Improve screening and referral to services for individuals with or at risk of tuberculosis.

**Strategies to attain the goal:**

Continue partnering with Kentucky Department for Public Health and the CMHCs to improve screening and referral protocols for individuals who have or are at risk for tuberculosis.
Ensure that CMHCs are systematically screening for tuberculosis among individuals receiving services for SUDs and when appropriate referring for services.
Offer CMHCs technical assistance in updating and improving their policies and procedures regarding tuberculosis screening and referral.
Introduce CMHCs to the monitoring tool being created to review for adequate screening and referral and include providers in the development of the tool and the process of reviewing client files for this information.

## Annual Performance Indicators to measure goal success

**Indicator #:** 1

**Indicator:** Screen persons who present for substance use services at the fourteen CMHCs for tuberculosis and provide appropriate referrals to services.

**Baseline Measurement:** At the end of SFY 2022, all fourteen CMHCs had submitted written policies that include processes for screening for TB and training staff. No monitoring tool exists to measure whether providers are following these policies that have been created and approved by DSUD.

**First-year target/outcome measurement:** At the end of SFY 2024, DSUD program staff will have developed a monitoring tool to utilize in reviewing client files regarding written documentation of tuberculosis screening and referral to services.

**Second-year target/outcome measurement:** At the end of SFY 2025, DSUD program staff will have reviewed a minimum of 20 client files at each of two CMHCs.

**Data Source:**

CMHC contract reporting requirements; DSUD monitoring documentation.

**Description of Data:**

The monitoring tool will be developed. A process will be created for monitoring client files. Once created, the tool will be available.
An 80% rate of compliance will be considered sufficient to meet the screening and referral requirement. If the rate is below 80%, the CMHC will be required to submit a plan to ensure meeting contract requirements and following approved policies.
At the end of SFY 2025, data outcomes from the first two reviews of CMHCs will be collected and may possibly be used to determine new performance indicators in the years ahead.

**Data issues/caveats that affect outcome measures:**

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

### Footnotes:

In all Performance Indicators utilizing data measures from the state client/event data set, baselines were set using SFY 2022 data, due to all state data being certified October 15th of each subsequent year. SFY 2023 data is not yet certified at the time of this application submission. For some indicators other data sets were utilized and the most recent data available was used to set baselines.

## Planning Tables

**Table 2 State Agency Planned Expenditures [SUPTRS]**

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2024/2025.
SUPTRS BG – ONLY include funds expended by the executive branch agency administering the SUPTRS BG.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

| Activity (See instructions for using Row 1.) | Source of Funds | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | A. SUPTRS BG | 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 (SUPTRS BG)[a] | J. ARP Funds (SUPTRS BG)[b] |
| 1. Substance Use Prevention[c] and Treatment | $30,114,016.00 | | $0.00 | $71,098,362.00 | $26,527,104.00 | $0.00 | $0.00 | | $14,134,605.00 | $0.00 |
| a. Pregnant Women and Women with Dependent Children[c] | $5,233,846.00 | | | $71,098,362.00 | $1,891,000.00 | | | | $764,050.00 | |
| b. Recovery Support Services | $232,794.00 | | | | $24,636,104.00 | | | | | |
| c. All Other | $24,647,376.00 | | | | | | | | $13,370,555.00 | |
| 2. Primary Prevention[d] | $8,943,864.00 | | $0.00 | $8,058,804.00 | $1,232,129.00 | $0.00 | $0.00 | | $4,011,170.00 | $0.00 |
| a. Substance Use Primary Prevention | $8,943,864.00 | | | $8,058,804.00 | $1,232,129.00 | | | | $4,011,170.00 | |
| b. Mental Health Prevention | | | | | | | | | | |
| 3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG) | | | | | | | | | | |
| 4. Other Psychiatric Inpatient Care | | | | | | | | | | |
| 5. Tuberculosis Services | | | | | | | | | | |
| 6. Early Intervention Services for HIV | | | | | | | | | | |
| 7. State Hospital | | | | | | | | | | |
| 8. Other 24-Hour Care | | | | | | | | | | |
| 9. Ambulatory/Community Non-24 Hour Care | | | | | | | | | | |
| 10. Crisis Services (5 percent set-aside) | | | | | | | | | | |
| 11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately | $3,531,944.00 | | | $3,454,400.00 | $1,813,600.00 | | | | $955,040.00 | |
| **12. Total** | **$42,589,824.00** | **$0.00** | **$0.00** | **$82,611,566.00** | **$29,572,833.00** | **$0.00** | **$0.00** | **$0.00** | **$19,100,815.00** | **$4,519,482.00** |

[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" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[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" MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 – June 30, 2025. Please enter SUPTRS BG ARP planned expenditures for the period of July 1, 2023 through June 30, 2025

[c] Prevention other than primary prevention

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

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**Footnotes:**

## Planning Tables

### Table 2 State Agency Planned Expenditures [MH]

Table 2 addresses funds to be expended during the 24-month period of July 1, 2023 through June 30, 2025. Table 2 now includes columns to capture state expenditures for COVID-19 Relief Supplemental and ARP funds. Please use these columns to capture how much the state plans to expend over a 24-month period (July 1, 2023 - June 30, 2025). Please document the use of COVID-19 Relief Supplemental and ARP funds in the footnotes.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

| Activity (See instructions for using Row 1.) | Source of Funds | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | A. SUPTRS BG | 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 (SUPTRS BG)[a] | J. ARP Funds (MHBG)[b] | K. BSCA Funds (MHBG)[c] |
| 1. Substance Use Prevention and Treatment | | | | | | | | | | | |
| a. Pregnant Women and Women with Dependent Children | | | | | | | | | | | |
| b. Recovery Support Services | | | | | | | | | | | |
| c. All Other | | | | | | | | | | | |
| 2. Primary Prevention | | | | | | | | | | | |
| a. Substance Use Primary Prevention | | | | | | | | | | | |
| b. Mental Health Prevention[d] | | | | | | | | | | | |
| 3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[e] | | $2,516,416.00 | | | | | | $206,250.00 | | $888,750.00 | |
| 4. Other Psychiatric Inpatient Care | | | $33,162,729.00 | $4,497,502.00 | $5,939,645.00 | | $27,022.00 | | | | |
| 5. Tuberculosis Services | | | | | | | | | | | |
| 6. Early Intervention Services for HIV | | | | | | | | | | | |
| 7. State Hospital | | | $78,937,417.00 | $47,853,294.00 | $159,395,529.00 | | $1,769,392.00 | | | | |
| 8. Other 24-Hour Care | | | | | $7,560,090.00 | | | | | | |
| 9. Ambulatory/Community Non-24 Hour Care | | $20,131,324.00 | $1,800,000.00 | $19,141,354.00 | $59,400,196.00 | | | $2,753,420.00 | | $12,430,486.00 | |
| 10. Crisis Services (5 percent set-aside)[f] | | $1,258,208.00 | | $2,004,924.00 | $30,837,596.00 | | | $462,000.00 | | $1,175,000.00 | |
| 11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately[g] | | $1,258,208.00 | $387,400.00 | $1,419,200.00 | $17,232,000.00 | | | $318,000.00 | | $350,000.00 | |
| **12. Total** | **$0.00** | **$25,164,156.00** | **$114,287,546.00** | **$74,916,274.00** | **$280,365,056.00** | **$0.00** | **$1,796,414.00** | **$3,739,670.00** | **$0.00** | **$14,844,236.00** | **$1,616,284.00** |

[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" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states. Note: If your state has an approved no cost extension, you have until March 14, 2024, to expend the COVID-19 Relief supplemental funds.

[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" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[c]The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is from **October 17, 2022 thru October 16, 2024** and the expenditure for the 2nd allocation of BSCA funding will be from September 30, 2023 thru September 29, 2025 which is different from the expenditure period for the "standard" MHBG. Column J should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

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

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

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

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

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**Footnotes:**

# Planning Tables

## Table 3 SUPTRS BG Persons in need/receipt of SUD treatment

To complete the Aggregate Number Estimated in Need column, please refer to the most recent edition of SAMHSA's National Survey on Drug Use and Health (NSDUH) or other federal/state data that describes the populations of focus in rows 1-5.

To complete the Aggregate Number in Treatment column, please refer to the most recent edition of the Treatment Episode Data Set (TEDS) data prepared and submitted to SAMHSA's Behavioral Health Services Information System (BHSIS).

| | Aggregate Number Estimated In Need | Aggregate Number In Treatment |
|---|---|---|
| 1. Pregnant Women | 2,266 | 157 |
| 2. Women with Dependent Children | 63,213 | 1,419 |
| 3. Individuals with a co-occurring M/SUD | 267,251 | 17,639 |
| 4. Persons who inject drugs | 11,940 | 4,821 |
| 5. Persons experiencing homelessness | 568 | 4,446 |

**Please provide an explanation for any data cells for which the state does not have a data source.**

a—Data for numbers 1,3,4 and 5 are from the TEDS-A data for Kentucky for 2020. The public use dataset was downloaded from here, https://www.samhsa.gov/data/data-we-collect/teds-treatment-episode-data-set b—The TEDS-A dataset does not include the number of women with dependent children. Thus, data from the KTOS intake survey data submitted in FY 2021 was consulted for data for number 2. c—The estimate for homelessness data reported in number 5 is based on a point-in-time estimate (i.e., one night in January 2020) and not within an entire 12-month period, so it is necessarily an underestimate.

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**Footnotes:**

# Planning Tables

## Table 4 SUPTRS BG Planned Expenditures

States must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations, including the supplemental COVID-19 and ARP funds. Plan Table 4 must be completed for the FFY 2024 and FFY 2025 SUPTRS BG awards. The totals for each Fiscal Year should match the President's Budget Allotment for the state.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

| | FFY 2024 | | |
|---|---|---|---|
| **Expenditure Category** | **FFY 2024 SUPTRS BG Award** | **COVID-19 Award[1]** | **ARP Award[2]** |
| 1 . Substance Use Disorder Prevention and Treatment[3] | $15,860,383.00 | $10,764,904.00 | $2,594,939.00 |
| 2 . Substance Use Primary Prevention | $4,471,932.00 | $3,080,871.00 | $736,401.00 |
| 3 . Early Intervention Services for HIV[4] | | | |
| 4 . Tuberculosis Services | | | |
| 5 . Recovery Support Services[5] | $116,397.00 | | |
| 6 . Administration (SSA Level Only) | $846,200.00 | $825,040.00 | $175,333.00 |
| **7. Total** | **$21,294,912.00** | **$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 expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19

Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[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 FY 2024 "standard" SUPTRS BG, which is October 1, 2023 - September 30, 2024. The SUPTRS BG ARP planned expenditures for the period of October 1, 2023 - September 30, 2024 should be entered here in the first ARP column, and the SUPTRS BG ARP planned expenditures for the period of October 1, 2024, through September 30, 2025, should be entered in the second ARP 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 use disorder Prevention and Treatment Block Grant (SUPTRS BG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the AtlasPlus HIV data report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP). The most recent AtlasPlus HIV data 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 SUPTRS BG 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 SUPTRS BG funds with the flexibility to obligate and expend SUPTRS BG 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 SUPTRS BG 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 will be allowed to obligate and expend SUPTRS BG funds for EIS/HIV if they chose to do so and may elect to do so by providing written notification to the CSAT SPO as a part of the SUPTRS BG Application.

[5]This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023.

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**Footnotes:**

Table 4 – SABG – “The total for primary prevention on row 2 = primary prevention totals on Table 5a + primary prevention totals on Table 6b, for regular SUPTRS-BG, COVID 19 supplement, and ARP respectively. Kentucky allocates 21% for primary prevention.”

# Planning Tables

### Table 5a SUPTRS BG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

| A | | B | | |
|---|---|---|---|---|
| **Strategy** | **IOM Target** | **FFY 2024** | | |
| | | **SUPTRS BG Award** | **COVID-19 Award[1]** | **ARP Award[2]** |
| 1. Information Dissemination | Universal | $347,002 | $251,648 | $55,036 |
| | Selected | $382 | $277 | $61 |
| | Indicated | $1,911 | $1,386 | $303 |
| | Unspecified | $0 | $0 | $0 |
| | **Total** | **$349,295** | **$253,311** | **$55,400** |
| 2. Education | Universal | $72,228 | $52,380 | $11,456 |
| | Selected | $382 | $277 | $61 |
| | Indicated | $1,529 | $1,109 | $242 |
| | Unspecified | $0 | $0 | $0 |
| | **Total** | **$74,139** | **$53,766** | **$11,759** |
| 3. Alternatives | Universal | $4,204 | $3,049 | $667 |
| | Selected | $0 | $0 | $0 |
| | Indicated | $0 | $0 | $0 |
| | Unspecified | $0 | $0 | $0 |
| | **Total** | **$4,204** | **$3,049** | **$667** |
| 4. Problem Identification and Referral | Universal | $21,783 | $15,798 | $3,455 |
| | Selected | $0 | $0 | $0 |
| | Indicated | $3,822 | $2,771 | $606 |
| | Unspecified | $0 | $0 | $0 |
| | **Total** | **$25,605** | **$18,569** | **$4,061** |
| | Universal | $3,346,203 | $2,426,688 | $530,723 |

| | | | | |
|---|---|---|---|---|
| 5. Community-Based Processes | Selected | $3,057 | $2,217 | $485 |
| | Indicated | $3,439 | $2,494 | $546 |
| | Unspecified | $0 | $0 | $0 |
| | **Total** | **$3,352,699** | **$2,431,399** | **$531,754** |
| 6. Environmental | Universal | $15,669 | $11,363 | $2,485 |
| | Selected | $0 | $0 | $0 |
| | Indicated | $0 | $0 | $0 |
| | Unspecified | $0 | $0 | $0 |
| | **Total** | **$15,669** | **$11,363** | **$2,485** |
| 7. Section 1926 (Synar)-Tobacco | Universal | $0 | $0 | $0 |
| | Selected | $0 | $0 | $0 |
| | Indicated | $0 | $0 | $0 |
| | Unspecified | $0 | $0 | $0 |
| | **Total** | **$0** | **$0** | **$0** |
| 8. Other | Universal | $0 | $0 | $0 |
| | Selected | $0 | $0 | $0 |
| | Indicated | $0 | $0 | $0 |
| | Unspecified | $0 | $0 | $0 |
| | **Total** | **$0** | **$0** | **$0** |
| **Total Prevention Expenditures** | | **$3,821,611** | **$2,771,457** | **$606,126** |
| **Total SUPTRS BG Award[3]** | | **$21,294,912** | **$14,670,815** | **$3,506,673** |
| **Planned Primary Prevention Percentage** | | **17.95 %** | **18.89 %** | **17.28 %** |

[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" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

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

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

**Footnotes:**

Table 5a – SABG – "The "total prevention expenditures" row include the totals from Table 5a plus the primary prevention non-direct planned expenditures on Table 6b, for regular SUPTRS-BG, COVID 19 supplement, and ARP respectively."

# Planning Tables

### Table 5b SUPTRS BG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

| Activity | FFY 2024 SUPTRS BG Award | FFY 2024 COVID-19 Award[1] | FFY 2024 ARP Award[2] |
|---|---|---|---|
| Universal Direct | $1,771,317 | $1,284,571 | $280,940 |
| Universal Indirect | $2,035,771 | $1,476,355 | $322,883 |
| Selected | $3,822 | $2,771 | $606 |
| Indicated | $10,701 | $7,760 | $1,697 |
| **Column Total** | **$3,821,611** | **$2,771,457** | **$606,126** |
| **Total SUPTRS BG Award[3]** | **$21,294,912** | **$14,670,815** | **$3,506,673** |
| **Planned Primary Prevention Percentage** | **17.95 %** | **18.89 %** | **17.28 %** |

[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" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

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

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

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**Footnotes:**

Each column total on Table 5b, when combined with the primary prevention totals on Table 6 equals the amounts on row 2 of Table 4 and equal 21%. (Kentucky allocates 21% for primary prevention)
Table 5b column one total - 3,821,611 + Table 6 column one total 650,321 = Table 4, row 2 total 4,471,932.
Table 5b column two total - 2,771,457 + Table 6 COVID column total 309,414 = Table 4, row 2 COVID total - 3,080,871
Table 5b column three total - 606,126 +Table 6 ARP column total 130,275 = Table 4, row 2 ARP total - 736,401

# Planning Tables

### Table 5c SUPTRS BG Planned Primary Prevention Priorities (Required)

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2024 and FFY 2025 SUPTRS BG awards.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

| | SUPTRS BG Award | COVID-19 Award[1] | ARP Award[2] |
|---|---|---|---|
| **Prioritized Substances** | | | |
| Alcohol | ☑ | ☑ | ☑ |
| Tobacco | ☑ | ☑ | ☑ |
| Marijuana | ☑ | ☑ | ☑ |
| Prescription Drugs | ☑ | ☑ | ☑ |
| Cocaine | ☑ | ☑ | ☑ |
| Heroin | ☑ | ☑ | ☑ |
| Inhalants | ☑ | ☑ | ☑ |
| Methamphetamine | ☑ | ☑ | ☑ |
| Fentanyl | ☑ | ☑ | ☑ |
| **Prioritized Populations** | | | |
| Students in College | ☐ | ☐ | ☐ |
| Military Families | ☑ | ☑ | ☑ |
| LGBTQI+ | ☑ | ☑ | ☑ |
| American Indians/Alaska Natives | ☐ | ☐ | ☐ |
| African American | ☑ | ☑ | ☑ |
| Hispanic | ☑ | ☑ | ☑ |
| Persons Experiencing Homelessness | ☐ | ☐ | ☐ |
| 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" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

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

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**Footnotes:**

## Planning Tables

### Table 6 Non-Direct-Services/System Development [SUPTRS]

Please enter the total amount of the SUPTRS BG, COVID-19, or ARP funds expended for each activity.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

| Expenditure Category | FFY 2024 | | | | |
|---|---|---|---|---|---|
| | A. SUPTRS BG Treatment | B. SUPTRS BG Prevention | C. SUPTRS BG Integrated[1] | D. COVID-19[2] | E. ARP[3] |
| 1. Information Systems | | $245,200.00 | | $83,164.00 | $7,050.00 |
| 2. Infrastructure Support | | | | | |
| 3. Partnerships, community outreach, and needs assessment | | $25,000.00 | | $32,750.00 | $9,250.00 |
| 4. Planning Council Activities (MHBG required, SUPTRS BG optional) | | | | | |
| 5. Quality Assurance and Improvement | | $35,000.00 | | | |
| 6. Research and Evaluation | | $255,121.00 | | | |
| 7. Training and Education | | $90,000.00 | | $193,500.00 | $113,975.00 |
| **8. Total** | **$0.00** | **$650,321.00** | **$0.00** | **$309,414.00** | **$130,275.00** |

[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 expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[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" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the federal planned expenditure period of October 1, 2023 - September 30, 2025. Please list ARP planned expenditures for each standard FFY period.

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**Footnotes:**

Table 6b – SABG – The amounts on Column D, row 8 (309,414) and on Column E, row 8 (130,275) are for primary prevention non-direct planned expenditures.

The total for primary prevention on Table 4, row 2 = primary prevention totals on Table 5a + primary prevention totals on Table 6b, for regular SUPTRS-BG, COVID 19 supplement, and ARP respectively.

# Planning Tables

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

Please enter the total amount of the MHBG, COVID-19, ARP funds, and BSCA funds expended for each activity

MHBG Planning Period Start Date: MHBG Planning Period End Date:

| Activity | FY Block Grant | FY [1] COVID Funds | FY [2] ARP Funds | FY [3] BSCA Funds |
|---|---|---|---|---|
| . | $ | $ | $ | $ |
| **8. Total** | | | **$** | **$** |

**Please wait while data loads...**

[1] The 24-month expenditure period for the COVID-19 Rel **21 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Per the ins res captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for mo oved no cost extension, you have until March 14, 2024 to expend the COVID-19 Relief supplemental funds.

[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 captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for most states.

[3] The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is **October 17, 2022** thru **October 16, 2024** and for the 2nd allocation will be **September 30, 2023** thru **September 29, 2025** which is different from the expenditure period for the "standard" MHBG. Column D should reflect the spending for the state reporting period. The total may reflect the BSCA allotment portion used during the state reporting period.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

# Environmental Factors and Plan

### 1. Access to Care, Integration, and Care Coordination – Required

Narrative Question

Across the United States, significant percentages of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not access needed behavioral health care. States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001**; **https://store.samhsa.gov/product/Approaches-in-Implementing-the-Mental-Health-Parity-and-Addiction-Equity-Act-Best-Practices-from-the-States/SMA16-4983**. The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1]Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. States should develop systems that vary the intensity of care coordination support based on the severity seriousness and complexity of individual need. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

[1]Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Medical care, 599-604.Avaiable at: **https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx**

**1.** Describe your state's efforts to improve access to care for mental disorders, substance use disorders, and co-occurring disorders, including detail on efforts to increase access to services for:

a) Adults with serious mental illness

b) Pregnant women with substance use disorders

c) Women with substance use disorders who have dependent children

d) Persons who inject drugs

e) Persons with substance use disorders who have, or are at risk for, HIV or TB

f) Persons with substance use disorders in the justice system

g) Persons using substances who are at risk for overdose or suicide

h) Other adults with substance use disorders

i) Children and youth with serious emotional disturbances or substance use disorders

j) Individuals with co-occurring mental and substance use disorders

a. Adults with serious mental illness

Each CMHC provides a full array of outpatient services including, but not limited to screening, assessment, individual therapy, group therapy, 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 ensure easy access to needed services. Additional areas of focus include:

• Recognizing the need to provide assertive outreach so fewer appointments are missed (most CMHCs report having a system for follow up of missed appointments);
• Ensuring medication continuity within the agency when level of care changes;
• Addressing shortages of professional staff, especially prescribers, that increase waiting periods for appointments;
• Ensuring continuity of care between CMHCs 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).

Kentucky Medicaid now reimburses for assertive community treatment, peer support services, comprehensive community support services, and intensive outpatient treatment for mental health. These services, that focus on adults with SMI, were not previously covered by Medicaid in Kentucky. DBHDID contracts with each CMHC to provide assertive community treatment and peer support services for individuals with SMI.

Additionally, Kentucky Medicaid now reimburses for several crisis services, including crisis intervention, mobile crisis services and crisis stabilization services. Thirteen (13) of the 14 CMHCs now have mobile crisis services that serve adults with SMI. This service, as it develops more robustly, will improve service access for this population.

In an effort to enhance engagement with adults with SMI, DBHDID supports many recovery-based programs and requires individuals with lived experience to serve on assertive community treatment (ACT) teams, first episode psychosis (FEP) teams, and on the steering committee for Individual Place and Support (IPS) supported employment programs. DBHDID also funds several statewide advocacy organizations and other programs to provide input and guide infrastructure for this population, including a statewide Center for Peer Excellence, that is staffed by peer support specialists.

Additionally, one state psychiatric hospital has an agreement with a local mental health advocacy organization to provide peer support specialists to work in the hospital providing recovery support, including individual and group support, and contact with family members during visitation. This contact with peers prior to discharge is helpful in connecting these individuals and their families with follow-up care.

b. Pregnant women with substance use disorders

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, recovery housing, and other community-based recovery supports

As part of the KY-Moms Maternal Assistance Towards Recovery (MATR) program, the Kentucky Division of Substance Use Disorder (DSUD), 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. 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 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 12 months after delivery. Prevention and case management services are designed to reduce harm to Kentucky children from maternal substance use during and after pregnancy

c. Women with substance use disorder who have dependent children

Kentucky continues to expand its Plan of Safe Care (POSC) initiative with pilot sites at 10 of the 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 for pregnant and parenting individuals and their families. From SFY 2016 to SFY 2022, it is estimated that more than 5,000 individuals and their children/families have received treatment and utilized services from over twenty-two selected providers across the state supported by these funds.

The DBHDID collaborates with the Department for Community Based Services (DCBS), Kentucky's child welfare agency, in its implementation of the Family First Prevention Services Act (FFPSA). Among the evidence-based/informed practices (EB/IP) on Kentucky's FFPSA plan are Sobriety Treatment and Recovery Team (START) and Kentucky Strengthening Ties and Empowering Parents (KSTEP). Both are aimed at supporting families who have child welfare involvement and in which parental substance use has been identified as a child safety risk as well as improving collaboration between child welfare and behavioral health treatment providers.

START serves families with at least one child under the age of six. It achieves this by pairing specially trained DCBS workers with family mentors who have at least three years of sobriety and previous involvement with DCBS, using a system-of-care and team decision-making approach with families. The program also partners with substance abuse treatment providers to ensure START participants have quick access to intensive treatment. Decision-making is shared among all team members, including the family and court.

KSTEP was initiated as a part of a Title IV-E Waiver aimed at reducing the need for out-of-home placement and reducing duration of such placements when needed by focusing on the complex needs of families involved with DCBS who have at least one child in the home under age ten and who are experiencing challenges with substance use by engaging families and giving them a voice in the services they receive. It utilizes the Solution-Based Casework (SBC) model and emphasizes collaboration between families, DCBS, and the provider community to achieve positive outcomes. The basic tenets of KSTEP include case coordination services, partnership with the family, rapid access, and provision of clinical services including substance misuse treatment. KSTEP facilitates family engagement and involvement in the assessment and case planning processes, which leads to the empowerment of families and a reduction in high risk behaviors.

Both programs also provide or refer for the provision of services for the children and youth in the families, as indicated, thus improving access for not only mothers with dependent children but for their partners and children as well.

d. Persons who inject drugs
DBHDID continues 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 and harm reduction efforts statewide. In addition, DBHDID will work to enhance access to peer support services to these individuals as well as access to evidence-based OUD services, including MOUD.

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 who are seeking substance use services and refer them for appropriate treatment services.

e. Persons with substance use disorders who have, or are at risk for, HIV or TB
The CMHC's are required by contract to submit their written policies and protocols detailing the process for offering education, HIV testing, screening for risk and referral for all individuals seeking services for substance use disorders. To continue to enhance oversight of 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 are now required to include training curriculum designed to ensure staff receive adequate instruction on effective and consistent implementation of HIV/AIDS protocols. Providers also consult the Department for Public Health, HIV/AIDS Program for technical assistance with writing their policies and protocols as needed

The Kentucky Department for Public Health has supported the development of syringe services programs (SSPs) across the state. There are currently 83 SSPs in 65 counties in Kentucky. Many of these programs provide outreach services, including harm reduction information/education, access to peer support and treatment services. Block grant funds are not used to support Syringe Services Programs.

f. Persons with substance use disorders in the justice system
Through the State Opioid Response (SOR) grants, the Kentucky Opioid Response Effort (KORE) has supported the provision of trainings and technical assistance designed to build and strengthen workforce capacity. As part of the Responsive Education to Support Treatment in Opioid Recovery Efforts (RESTORE) program, the Administrative Office of the Courts implemented a quarterly training series for court staff (i.e., judges, attorneys, clerks) to increase their knowledge, attitudes, and behaviors as it relates to serving individuals with opioid and/or stimulant use disorder. The department strives to link individuals who are justice involved with an array of services and supports in their local communities. Reintegration specialists assess and identify individual needs for those with substance use disorder prior to release from custody. Appropriate substance use disorder, mental health disorder and physical health treatment is available and coordinated as needed, as well as harm reduction and peer support services.

In addition, the DBHDID is collaborating with the Kentucky Department for Medicaid Services (DMS) and the Kentucky Department for Juvenile Justice (DJJ) to draft an 1115 Waiver that will allow for the provision of substance use treatment services for youth in DJJ placement. If approved, this will provide first time access to Medicaid reimbursable substance use treatment services for youth while they are placed in DJJ facilities.

g. Persons using substances who are at risk for overdose or suicide
DBHDID has worked to increase access to behavioral health services for individuals at risk of overdose or suicide by expansion of Quick Response Teams (QRT) in Kentucky. Quick Response Teams (QRTs) provide compassionate, assertive outreach to adult and adolescent overdose survivors to facilitate treatment and harm reduction services. Teams are composed of peer specialists, treatment providers and first responders. CMHCs provided QRT services in 16 counties during SFY 2021 and in 30 counties during SFY 2022.

h. Other adults with substance use disorders

Kentucky's behavioral health system of care includes fourteen Community Mental Health Centers (CMHCs) as well as multiple licensed and credentialed private providers as specified in 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 services focused on those populations. Those populations include Service Members Veterans and their Families (SMVF), adolescents, pregnant and parenting persons, individuals experiencing homelessness, older adults, 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 through 36, state-certified Narcotic Treatment Programs that dispense suboxone, methadone or other FDA-approved forms of MOUD in tandem with additional 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 FindHelpNowky.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. FindHelpNowky.org also contains a multidisciplinary information center to help answer questions about substance use, treatment, and recovery resources. FindHelpNowky.org was created by the Kentucky Injury Prevention and Research Center (KIPRC) as an 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 (Unlawful Narcotics Investigations, Treatment and Education).

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 CMHC contracts with DBHDID require the use of ASAM Criteria for level of care determination for SUD treatment services. Training on the ASAM Multidimensional Assessment was offered statewide and included ASAM Criteria Overview, ASAM Criteria Skill Building, Individualized Service Planning, and Motivational Interviewing, as an effort to build workforce capacity and increase access.

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 training, and Peer Support training. In March 2023, a program recognizing SBIRT Instructors was created. Through this program a uniformed training was established, technical assistance is being provided, and recognition of implementation sites will take place. As of June 2023, there are 26 SBIRT Instructors and 5 SBIRT for Suicide Prevention Instructors statewide. In collaboration with the Children's Mental Health and Recovery Services Branch, there are 325 Trauma-Informed Care Trainers statewide in which the Substance Use Treatment and Recovery Services Branch assists with facilitation of ongoing training efforts and technical assistance.

The Division of Substance Use Disorder (DSUD), which has operated a revolving loan fund in partnership with the Kentucky Housing Corporation since the early 1990s, transitioned operational control of that loan fund during calendar year 2023 to Oxford Housing, Inc. The evidence-based Oxford House model was chosen to establish additional recovery homes utilizing that loan fund. Beginning in January 2016, DBHDID 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 houses in Northern Kentucky providing 32 recovery beds, to 112 houses with 877 beds across the state including houses for men with children and houses for women with children. The contract with Oxford House, Inc. provides our state with outreach workers who identify, open, and sustain community-based recovery housing, who then establish relationships with local service providers to ensure linkages to the available continuum of care. There is also an Oxford House women's resource coordinator who is responsible for services focusing on women and women with children.

DSUD become the state affiliate of the National Alliance for Recovery Residences (NARR) on April 1, 2020. Since then, DSUD has operate the Kentucky Recovery Housing Network (KRHN), a voluntary certification program for recovery housing. To date, KRHN has certified 54 recovery residences with 566 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. The KRHN advisory board has also worked with community partners, providing input on HB 248, which mandates that all recovery houses operating in Kentucky become certified through KRHN. This bill allows for the exception of Oxford Houses, Recovery Kentucky Centers operated by the Kentucky Housing Corporation, or faith-based non-profits directly affiliated with a faith-based organization in their county. In addition, KRHN worked with the Kentucky Injury Prevention Research Center (KIPRC) at the University of Kentucky to develop FindRecoveryHousingNowKY.org, a recovery housing directory that helps potential residents and community partners locate quality recovery housing.

Historically, the older adult population with substance use disorder has been given less attention, nationally and locally, than other populations. Little attention has been given to the possible increase in the likelihood of becoming a victim of adult abuse, self-neglect, and suicide within this population. Kentucky has identified older adults with SUD as a population needing focus and has assigned staff in the DSUD to work to enhance services for this population. DSUD has partnered with the Department of Aging and Independent Living (DAIL) to create a recovery oriented system of care for the lifespan. Identified tasks include: form a multi-agency workgroup to address the issue of SUD in the aging population; work with community partners to promote the awareness campaign; expand screening/assessment/linkages to services by utilizing community partners such as Senior Centers through amended contracts with CMHCs and the Area Agencies on Aging (AAAs); provide educational materials on screening/assessment to doctor's offices, emergency departments, first responders and Department for Community Based Services

(DCBS) frontline workers; and define and create a recovery capital scale for the aging population.

i. Children and youth with serious emotional disturbances or substance use disorders
In Kentucky services for children, youth, transition age youth, and their families that are delivered through Kentucky's public behavioral health safety net (14 regional Community Mental Health Centers) have been provided in accordance with the system of care (SOC) framework since the late 1980s. The SOC framework is built around core values of being: family- and youth-driven; community-based; and culturally- and linguistically-responsive, and set of guiding principles that includes, among others, the integration of physical and mental health, as well as the adoption of a public health model of care, prioritizing equitable access, services, and outcomes across the continuum of promotion, prevention, early intervention, treatment, and recovery so that services and supports can be put in place to ameliorate symptomology as early in the course of treatment as possible.

Kentucky's SOC strives for equitable mental health and substance use access, services, and outcomes for all children and youth, regardless of how they enter care. To that end, the DBHDID collaborates with numerous state agencies and other partners to identify and implement processes that reflect the SOC values and principles. The goal is for entry into care to be streamlined and non-duplicative for both families and providers while also reducing burdens on children, youth, and families across the lifespan and among service types.

Kentucky's statewide Early Childhood Mental Health (ECMH) program has been in existence for twenty years and was originally created to provide outreach, education, consultation, and training for early care and education providers, families, and mental health treatment providers in order to improve their ability to identify and manage social, emotional, and behavioral challenges of children age birth through five and make appropriate referrals to treatment as indicated. Over time, the ECMH program saw an increase in young children who were determined to need further assessment and treatment, thus the focus shifted to the provision of developmentally appropriate, evidence-based/informed clinical treatment for identified children and their families. As a result, the provision of consultation and education for the early childhood population decreased. Simultaneously, the number of children entering the child welfare system with familial substance use as an identified risk factor began to increase. This elevated the need for consultation and support to providers serving these families and the families themselves, as well as improved coordination across early childhood mental health, adult substance use treatment, child welfare, perinatal care, and early care and education. The DBHDID responded to this need by providing funding to the CMHCs aimed at creating and Early Childhood Consultant (ECC) position to begin addressing these needs. Unlike existing Early Childhood Mental Health Specialist positions, ECCs are not required to provide clinical treatment services, thus allowing them to spend more time in the community raising awareness of the needs of very young children exposed to substance in utero and/or in their home and streamline referral pathways.

At the opposite end of the age spectrum for youth, Kentucky has made significant strides in improving access to developmentally appropriate evidence-based/informed practices for transition age youth (age 16-25). A Transition Age Youth (TAY) Cross Branch Implementation Team has been initiated within the Division of Mental Health and the Division of Substance Use Disorder that includes key liaisons within each branch. This team works to enhance the seamless coordination of transition age youth mental health services across child and adult services as well as substance use prevention and treatment. Key goals include increasing service capacity and easy access to care; improving youth voice in services and the youth leadership network; improving the public's awareness of behavioral health issues and reducing stigma; and improving cross-system collaboration and training.
At the local level, a Transition Age Youth Coordinator has been established in each CMHC region. This position serves as the regional expert in transition age youth best practices and work to build the capacity within the region to provide excellent supports and services for the TAY population between 16-25 years old. They provide consultation, referral, education, training, technical assistance, coaching, outreach, and system development within the regional CMHC community to increase seamless and easily accessible supports for TAY. Each CMHC is also required to have a Youth Substance Use Treatment Coordinator who specializes in substance use and co-occurring supports for youth and young adults.
Building on the success of the present 2019 Healthy Transitions Grant, (TAYLRD 2.0), funding has also been used to expand a drop-in center model of behavioral health care. There are now 11 TAYLRD Drop-in Centers across the state that work to follow the TAYLRD Practice Guidelines established through the Healthy Transitions Grant. An array of behavioral health services is provided in an environment that is easily accessible and inviting to youth and young adults. These supports are developmentally appropriate, culturally responsive, promote protective factors, and are tailored to the individual needs of TAY. Services 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. The DBHDID has also provided funding for two additional CMHC regions to enhance outpatient office environments and the service arrays within these offices to be more inviting for young people, as a drop-in center approach is not feasible in all areas of the state.
The DBHDID contracts with eight CMHCs to provide Coordinated Specialty Care to youth/young adults between 15-30 with or at risk of developing First Episode Psychosis. These programs, called iHOPE (Helping Others Pursue Excellence), include staff who have specialized training to work specifically with this population of young people. All 14 CMHCs are also required to designate First Episode Psychosis Key Contacts within their Child and Adult service system. CMHC regions that operate both iHOPE Programs and TAYLRD Drop-in Centers are expected to collaborate to increase easy access to care for young people. This collaborative model has shown to be effective, as one CMHC with both iHOPE and TAYLRD Drop-In Center programming, has now expanded to a second iHOPE Program in order to adequately serve the number of young people identified in need of this service.
At the system level, the State Interagency Council (SIAC) for Services and Supports to Children and Transition-Age Youth was established by statute in 1990 to serve 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 served as the governing body for all past and present SAMHSA SOC and adolescent CSAT grants, as well as other federal grants (suicide prevention; healthy transitions; Children's Bureau trauma; and others) and state-

level initiatives focused on these populations and their families. The SIAC members include:
• Commissioner-level representatives from 12 state agencies (across 5 Cabinets) that serve children, transition-age youth, and their families;
• Nonprofit Family Organization;
• Youth Representative;
• Parent Representative; and
• Subcommittee for Equity & Justice for All Youth (SEJAY).

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 standing committees that support the work of the SIAC. The standing committees are: Social and Emotional Health and Wellbeing; Racial, Ethnic, and Equity Disparities; Service Array, and Disabilities. The SIAC meets monthly and works in alignment with its two-year strategic plan. Standing Committees meet monthly and complete tasks identified on SIAC's multi-year strategic plan.
Of particular note is the current work of the Service Array Standing Committee. That group serves as a multi-agency hub for communication, coordination, and alignment of myriad statewide workgroups, committees, etc. that address system enhancements and improvements and decrease duplication of effort. This group is engaged with the Innovations Institute at the University of Connecticut to convene stakeholders that will co-design Kentucky's first comprehensive, multi-agency children's behavioral health plan (CBHP) The CBHP will serve as a blueprint for expanding and sustaining the SOC across agencies and funding sources.
In addition to the SIAC, eighteen Regional Interagency Councils (RIACS) with similar membership serve as regional loci of accountability for the system of care by:
• Conducting regional system of care planning and operations
• Coordinating system-level continuous quality improvement
• Identifying and developing system of care expansion opportunities
• Promoting system of care awareness
• Initiating and adopting interagency agreements as necessary for providing services & supports to children and transition-age youth with behavioral health needs by agencies on the RIAC
• Advising the SIAC regarding the system of care within the region

RIAC membership is similar to that of the SIAC, with the flexibility to add members based on identified regional needs.

These statutorily mandated bodies craft policy aimed at improving access to and availability of services and supports with children, youth, and transition age youth with or at risk of developing a SED, and their families that align with the System of Care framework, ensuring that an individualized, collaborative, and integrated approach to planning, coordinating, delivering, and evaluating services and supports for children, youth, and transition age youth with or at risk of developing a SED and their families.

j. Individuals with co-occurring mental and substance use disorders
To improve access to services and supports that better meet the developmental and treatment needs of children/youth with co-occurring mental and substance use disorders, early intervention, treatment, and recovery services and supports for this age group are provided primarily through children's services divisions of the Community Mental Health Centers (CMHCs) rather than through substance use treatment services divisions, where services and supports are more appropriate for adults. Child, youth, and family programs within the CMHCs operate in accordance with the system of care framework that takes a collaborative, strength-based approach to supporting the whole child/youth and family throughout a continuum of promotion, prevention, early intervention, treatment, and recovery. To that end, each of the 14 regional CMHCs has funding to support a full time Youth Treatment Coordinator (YTC). The YTCs are dedicated to raising awareness of the prevalence and possible indicators of youth substance use and co-occurring mental health concerns; educating the community and child-serving agencies about youth co-occurring mental health and substance use issues; and how to screen and make referrals for further assessment. Additionally, they are charged with educating CMHC clinicians on the unique treatment needs these youth have, connecting them to training opportunities in evidence-based/informed prevention, assessment, treatment, and recovery practices for this population, and supporting collaboration across and within CMHC divisions (i.e., substance use treatment, substance use prevention, children's behavioral health).

Services for adults with co-occurring serious mental illness and substance use disorder include a full array of community-based services, including but not limited to: targeted case management, peer support, Individual Placement and Support (IPS) supported employment, supportive housing services, assertive community treatment, individual/group therapy, intensive outpatient treatment, therapeutic rehabilitation, and comprehensive community support services. In addition, these individuals have access to a full array of services on the crisis continuum, including crisis call centers, walk-in crisis services, crisis intervention services, mobile crisis services and crisis stabilization services.

Young people who are experiencing their first episode of psychosis are frequently also diagnosed with SUD. All iHOPE teams have capacity to adequately screen, assess and provide necessary integrated treatment. Similarly, many adults with SMI served by assertive community treatment (ACT) teams also have SUD. The ACT teams also have capacity to screen, assess and adequately treatment the co-occurring issues, and many ACT teams have SUD experts as part of their team.

DBHDID contracts with an advocacy organization to provide statewide training on Double Trouble in Recovery (DTR), a twelve step

support group for adults with co-occurring mental and substance use disorders. Traditional twelve step groups are not always tailored for this specific population, and in fact sometimes impede mental health recovery. To implement this DTR support group, DBHDID provides funding for materials, training, and other support necessary to have peers trained as leaders for implementing these support groups. DTR groups are led by peers with lived experience with co-occurring mental health and substance use disorders and several communities across Kentucky have active DTR groups.

Lastly, to assist with access, Kentucky has eight Consumer Operated Services Programs (COSPs) across the state, with one additional in development. These programs are based on the SAMHSA toolkit and are staffed by peers with lived experience. Each program is connected to their respective CMHC that provides necessary support for maintenance. These programs are a drop-in model for adults with SMI and those with co-occurring SUD and assist with access by identifying individuals in need of services and providing necessary connections.

**2.** Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance parity enforcement and increase awareness of parity protections among the public and across the behavioral and general health care fields.

Following the Mental Health Parity and Addiction Equity Act of 2008, Kentucky legislature passed a version of its own parity law. However, this law was not fully realized until the Affordable Care Act was implemented, and more attention was focused on parity.

In 2015, Kentucky legislature passed a bill requiring DMS to cover services for SUD. When a new Medicaid State Plan Amendment (SPA) was approved around that time, SUD services were reimbursable by Medicaid for the first time in Kentucky. (except for pregnant women, who were covered previously).

DBHDID collaborated with Kentucky DMS and others during the creation of Kentucky's insurance marketplace, as the Affordable Care Act was implemented in Kentucky. Part of this collaboration was providing input on coverage for essential mental health/substance use disorder services that needed to be provided by marketplace insurance companies.

Kentucky legislation currently requires parity as mandated in the Mental Health Parity and Addiction Equality Act of 2008 through Kentucky statute:
KRS 30417A-660.
https://apps.legislature.ky.gov/law/statutes/chapter.aspx?id=38715 .
This Kentucky statute now defines "mental health disorder" as any diagnosis contained in the Diagnostic and Statistical Manual (DSM), including substance use disorders.

**3.** Describe how the state supports integrated behavioral health and primary health care, including services for individuals with mental disorders, substance use disorders, and co-occurring mental and substance use disorders. Include detail about:

a) Access to behavioral health care facilitated through primary care providers

b) Efforts to improve behavioral health care provided by primary care providers

c) Efforts to integrate primary care into behavioral health settings

a. Access to behavioral health care facilitated through primary care providers
Kentucky has piloted several initiatives that have focused on creating access to behavioral health care through primary care providers. Several CMHCs operate or are partners in Federal Qualified Health Centers (FQHCs) in western as well as eastern Kentucky. These partnerships represent an opportunity for not only screening during primary care visits, but also direct, warm hand-offs to behavioral health providers when needed. As the populations of these two regions tend to be less physically healthy, than the general population of the state, use of the rural health centers for chronic conditions such as diabetes, heart disease, and tobacco-related illnesses. Adults with mental illness die on average 10 years and adults with SMI, 15-25 years earlier than the general population, largely due to treatable/ preventable health conditions (e.g., cardiovascular, pulmonary, infectious diseases) (Insel, 2015; De Hert, et al., 2011; Parks, et al., 2006). Up to 68% of adults with a mental illness have one or more treatable/preventable chronic physical conditions (SAMHSA, 2014). Kentucky has also applied for the SAMHSA Integration of Primary and Behavioral Health Care grant offered earlier in 2023. That project proposes a partnership between a CMHC and FQHC in Warren County and in Hopkins County in far western Kentucky near the border of Tennessee. Sub focus populations include women, minoritized populations including Blacks and refugees/immigrants, and military-connected individuals. Physical health conditions that will be prioritized include obesity, diabetes, hypertension, hyperlipidemia, sexually transmitted diseases, viral hepatitis, and nicotine dependence. If awarded, the project will serve as a pilot site for translation of processes, protocols and policies in order to expand the concept across the state.

b. Efforts to improve behavioral health care provided by primary care providers
In addition to the initiatives noted in section a above, DBHDID program provide technical assistance and access to training for primary care providers focused on understanding the co-occurring nature of behavioral health issues and physical health needs. The TA and trainings highlight opportunities to screen for mental health needs during regular and emergency primary care visits, as well as support primary care providers in identifying the appropriate community-based resources needed to support that clients' behavioral health needs. This is vital as anecdotal information from primary providers has indicated that many providers don't know to whom they should refer clients in some situations. Engaging with universities, medical boards, continuing education providers, and others with access to primary care providers is vital in providing appropriate education as well as

implementation support in embedding behavioral health care into primary care. One specific example is a partnership with local pediatricians to screen for self-harm and suicide, but also to educate on the importance of securing weapons in homes with children. More than 80% of Kentucky's suicide deaths are with the use of a firearm. Identifying risk of children who might be in danger of dying by suicide while at the same time, creating prevention opportunities is one manner in reducing not only the co-occurring behavioral health issues, but also in reducing death by suicide. Similar initiatives are being considered for the older adult population as well.

c. Efforts to integrate primary care into behavioral health settings
The Kentucky Primary Care Association, in partnership with Hazelden Betty Ford Foundation, provides monthly training available to Federally Qualified and Rural Health Clinics on OUD and Stimulant Use Disorder (StimUD) treatment. In the past year, this has included 34 hours of weekly Peer Support Specialist supervision, 4 medical provider sessions, three in-person site assessments and technical assistance support (two-day sessions), five monthly continuing education trainings, and seven provider case consultations. The Kentucky Hospital Association operating the Statewide Opioid Stewardship Program provides monthly virtual training to all hospitals on the topics of opioid stewardship and alternative treatments for pain management. Unshame KY, a statewide anti-stigma campaign holds monthly virtual trainings, available to all Kentuckians, on topics that relate to stigma reduction. (i.e., Recovery Allies & Recovery-Friendly Communities and Redefining Influencers: Connecting with your Community). Kentucky's teaching hospitals, the University of Louisville and University of Kentucky are also funded to support training of their medical students annually, regarding behavioral health. In addition, a four-module Kentucky Perinatal Action for Concurrent Tobacco Treatment (K-PACT) training was fully developed and produced on the University of Kentucky's CECentral platform, https://www.cecentral.com/K-PACT . The training program includes modules on Basics of Perinatal Tobacco Treatment, Electronic Nicotine Delivery Systems and Perinatal Women, Children, and Families, Concurrent Tobacco Treatment Among Pregnant Women and Women of Childbearing Age with Opioid Use Disorder, and A Behavioral Intervention for Tobacco Cessation. A total of 160 providers have been trained since the training's commencement in October 2021 from various specialties (health educators, counselors, nurses, APRNs, physicians, respiratory therapists, public health professionals, social workers, etc.). Positive outcomes include knowledge gained (comparison of pre- and post-assessments), acceptability, and practice commitments.

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 Conferences. Although some trainings were not completed due to the COVID-19 pandemic, virtual and some in -person trainings began in SFY 22 and SYF 23 and have continued. Educational offerings have included the Prevention Academy and the System of Care Academy along with trainings for peer support specialists, case managers and for staff providing services to specific populations including PPW, SMVF, and older individuals. The Division of Substance Use Disorder within DBHDID has also established the Community Behavioral Health Training Program which offers Mental Health First Aid (MHFA) trainings virtually. During SFY 22, this program provided eight adult and youth MHFA trainings with 123 participants.

Four (4) of Kentucky's CMHCs are now certified as CCBHCs. These providers have capacity to provide physical health care to the individuals they serve, including those with SMI, SED, SUD. One CMHC in far eastern Kentucky has created co-located physical health care centers, called Homeplace Clinics in their coverage area, including one clinic that specifically cares for adults with SMI. Two (2) additional CMHCs who are now certified as a CCBHC have purchased large travel vehicles that serve as mobile clinics for their coverage areas and include health care services.

**4.** Describe how the state provides care coordination, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:

a) Adults with serious mental illness

b) Adults with substance use disorders

c) Children and youth with serious emotional disturbances or substance use disorders

a. Adults with serious mental illness

In Kentucky, there are six Managed Care Organizations (MCOs) that assist with care coordination for the individuals who are covered by Medicaid insurance. Additionally, Kentucky has a separate State Plan Amendment (SPA) through Medicaid that covers Targeted Case Management services for adults with SMI, children and youth with SED and adults with SUD. In addition, this SPA covers individuals with SMI, SED, SUD, and co-occurring chronic physical health conditions, which recognizes that these individuals have complex needs and require greater case coordination.

DBHDID provides state funding and federal block grant funding to provide case management services for individuals with SMI/SED/SUD who are not covered by Medicaid insurance. These services are provided through CMHCs or other community-based providers. In addition, DBHDID provides some flexible state general funds for the CMHCs to assist with additional needs as required to coordinate care for SMI/SED/SUD populations.

b. Adults with substance use disorders

In Kentucky, there are six Managed Care Organizations (MCOs) that assist with care coordination for the individuals who are

covered by Medicaid insurance. Additionally, Kentucky has a separate State Plan Amendment (SPA) through Medicaid that covers Targeted Case Management services for adults with SMI, children and youth with SED and adults with SUD. In addition, this SPA covers individuals with SMI, SED, SUD and co-occurring chronic physical health conditions, which recognizes that these individuals require greater case coordination.

DBHDID provides state funding and federal block grant funding to provide some case management services for individuals with SMI/SED/SUD who are not covered by Medicaid insurance. These services are provided through CMHCs or other community-based providers. In addition, DBHDID provides some flexible state general funds for the CMHCs to assist with additional needs as required to coordinate care for SMI/SED/SUD populations.

c. Children and youth with serious emotional disturbances or substance use disorders

Care Coordination for children and youth with SED, SUD, or co-occurring SED/SUD is primarily available through the fourteen regional Community Mental Health Centers (CMHCs) via Targeted Case Management (TCM) and High Fidelity Wraparound (HFW). Certified Community Behavioral Health Clinics (CCBHCs) and Behavioral Health Service Organizations (BHSOs) can also provide TCM. The TCM service is included in Kentucky's Medicaid State Plan, however HFW, a more intensive model for youth with SED and additional risk factors, is not yet included so is built upon a TCM model with state general funds to support costs related to lower caseload requirements and additional supervision. Currently, DBHDID and DMS are drafting a Medicaid state plan amendment that will add HFW as a covered service in addition to and separate from TCM, and a companion provider training regulation.

There are also six Managed Care Organizations (MCOs) that assist with care coordination for the individuals who are covered by Medicaid insurance.

**5.** Describe how the state supports the provision of integrated services and supports for individuals with co-occurring mental and substance use disorders, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

As described in item 1.j. above, services and supports for youth with co-occurring mental health and substance use disorders are coordinated through the children's divisions within the CMHCs. This differs from the adult service system in that for adults, substance use treatment services and supports are coordinated through CMHC SUD treatment divisions and adult mental health treatment is coordinated through mental health divisions.
Related to integrated services and supports for adults with co-occurring disorders, the description of the service system is also in item 1.j. above.
Related to screening and assessment tools, all CMHCs are required to provide American Society for Addiction Medicine (ASAM) assessments on all individuals with SUD and Level of Care Utilization System (LOCUS) assessments on all individuals with SMI. Additionally, the eight iHOPE teams utilize the PRIME Screen tool and the Structured Interview for Psychosis Risk Syndromes (SIPS) to determine level of necessary care for young people referred to iHOPE teams. CMHC contracts include a requirement for an appropriate warm hand-off within 48 hours of determination that an individual is not appropriate for iHOPE services.
Many CMHCs utilize Integrated Dual Diagnosis Treatment (IDDT) as implemented based on SAMHSA's toolkit within the last decade. DBHDID staff have provided reviews utilizing the Dual Diagnosis Capability in Addiction Treatment (DDCAT) and Dual Diagnosis Capability in Mental Health Treatment (DDMHT) assessments with all CMHCs and most, if not all, CMHCs were determined to be co-occurring capable at that time. Workforce issues that have occurred during and after the pandemic requires DBHDID to reconsider assisting providers more closely with this work. The Division of Substance Use Disorder is the process of hiring a program administrator for co-occurring disorders. The Division of Mental Health already includes co-occurring program staff for children, youth and transition age youth. Work in this area continues.

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

N/A

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

# Environmental Factors and Plan

### 2. Health Disparities - Required

Narrative Question

In accordance with Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (Executive Order 13985), Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals (Executive Order 14075), the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[1], **Healthy People, 2030**[2], **National Stakeholder Strategy for Achieving Health Equity**[3], 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 orientations, gender identities, races, and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (e.g., 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 **Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[4].

Collecting appropriate data are 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[5]. 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[6]. 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, LGBTQI+ 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. In addition, LGBTQI+ individuals are at higher risk for suicidality due to discrimination, mistreatment, and stigmatization in society. 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.

[1] **https://www.minorityhealth.hhs.gov/assets/pdf/hhs/HHS_Plan_complete.pdf**

[2] **https://health.gov/healthypeople**

[3] **https://www.mih.ohio.gov/Portals/0/Documents/CompleteNSS.pdf**

[4] **https://thinkculturalhealth.hhs.gov/**

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

[6] **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?

DBHDID has a robust department-wide Racial Equity Action Plan.

This work has expanded to include federal grants including the System of Care: Families-Involved Valued Empowerment (SOC FIVE) grant. The SOC FIVE grant is supported with funds from a four-year SAMHSA grant. SOC FIVE aims to improve behavioral health outcomes for children and youth (birth to age 21) who meet criteria for SED (Serious Emotional Disturbance) and their families and who have child welfare involvement. Specifically, the population of focus is child welfare-involved families with active in-home services and for whom DCBS (Department for Community Based Services) does not have custody. In building infrastructure, the grant provided opportunities to focus on equity. In year two, the grant developed a Racial Equity Change Team (RECT) comprised of those with lived experience and community partners from behavioral health, child welfare, and Kentucky Partnership for Families and Children (KPFC). An action plan was developed to provide opportunities for those serving the grant's population of focus. The team is co-chaired by a member of DCBS and SOC FIVE staff.
Disparity Dashboard: The SOC FIVE team worked across systems to demonstrate the importance and process of disaggregating data by race and ethnicity by sharing findings from the in-home, out-of-home, and Family First Preservation Services Act (FFPSA), as appropriate, across the system of care throughout the grant. Also, by disaggregating family satisfaction with youth services by race helped to assess if there were any significant differences noted related to racial equity. The University of Kentucky, Human Development Institute (UK HDI) built a National Outcome Measures (NOMs) Disparities Dashboard to better understand how families are engaged in services across racial and ethnic groups. This dashboard measures demographic disparities by comparing NOMs data at baseline to population estimates within the overall SOC FIVE geographic catchment area.
Progress was made in SFY 2022 to collect disaggregated data on gender, gender identity and sexual orientation from providers. However, the state is currently adjusting to mandates passed by state legislation during the 2023 session, and subsequent legal challenges in the court system. Department staff continue to explore how to advocate and best serve LGBTQ or SOGIE youth.

Kentucky's 988 Capacity Grant and Garrett Lee Smith (GLS) Suicide Prevention initiatives implemented through SAMHSA discretionary grants also include racial equity components. The 988 grant includes a Bootcamp Translation Project, a community-based marketing efforts that utilizes a series of focus groups and one-on-one discussions with individuals with lived experience in underserved populations. The 988 grant focuses specifically on people of color and those who identify as LGBTQ. The GLS grant focuses efforts on students who identify as questioning or as LGBTQ. The Bootcamp Translation Project ensures that marketing messages can be "heard" by the populations of focus and are representative of their voices in the design and execution. In addition, the 988 Capacity grant provides training to crisis call staff to ensure they are specifically trained to be culturally humble with callers of color, and those who identify as LGBTQ, as Service Members, Veterans and their Families (SMVF), and rural farmers. These populations have all been identified as having health disparities related to behavioral health needs and working to ensure access to services that are culturally humble is vital in keeping population members safe during a behavioral health crisis.

Data is also collected regarding the age of individuals served in the CMHC system. The Division of Mental Health (DMH) 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. Staff turnover during the pandemic has slowed progress, however DBHDID is a recent partner with the Department on Aging and Independent Living in a grant application to equip community members who serve meals on wheels to the elderly or homebound population with the knowledge and skills to recognize when an individual may be in a behavioral health crisis, awareness of available resource to which to connect the individual and their family, and opportunities for self- care in ensuring

those volunteers have the means to stay mentally well themselves. A new program administrator position to manage initiatives is being hired during SFY 2024 to lead efforts. In addition, a team including staff from the substance use treatment branch, adult mental health branch and suicide prevention meet regularly with sister agencies supporting this population to ensure services are available.

The Adult Substance Use Treatment and Recovery Services Branch is continuing to develop a dashboard using CMHC reported data to identify disparities within underserved communities. The branch is also planning to provide trainings on equity and inclusion to partner agencies for clinical and non-clinical staff with specific focus on CMHCs, peer support specialists, recovery housing programs, and programs for persons who are pregnant and parenting. The branch currently monitors some specialty programs related to pregnant and parenting persons and focuses on services across the lifespan including older adults.
The State Epidemiological Outcomes Workgroup (SEOW), which includes some Department staff, analyzes data to determine where health disparities exist in order to guide primary prevention intervention delivery. The SEOW has identified disparities in the health outcomes and level of prevention services provided to communities of color and LGBTQ + individuals. The SUD Prevention and Promotion Branch is utilizing this data to identify trainings for internal staff and contracted providers, develop initiatives to address the disparities including filling the service gaps, and evaluating efforts to ensure that these needs are addressed, and prevention efforts are modified as needed.
DBHDID's Deaf and Hard of Hearing Services program has a plan for users of American Sign Language (ASL) and those with language dysfluency. Individuals with Limited English Proficiency are not currently included in this plan, but some programs have translated materials into Spanish and a variety of other languages, as needs have been identified.

The Adult Substance Abuse Treatment and Recovery Services branch has identified the Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care Standards as a focus area.

DBHDID has strengthened its efforts to train both central office staff and CMHC partners in cultural humility and identifying and addressing structural racism. Efforts have also been made to increase awareness and build skills around targeted approaches to working with different populations. For example:
• Racial Equity:
o The Behavioral Health Equity Action Planning (BHEAP) workgroup continues to focus on racial equity per Cabinet focus. In the past two years, staff have learned to use the GARE (Government Alliance on Race and Equity) tool to evaluate programs and services.
o The Cabinet for Health and Family Services, including DBHDID, continues to hold regular webinars on racial equity and trauma and resilience. This builds the knowledge base of our staff and partners and helps move the work forward in individual departments.
o Racial Equity Change Teams at the Division, Branch, Department, and Cabinet levels continue to meet as communities of practice.
• Deaf and Hard of Hearing Services:
o Time-limited funds were allocated for a Deaf Peer Support Incubator Project. Expanding peer support statewide is a main strategy for workforce development.
o In-person training for CMHCs regarding serving this population resumed.
o A virtual "lunch and learn" series launched to address topics for professionals and members of the Deaf community.
o Staff collaborated with Hamilton Relay to host two townhall meetings regarding use of relay services for 988 calls.
o Multiple trainings were offered to CMHC staff regarding increasing access to 988. Deaf and Hard of Hearing Services staff have also collaborated with NASMHPD to provide similar training and panels on a national basis.
• Children's Services
o Equity Audit of the Families First Prevention Services Act (FFPSA): Dr. Brandy Kelly Pryor with BKP Strategies completed a health equity impact assessment of Kentucky's implementation of the prevention services component of the FFPSA. A Health Equity Learning Academy (HELA) was completed with 40 community champions. This workshop series consisted of four sessions designed to increase participants' understanding of health equity and provide tools and resources to examine operational processes. SOC FIVE's racial equity champions from DBHDID, KPFC, DCBS, and UK HDI participated to increase advocacy, internal training, and discussion aimed at systems change. Dr. Pryor also conducted a racial equity impact audit (REIA) through an evaluation of the implementation of FFPSA. BKP Strategies provided the assessment findings and recommendations to stakeholders in various meetings, as well as provided consultation. Dr. Pryor continues her work around implementation support into Year-Four of the grant.
o Youth Racial Trauma Therapy protocol: Dr. Steven Kniffley of Spalding University's Collective Care Center provided training, screening, and assessment resources to build the competency of behavioral health providers to address youth racial trauma. Dr. Kniffley also developed and provided consultation and training sessions on the Kniffley Youth Racial Trauma Therapy Model. This model is a promising model for the assessment and treatment of race-based stress and trauma in BIPOC youth that focuses on awareness, advocacy, and affirmation.
• Federal grant funds have also been leveraged to further equity efforts:
o Kentucky Opioid Response Effort (KORE) provides funding to the Foundation for a Healthy Kentucky to provide small, competitive grants to BIPOC led and BIPOC serving organizations. Projects are aimed outreach and engagement to minoritized communities to provide linkages to treatment for opioid and stimulant use.
o KORE incorporates equity into contract language with a focus on ensuring accessibility to minoritized populations.
o KORE monitors its disaggregated data to measure outcomes, and assist in determining directing programmatic effort
• 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:
o Through a partnership with the Kentucky Injury Prevention and Research Center (KIPRC), a video was created in American Sign Language (ASL) with captioning and voiceover to assist individuals in finding substance use treatment. https://youtu.be/bmqQhFahaow.
• A second partnership between Aetna Better Health of Kentucky, the Department for Community Based Services, the Kentucky Commission on the Deaf and Hard of Hearing, and DBHDID works to address language deprivation in children experiencing out-of- home care. A Value Added Benefit includes a communication skills assessment and a Deaf or Hard of Hearing Guide. DBHDID funds are used for stakeholder meetings and training for providers.

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).

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

# Department for Behavioral Health Developmental and Intellectual Disabilities
# Racial Equity Action Plan 2022 through 2023

**Purpose**: The Department for Behavioral Health Developmental and Intellectual Disabilities (BHDID) is committed to becoming a racially equitable organization. Our work will include a focus on our internal development as the state behavioral health authority, as well as our external development in relation to the state behavioral health system. Our racial equity action plan will be a continuously evolving document outlining our goals, objectives, and progress in eliminating racial disparities.

## BHDID Racial Equity Core Team

| | | |
|---|---|---|
| **Key Stakeholders** | Wendy Morris, Commissioner<br>Stephanie Craycraft, Deputy Commissioner<br>Dr. Shambra Mulder, Deputy Commissioner<br>Dr. Allen Brenzel, Clinical Director | Dr. Vestena Robbins, Executive Advisor<br>Dr. Brittney Allen, Director<br>Claudia Johnson, Director<br>Rashaad Abdur-Rahman, Executive Advisor<br>Miriam Silman, Program Administrator<br>Dr. Katie Marks, Project Director<br>Tal Curry, Director<br>Maria Browning, Executive Staff Advisor |

| Racial Equity Team Leaders | Division/Program Represented |
|---|---|
| Rashaad Abdur-Rahman | BHDID Core Team Lead |
| Michelle Niehaus | Behavioral Health |
| Connie Crowe<br>Kay Shanker | Administration and Finance |
| James Kimble | Developmental and Intellectual Disabilities |
| Dr. Greta Jones<br>Lynn Lockridge | Program Integrity |
| Tal Curry | Office of Autism |
| Kendall Jordan | Kentucky Opioid Response Effort |
| Maria Browning | Human Resources |

## Alignment with Department 2020 Strategic Goals

| Department Goal | Alignment with Racial Equity |
|---|---|
| Goal #1: Mitigate adverse behavioral health outcomes exacerbated by the pandemic and racial inequity while preserving and enhancing the behavioral health safety network. | "…adverse behavioral health outcomes exacerbated by the pandemic and racial inequity…" |
| Goal #2: Continue to develop and expand recovery-oriented system of care to address the opioid crisis and other substance use disorders. | The opioid crisis is harmfully impacting Black families in KY at disproportionate rates. |
| Goal #3: Support and promote the behavioral health and wellness of children and families involved with or at risk of involvement with child welfare. | Black children and families in KY are disproportionately and disparately involved in the child welfare system. |
| Goal #4: Advance efficient/effective operations of the state inpatient and residential facilities. | Inpatient and residential facilities are a key part of the state behavioral health system. They are integral to promoting racially equitable outcomes across the state. |
| Goal #5: Assure a safe and adequate system of care for individuals with intellectual and developmental disabilities. | Black, Brown, and Indigenous people with intellectual and developmental disabilities experience additional intersectional forms of discrimination. |

# Racial Equity Action Plan Goals

The below goals represent **enterprise** wide racial equity goals for the department in addition to **division** specific goals. Organizational racial equity will require intentional efforts at the division and branch levels as well as a focus on broad efforts that are inclusive of the entire organization. For example, each division will be responsible to pursue ***both*** its unique racial equity goals as well as the enterprise racial equity goals.

# Enterprise Racial Equity Goals

**Enterprise Goal #1**: **The G.A.R.E Racial Equity Tool will continue to be utilized by 100% of BHDID branches. Ongoing timeline.**

| # | Objective | Who | Why | Checkpoint/KPI | When Completed | Status |
|---|---|---|---|---|---|---|

| | | | | | | |
|---|---|---|---|---|---|---|
| **1** | Branches will report the use of the racial equity tool to the team leads and division leadership. | Racial Equity Core Team | Continued use of the racial equity tool across the enterprise will support equitable decision-making. | All branches provide completed racial equity tool to team leads and division leadership. | Ongoing | |
| **2** | Use of a racial equity tool will be codified in department policy and/or procedures/protocols. | Racial Equity Core Team | Consistent use of the racial equity tool over time requires explicit description of the expectation. | Completion of a department racial equity policy. | 09.30.22 | |
| **3** | Confirm fidelity of implementation. | Racial Equity Team Leads | We need to ensure that our work across the department maintains a high level of quality. | BHDID Core Team will review completed tools. | Ongoing | Need Core Team leads to confirm use of the tool within each branch. |

**Enterprise Goal #2**: **BHDID will increase racial equity in hiring by 5% by December 31st, 2022**.

| # | Objective | Who | Why | Checkpoint/KPI | When Completed | Status |
|---|---|---|---|---|---|---|
| **1** | BHDID will collect current vacancy data disaggregated by race. | Maria Browning | We need clear insights related to our current baseline to set relevant goals. | Quarterly (at minimum) BHDID personnel reports disaggregated by race. | 03.31.22<br>06.30.22<br>09.30.22<br>12.30.22 | **In Progress** |
| **2** | BHDID department leadership will set racial equity hiring targets. | Commissioners Office<br>Department Leadership<br>Racial Equity Team Leads | Clear targets allow us to increase accountability and track progress. | Hiring target set for FY 22 – 23. | 05.01.22 | **Complete** |

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| **3** | BHDID divisions and branches will begin utilizing recommendations from G.A.R.E Public Sector employment guide. | Department Leadership Racial Equity Team Leads | Our success will require us to implement national best practices. | 3 to 5 strategies will be identified and incorporated into our racial equity action plan. | 07.30.22 | **Not Started** |
| *3.1* | Add racial equity language in job postings. | Maria Browning Racial Equity Team Leads | The job posting is an effective opportunity to signal the desire for equity within the workforce. | Racial equity language will be crafted for addition into all future job postings. | Ongoing | |
| *3.2* | Establish racially equitable interview teams. | Maria Browning Racial Equity Team Leads | Racially equitable teams allow for various perspectives and protects against "group think." | Each division will identify and report who their interview team is. | 07.30.22 | |
| *3.3* | Review the interview questions and screening criteria that are being used in the department. | Maria Browning Racial Equity Team Leads | Interview/screening questions can sometimes perpetuate bias. We want to use our questions to assess for a commitment to equity. | 3 or more questions pertaining to racial equity will be added to interview questions. All screening criteria will be reviewed. | 08.30.22 | |
| *3.4* | Advertise federally funded time limited (FFTL) positions to increase applicant pool. | Maria Browning | Creating the opportunity for all to apply to a vacancy will increase the applicant pool for our positions | 100% FFTL position establishments will be posted. | Ongoing | |
| *3.5* | Update department job titles. | Maria Browning Racial Equity Team Leads | Updating job titles may make it more clear to a wider range of candidates that they are eligible. | Review applicant pool for any increase in racial equity. | ??? | |

***Enterprise Goal #4: BHDID will increase racial equity in procurement by June 30th, 2023**.

*__Note__: The Office of Administrative Services (OAS) has been tasked with exploring this process across the cabinet. We will continue working closely with OAS to help better determine data and metrics.

| # | Objective | Who | Why | Checkpoint/KPI | When Completed | Status |
|---|---|---|---|---|---|---|
| **1** | Commissioner's Office/Department Budget | Commissioners Office, Division of Administration and Finance (AFM) | Department resources dedicated specifically to the racial equity initiative will support sustainability and help to further awareness and understanding of how racial equity is beneficial to our mission. | A budgetary line item established for racial equity (e.g., training, materials and resources, etc.). Funds are currently set aside for training purposes in FY23. Additional training funds may be provided for other staffing/resources. | TBD | Ongoing |
| **2** | Develop a training resource for facilities. | AFM | Consistency in procurement processes among facilities and central office improves efficiency and allows racial equity in resource distribution to be practiced statewide. | Increase in number of registered minority vendors and minority procurements. This is currently in process. | TBD | Ongoing |
| **3** | Plan and/or participate in a vendor fair. | Commissioners Office, AFM | The purpose of a vendor fair is to make connections between resource providers and resource consumers. | Host and attendee satisfaction in quality of connections/information exchanged. AFM has requested to work with OAS to possibly advance this goal and to determine the best way to increase the number of minority vendors through existing identification processes (i.e. EMARs). AFM and OAS will collaborate to | [TBD] | In progress |

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| | | | | participate in procurement/ vendor fairs. | | |
| **4** | BHDID will collect current department procurement data disaggregated by business type. | AFM | We need clear insights related to our current baseline in order to set relevant goals. | Quarterly (at minimum). Generate BHDID procurement reports disaggregated by business type, conduct surveys with Cabinet employees, monitor any increases in contracts with minority vendors, assess updates and changes within Cabinet statistical data. AFM and OAS will work together to correlate specific data sets for Cabinet use. | Quarterly | Ongoing |
| **5** | BHDID leadership will set goals for racially equitable procurement. | Commissioner's Office, Department Leadership, Racial Equity Team Leads | Clear targets allow us to increase accountability and track progress. | The Key Performance Indicator should be the procurement target. AFM will work with Cabinet officials to determine baselines for racial equity parameters. | | Accomplishment of this Goal may require working with the OAS and the Finance & Adm. Cabinet. |
| **6** | Include language to contracts, RFPs and NOFOs emphasizing racial equity. | Commissioner's Office, Department Leadership, Racial Equity Team Leads | Allows CHFS to express their commitment to pursuing partnerships with businesses owned by minorities. | The insertion of language into contracts, RFPs, and NOFOs department wide will indicate the completion of this objective. AFM will work with OAS to include template contract language in all contracts to address Racial inequities. KORE contracts | Ongoing | Procurement target set for FY22-23. This Goal has been partially achieved through the KORE procurement and contract process. |

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| | | | | have previously included Racial Equity language. Additionally, information provided to new vendors will include information related to the Minority and Women Business Enterprise Certification Program and stress the importance of registering as a minority vendor through Kentucky's Vendor Self-Service (VSS) system. | | |

**Enterprise Goal #5: BHDID will support the integration of racial equity throughout the state behavioral system by June 30th, 2023**.

| # | Objective | Who | Why | Checkpoint/KPI | When Completed | Status |
|---|---|---|---|---|---|---|
| **1** | BHDID will develop an inventory of all statewide engagements and partnerships with community-based organizations to identify other areas of advocacy. | BHDID Core Team | Community partnerships will help support implementation and accountability. | Completed inventory representing partnerships in each BHDID division. | 09/30/22 | |
| **2** | BHDID will continue consultation and support with CMHC's and Facilities who are establishing racial equity efforts in their organizations. | BHDID Core Team<br>Adult Branch | The behavioral health safety net is positioned well to help reduce racial health disparities. | -1:1 Consultations.<br>-Monthly community of practice meetings.<br>-Completion of racial equity action plans by CMHC's and Facilities.<br>-Successful completion of CARF equity standards by CMHC's. | Ongoing | |

# Division Racial Equity Goals

**Division of Behavioral Health Goal #1: The BHEAP core team will work with each branch to embed equity practices into all projects and programs.**

| # | Objective | Who | Why | Checkpoint/KPI | When Completed | Status |
|---|---|---|---|---|---|---|
| 1 | Each BHEAP member will review the DBHDID RE Plan with their branch and discuss how best to move forward with the knowledge and experience we now have with RE work. | BHEAP | Increase shared ownership of equity activities | | Ongoing | Reviewed during 3/7/2022 BHEAP Meeting |
| 2 | BHEAP members and Branch Managers will process discussion of the RE Plan and next best steps for their team | BHEAP and Branch Managers | Refocus and recommit. Prepare for SAMHSA Site Review. | | Ongoing | Reviewed during 3/7/2022 BHEAP Meeting |
| 3 | BHEAP will continue to host department-wide debriefing and discussions based on the CHFS Racial Equity Panels. | BHEAP with DBHDID Change Team Leaders | Reducing siloed thinking and isolated activities requires ongoing trust-building and conversation department-wide | Debriefings hosted monthly. | Ongoing | |
| 4 | Division Leadership alongside BHEAP members will identify points of influence for equity work in change | BHEAP<br>Branch Managers | Equity work must be infused through | Quarterly BHEAP meetings with Branch Managers to plan infusion of equity | Ongoing | Started in February Branch Manager Meeting |

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| | processes occurring in the department. (ex. Contract writing, DPR Forms Project, sample interview questions, etc). | Division Directors Office | all activities by all staff. | work in ongoing departmental priorities | | |

**Division of Behavioral Health Goal #2: DBH will support the expanded capacity of clinical staff to address racial trauma in Community Mental Health Center settings.**

| # | Objective | Who | Why | Checkpoint/KPI | When Completed | Status |
|---|---|---|---|---|---|---|
| **1** | DBH will support the conclusion of the Kniffley Racial Trauma Training and Coaching project. | Michelle Niehaus<br>Marcie Timmerman (MHA)<br>Dr. Kniffley | Increase the capacity of CMHC staff to address racial trauma in clinical settings; current gap in clinical skill set; increased recognition of racial trauma | Two group calls per month and 1:1 as needed for trainees to complete certification | May 2022 | COMPLETE |
| **2** | DBH will create a directory of clinicians who have completed the Racial Trauma Treatment training and received certification through the Collective Care Center | Michelle Niehaus<br>Marcie Timmerman<br>Dr. Kniffley | Individuals seeking CMHC services need access to information on the qualifications and skills of those who may treat them. | List of certified clinicians received by June 30, 2022 | July 2022 | COMPLETE |

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| **2a** | Participants and team leads in the RTT initiative will identify strategies for implementation of the clinical approach into CMHC practices and overall RE strategic plans | Michelle Niehaus<br>Dr. Kniffley<br>Rashaad Abdur-Rahman | Success of the initiative hinges on the sustained application of principles at the clinical level. Leadership support is critical and work should not be done in silos. | Satisfaction Surveys for BIPOC for CQI practices?<br>Determined individually by each CMHC or facility team? Calls on sustainability? | August 2021-June 30 2022 | Not Started |

**Behavioral Health Goal #5: The Children's Branch.**

| | Objective | Who | Why | Checkpoint / KPI | When Completed | Status |
|---|---|---|---|---|---|---|
| **1** | Short Term Goal: RIACs will incorporate equity into meeting discussions. | . | RIACs are an important venue for discussing equity because they are at the regional level and their membership includes many community partners. | 1. DBH staff will provide an overview of DBHDID and CHFS equity activities.<br>2. RIACs will consider including equity as a recurring meeting agenda item. | June 2022<br>October 2022 | Initial Discussion Complete<br>GARE Training Fall 2022 |
| **2** | Intermediate Goal. RIACs will incorporate equity into their workplans. | | RIAC partnerships provide a powerful opportunity to increase equity at the local and regional levels. | 1. RIACs will incorporate goals to increase equity into their workplans.<br>2. Children's branch will determine a way to monitor progress and | January 2023<br>June 2023 | |

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| | | | | celebrate successes. | | |
| **3** | | | | | | |
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**Division of Behavioral Health Goal #3: Perform a multi-tier, hierarchical analysis of the SUD treatment and recovery services offered by CMHCs and other SUD treatment partners.**

| # | Objective | Who | Why | Checkpoint/KPI | When Completed | Status |
|---|---|---|---|---|---|---|
| **1** | Provide a system-wide overview of service availability and utilization | SUD Branch | System-wide information will provide insight into what SUD treatment services are missing or underutilized across the Commonwealth | (1) CDAR Report: Health Disparities Among Substance Abuse Treatment Clients (2018-19); (2)Compilation of internally maintained SUD service data; (3)Review, interpretation, and presentation of findings and outcomes | Dec 2020 | Checkpoints 1 & 2 Complete<br><br>Checkpoint 3 In Progress |
| **2** | Provide detailed information about utilization of specific SUD services at the CMHC and individual client level | SUD Branch | This will provide information about strengths and weaknesses in SUD treatment services across the CMHC network to identify specific areas in need of attention and clear opportunities for technical assistance | (1) CDAR Report: Health Disparities Among Substance Abuse Treatment Clients (2018-19); (2) Compilation of internally maintained SUD service data; (3) Review, interpretation, and presentation of findings and outcomes | Dec 2020 | Checkpoints 1 & 2 Complete<br><br>Checkpoint 3 In Progress |

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| **3** | Compare obtained SUD treatment services information across racial and ethnic groups | SUD Branch | These comparisons will provide direct insight into equitability in access to and utilization of SUD treatment services across groups | (1) CDAR Report: Health Disparities Among Substance Abuse Treatment Clients (2018-19); (2) Compilation of internally maintained SUD service data; (3) Review, interpretation, and presentation of findings and outcomes | Jan – Apr 2021 | Checkpoints 1 & 2 Complete<br><br>Checkpoint 3 In Progress |
| **4** | Begin work to address disparities | SUD Branch | Affect change in different areas(e.g., policies, contract deliverables, training, etc.) to increase equity in access to and utilization of SUD treatment services | TBD | May – Jun 2021 | Not Started |

**Division of Behavioral Health Goal #4: The Children's Branch will focus on racial equity practices through emphasis on increasing outreach for trainings on serving transition-aged youth.**

| # | Objective | Who | Why | Checkpoint/KPI | When Completed | Status |
|---|---|---|---|---|---|---|
| **1** | Short Term Goal: Learn more about training participants. | Transition Age Youth Coordinators | It is important to ensure that information about TAY services (age 14-26) is reaching everyone. | 1. Add demographic questions to training evaluations.<br>2. Review training demographic data to determine under-represented populations. | August 2022 | |

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| **2** | Intermediate Goal. Increase outreach to underrepresented populations. | TAY Coordinators | Increase targeted outreach to underrepresented populations. | How? What will that look like? | May 2023 | |
| **3** | Long Term Goal. TAY services are accessible to everyone. | TAY Coordinators | Targeted outreach is essential to improving access to services. | 1. Compare CMHC service data to population data.<br>2. Target outreach to under-represented populations. | May 2024 | |

**Division of Behavioral Health Goal #5: the Prevention and Promotion Branch**

| # | Objective | Who | Why | Checkpoint/KPI | When Completed | Status |
|---|---|---|---|---|---|---|
| **1** | Create a resource collection on BYNDER available to all RPC Staff with resources on racial and health equity by May 1, 2022. | Camille, Prevention Branch | Will allow Branch staff and RPC staff to share needed resources easily and make these resources accessible for all staff. | BYNDER collection will be created and published on system by May 1, 2022. Will check monthly for new uploads, downloads of materials to collection by staff. | As of 4/6/22, a new issue titled "equity" was added to Bynder as a way to sort resources by that topic.<br><br>As of 4/6/22, a new collection titled "Racial and Health Equity" was created on Bynder to store and share resources about equity topics. Link | Complete |
| **2** | Determine the top 5 most spoken languages within each region and/or county for program materials (DTP, Synar) by June 1, 2022. | Steve (with Hope Beatty) | Will ensure that branch materials are accessible for intended audiences. | Regional/County list provided with Top 5 languages.<br><br>Will place the list in BYNDER collection so it is accessible for all staff. | | |
| **3** | | | | | | |

**Division of Behavioral Health Goal #6** Using the GARE tool the Adult Services Branch will perform an analysis of the PATH grant and homeless services provided by grantees.

| # | Objective | Who | Why | Checkpoint/KPI | When Completed | Status |
|---|---|---|---|---|---|---|
| **1** | Organize available data from HMIS and state data on the homeless population in Kentucky. Cross Reference data disaggregated by race from the Homelessness Management Information System (HMIS), existing PATH partners, and the Census. | Adult Branch | Analysis will provide insight into the underutilization of PATH homeless services by people of color. | Jason obtaining HMIS data. Alison and Deb obtaining census data. PATH data disaggregated. Started using the GARE Tool week of 3/15/2021. Will review q 2 weeks as part of Adult Services Branch meeting | 12/30/21 | In Progress |
| **2** | Compare utilization of PATH services to statewide rates in each PATH region of homelessness across racial and ethnic groups.<br><br>Apply knowledge gained from GARE tool to identify goals with PATH partners | Adult Branch | Implementation of change will happen with PATH partners | Work with Jason to ensure that Racial Equity Action Planning is part of each quarterly peer group meeting agenda. Allow time for shared goal setting. | 12/30/21 | Not Yet Started |
| **3** | Organize training for all CMHCs statewide around Racial Equity and Trauma and Resilience | Adult Branch | Increase knowledge of CMHC staff of racial equity and trauma issues. | Work with Rashaad and Miriam on available dates of training.<br><br>Deb will conduct a survey of CMHCs regarding their current efforts around RE training and unmet needs. | Report Survey Results to BHEAP by May 31, 2020 | In Progress |

**Kentucky Opioid Response Effort Goal #1:** Monitor KORE data disaggregated by race / ethnicity to identify potential disparities and targets for improvement.

| # | Objective | Who | Why | Checkpoint/KPI | When Completed | Status |
|---|---|---|---|---|---|---|
| 1 | Disaggregate KORE data by race, ethnicity, and social determinants of health. | KORE | Improving access and utilization of KORE-funded services by clients of color and marginalized groups requires that we first understand disparities in service access. | Continue to refine data monitoring processes by reviewing program, provider type, regions, as well as other identified parameters. | Ongoing | Quarterly reviews starting April 15th and then ongoing |
| 2 | Incorporate findings into presentations or report. | KORE | Improving access and utilization of KORE-funded services by clients of color and marginalized groups requires that we first understand disparities in service access. | Development of the reports for KORE program review | Ongoing | Quarterly starting August 15th and then ongoing |

**Kentucky Opioid Response Effort Goal #2:** Expand partnerships with new organizations and projects that prioritize equitable delivery of prevention, harm reduction, treatment, and recovery services

| # | Objective | Who | Why | Checkpoint/KPI | When Completed | Status |
|---|---|---|---|---|---|---|
| 1 | Disseminate grants to BIPOC-serving and BIPOC-led organizations to implement | KORE | To provide and elevate opportunities to BIPOC | Quarterly program updates. | June 2023 | |

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| | stigma reduction, MOUD education, Narcan/harm reduction media campaigns. | | serving and BIPOC led organizations. | | | |
| **2** | Conduct bi-annual grant writing seminars in collaboration with federal and state partners to increase engagement of predominantly BIPOC-serving organizations | KORE | To provide BIPOC led and BIPOC serving organizations with the resources to obtain funding. | Number of grant writing seminars conducted. | Initiated 2/28/22. Ongoing bi-annually thereafter. | |
| **3** | Utilize implementation strategies to increase partner knowledge on the access and utilization of data collection and reporting. | KORE | To provide BIPOC led and BIPOC serving organizations with resources for funding. | Training and technical assistance on monthly basis through ongoing projects (I.e. NSPIRE). | 2/18/2022 and ongoing. | |
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**Kentucky Opioid Response Effort Goal #3:** Enhance diversity, equity, and inclusion through implementation strategies, such as technical assistance, for KORE-funded agencies

| # | Objective | Who | Why | Checkpoint/KPI | When Completed | Status |
|---|---|---|---|---|---|---|
| **1** | Partner with Opioid Response Network (ORN) and other technical assistance providers to obtain training and technical assistance for KORE Implementation Specialists and other program monitors on implementation facilitation for equity initiatives | KORE & ORN | To provide KORE implementation specialists with the resources and skills to aid KORE funded programs to embed racial equity as a fundamental practice. | Second ORN training for KORE scheduled for March 24th. Will utilize post event surveys and program feedback to drive next steps. | Ongoing | |
| **2** | Review KORE Notice of Funding Opportunities and contracts using an equity lens. | KORE | To provide funding through KORE with racial equity as one of the key determinants of funding. | Established internal review for contract modifications | Contract modifications in August 2022 | |
| **3** | Review partner program policies using an equity lens through provision of technical assistance. | KORE | To provide guidance on increasing sustained equitable access through addressing provider practices. | Review program policies at initial contracting, during contract modification, and monthly implementation calls. | Start of fiscal year and ongoing | |

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| **4** | Partner with the Opioid Response Network to continue Racial Equity training for SOR-funded programs | KORE & ORN | To provide KORE funded programs with the resources and skills to embed racial equity as a fundamental practice. | Second ORN training for KORE scheduled for March 24th. Will utilize post event surveys and program feedback to drive next steps. | March 24th from 1-3. | |

**Kentucky Opioid Response Effort Goal #4:** Develop inclusive, multi-directional communication with diverse stakeholder groups to drive strategic planning.

| # | Objective | Who | Why | Checkpoint/KPI | When Completed | Status |
|---|---|---|---|---|---|---|
| **1** | Create new opportunities for BIPOC-led partners to provide input into KORE strategy as it relates to diversity, equity, and inclusion. | KORE | Broader community input to ensure a more comprehensive, inclusive, and responsive KORE strategic plan. | Identify existing and missing stakeholder representation to inform planning; Identify strategies to support effective engagement; Establish opportunities for input; Establish process for feedback loops | Ongoing | |

**Division of Developmental and Intellectual Disabilities Goal #1:** Identify existing racial disparities experienced by individuals with intellectual/developmental disabilities served in programs under DDID oversight.

| # | Objective | Who | Why | Checkpoint/KPI | When Completed | Status |
|---|---|---|---|---|---|---|
| 1 | Identify existing and needed data resources. | DID Racial Equity Change Team | Identify areas where individuals served are impacted by racial disparity. | Have received emails/responses from pertinent management staff | 3/15/2021 | Complete |
| 2 | Develop and disseminate data collection instruments to provider networks as necessary to collect | DID Racial Equity | Widen scope to ensure pertinent additional data | Question/s to be developed for the Provider Survey and | 11/30/21 | Complete |

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| | relevant information. (Create racial equity related questions for the Provider Survey) | Change Team | captured for racial/ethnicity info for waiver provider ownership and initiatives providers are involved with or interested in regarding racial equity | incorporated into existing survey | | |
| 3 | Collect and analyze data that determines the level and types of disparities experienced by individuals with intellectual/developmental disabilities. | DID Racial Equity Change Team | To determine actions needs to respond to disparities. | Review info gathered from Provider Survey. Use feedback from provider survey to inform upcoming sessions (areas of potential growth, questions, ideas) Follow-up with specific agencies about their comments/suggestions | 6.30.22 | In progress |
| 4 | Share specific innovative ideas providers have put into action | DID Racial Equity Change Team | To share with providers innovative ideas from other providers | Arrange for presentation during Monthly meetings for good story sharing | 9/30/22 | In progress |

**Division of Developmental and Intellectual Disabilities Goal #2:** Enhance the knowledge, ability and empowerment of Division staff to provide technical assistance that enhances racial equity among consumers and providers.

| # | Objective | Who | Why | Checkpoint/KPI | When Completed | Status |
|---|---|---|---|---|---|---|
| 1 | Disseminate the terminology of racial equity being used across CHFS, including the areas of disparity within the current service delivery system. | DID Racial Equity | The department must proceed with common definitions in order to | Done - Initial readiness discussions complete. | 4/30/21 | Complete |

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| | | Change Team | understand benchmarks and communicate clearly. Shared language and commitment | Establish training material using definitions document<br><br>Establish training schedule to share terminology training over 3 or 4 weekly all staff virtual meetings. | | |
| 2 | Work with BHDID Core Team to secure existing and/or needed training and resources that provide detailed information regarding racial equity, person-centered practices, and race/disability intersectionality, as informed by data in both Goal 1 and Goal 2.1. | DID Racial Equity Change Team | Using universal design, CDS, and modalities that work across different learning styles; Level setting;<br>Identification of Internal Potential Roadblocks | Present to DDID directors the identified and needed resources. | 4.30.21 | Complete |
| 3 | Develop a staff plan for use as a guidance document to enhance DDID staff knowledge of racial equity, person-centered practices, and race/disability intersectionality. | DID Racial Equity Change Team | Using universal design, CDS, and modalities that work across different learning styles; Level setting;<br>Identification of Internal Potential Roadblocks | Present training plan to DDID directors along with the identified and needed resources. | 4.30.21 | Complete |
| 4 | Work with BHDID Core Team to develop needed training and resources to increase staff knowledge and ability to address concerns related to racial equity, person-centered practices, and applicable intersectionality as identified | DID Racial Equity Change Team | Using universal design, CDS, and modalities that work across different learning styles; Level setting; | Present developed training to DDID directors and supervisors for input and approval to implement. | 5.30.21 | Complete |

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| | by data in Goal 1 and Goal 2.1 and 2.2 with consumers and providers. | | Identification of Internal Potential Roadblocks | | | |
| 5 | Implement training developed as part of Goal 2.3, utilizing presentations at monthly staff meetings to train on Racial Equity Definitions and A.C.T. method | DID Racial Equity Change Team | Creating a space to process and discuss, normalizing and modeling conversations, and cross-pollinating ideas. | Documentation of event percentage of DDID staff who attend; Recording the presentations for future viewing; Solicitation of feedback for future training needs | 9.30.21 | Equity Def training complete. ACT training complete. |
| 6 | Assign CDS cultural awareness modules to DDID staff to be completed by end of 2021. | DID Racial Equity Change Team | Provide and ensure all DDID staff have cultural awareness training | CDS modules are set with due dates that can be reviewed for completion and CDS modules have a built-in test | 12/31/21 | Complete |
| 7 | Develop training packet for new employees that includes CDS cultural awareness modules, racial equity definitions | DID Racial Equity Change Team | Ensure new DDID staff participate in the same trainings as existing DDID staff | CDS modules for cultural competency assigned for all DDID staff | 12/31/21 | Complete |
| 8. | Conduct a racial equity multi-session listening/discussion for the series, The Reckoning. | DID Racial Equity Change Team | Create an environment of consistent learning and discussion regarding racial equity and in particular, its effects and history in KY | The series has multiple episodes, and we will do 1-hour sessions bi-weekly available to all DBHDID staff. Other Division supervisors made aware so they can choose to share with their staff. This event will conclude near the beginning of autumn 2022. | 9/30/2022 | In progress. Just complete Episode 5 |

**Division of Developmental and Intellectual Disabilities Goal #3:** Include Racial Equity training/resources in the Provider Development process

| # | Objective | Who | Why | Checkpoint/KPI | When Completed | Status |
|---|---|---|---|---|---|---|
| 1 | Give providers access to racial equity resources as part of New Provider Orientation | DDID Provider Development | Increase provider awareness of racial equity issues | Various documentation added to resources available to providers seeking to be certified to provide SCL/MPW services | 9-30-21 | Complete |
| 2 | Incorporate Racial Equity definition training into the Provider Development/Enrollment process. | DDID Provider Development | Increase provider awareness of racial equity issues | Existing training regimen during Provider Development to include racial equity definitions training | 10-31-21 | Complete |
| 3 | New Providers to be encouraged to include policy and procedures regarding racial/ethnic diversity | DDID Provider Development | Providers to have a plan in place to help create awareness of racial equity and have policy in place to do the same | Documentation and training materials to be updated to encourage new providers to have Racial Equity policy and procedures | 12-31-21 | Complete |
| 4 | Review policy and procedures being written by providers | DDID Provider Development | Get an idea of what kinds of policies providers are coming up with on their own and/or with technical assistance from DDID | Policy and procedures written to inform ways to advise providers on writing them and ideas learned from what they write can inform DDID. | 12/31/22 | In progress |

**Division of Developmental and Intellectual Disabilities Goal #4:** Racial Equity/Cultural Considerations within Regulation

| # | Objective | Who | Why | Checkpoint/KPI | When Completed | Status |
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| 1 | Discuss 5(1)(c)3 –"A person-centered service plans shall: Use a process that: Reflects cultural considerations of the participants;" with Providers | DDID Division Director | Highlight the section of the regulation and discuss how it can be used to ensure equity | During a or several monthly sessions with the Providers. I In fall of 2022, do a deeper dive with the providers into section 5(1)(c)3 of the SCL regulation | 12/31/22 | In progress |
| 2 | Consider making regulatory recommendations to the participant rights (in Section 3) and in the covered services (Section 4) sections of the SCL waiver regulation and in appropriate sections of the MP waiver regulation | DDID Division Director | Enhance the wording of the regulation to more specifically address concepts of racial equity | Meetings with Medicaid regarding regulation changes | 12/31/22 | In progress |

**Division of Program Integrity Goal #1**: Develop auditing tools that support the monitoring of external organizations on their performance against racial equity goals.

| # | Objective | Who | Why | Checkpoint/KPI | When Completed | Status |
|---|---|---|---|---|---|---|
| **1** | Coordinate with other BHDID program employees in the development of compliance tools that include racial equity data in the monitoring of the internal and external organizational contracts. | PI Racial Equity Change Team | To encourage organizations to be intentional in ensuring public relations materials target the racial makeup of our customers and highlight racial equity concerns. | Existing and new Contracts to include language that provide measurable data that demonstrate racial equity outcomes. | 9.31.22 | In Progress. Through the division's monitoring reviews of department contracts, vendors have started incorporating required racial equity contract deliverables via the |

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| | | | | | | direction of the Department |

**Division of Program Integrity Goal #2**: **Increase awareness of racial equity initiatives internally and externally.**

| # | Objective | Who | Why | Checkpoint/KPI | When Completed | Status |
|---|---|---|---|---|---|---|
| **1** | Launch a division informational training activity<br><br>*Subsequent activities be held monthly | PI Racial Equity Change Team and leadership | To bring awareness of the division and department's racial equity goals and to solicit support and volunteers in the division's racial equity initiatives. | The checkpoints continue to include data based on the number of employees in attendance at sponsored voluntary meetings and activities. | 01.29.21<br><br>*On-going | Completed<br>*Full staff meetings are held monthly as well as on-going Core Team meetings. Racial Equity activities – with emphasis on trauma resilience continue to be held monthly, staff participation continues to increase. |
| **2** | Provide BHDID program and service information virtually to various racial groups. | PI Racial Equity Change Team and specialists within DBHDID | To bring awareness of mental health, substance use, intellectual disabilities services and racial equity initiatives to minority groups. | The checkpoint will include data based on the number of individuals who attend virtual sessions. | On-going | In Progress. A PowerPoint presentation has been created & awaiting approval. The first group may involve Nigerians. |
| **3** | Explore a Mentoring Program for students of color from various educational institutions who are interested in obtaining employment in disciplines within BHDID. | PI Racial Equity Change Team and leadership | To network and partner state employees with students of color to educate them on various aspects | The checkpoint will include data based on students of color who participate in the pilot mentoring program. | 12.31.22 | Plans are in progress for a pilot mentoring program in partnership with KY State University Master of Public |

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| | | | DBHDID including employment opportunities | | | Administration Program for the fall 2022 semester. |

**KYACA/Office of Autism Goal #1: The Executive Committee will work with Council & Subcommittee to integrate the racial equity commitments into the work and public facing efforts of the Council.**

| # | Objective | Who | Why | Checkpoint/KPI | When Completed | Status |
|---|---|---|---|---|---|---|
| **1** | Have content expert/guest speaker introduce and lead a discussion on the racial equity commitments. | Rashaad Abdur-Rahman | Integration with DBHDID Racial Equity Initiative | Council members feedback at and after meeting | August 13, 2020 | **Complete** |
| **2** | Adopt revised DBHDID racial equity commitments as Council and provide educational opportunities to Council & Subcommittees | Executive Committee | Leadership continues to be key in setting the tone for urgency and importance of this effort. | Discussion on the adoption of racial equity commitments at November 5, 2020 Meeting – Tabled until final commitments are approved (TBD: based on state approval) | Early 2021 & ongoing | Complete |
| **3** | Add Racial Equity Update/Discussion as a regular agenda item of Council | Executive Committee | Regular and effective communication is a critical component of any initiative. | Evidenced by agenda and meeting minutes at each quarterly meeting | November 5, 2020 | Complete |
| **4** | Publish BHDID racial equity resource list and other agency racial equity resources to Council and Subcommittees | Executive Committee | Universal racial equity resources accessible to everyone for ongoing council education | Resource list distributed via email and added to the KYACA website. | Early 2021 & ongoing | Ongoing |
| **5** | Introduce & explore opportunity to use BRIEF GARE RACIAL EQUITY TOOL with at least one project in each subcommittee | Tal Curry & Subcommittee | Racial equity analysis should occur in places where we are making decisions. | Shared with all 3 subcommittees and sent tool to begin utilizing with tasks of subcommittee | April 2021 | Ongoing |

**KYACA/Office of Autism Goal #2: Plan to increase and retain the representation of Black, Brown, Indigenous, Immigrant, and people of color on the Council, subcommittees, and volunteers.**

| # | Objective | Who | Why | Checkpoint/KPI | When Completed | Status |
|---|---|---|---|---|---|---|
| 1 | Autism Council will compile a list of (active) KYACA and subcommittee members by race, parent, self-advocate, agency, etc. (possible survey with other variables), recognizing that some members may elect not to disclose race and race is not always visually apparent | Executive Committee | Need baseline in order to set relevant goals and increase committee understanding of lack of broad representation and racial diversity. | Review at Exec. Committee meetings for baseline and review numbers for Council, subcommittees, & ad-hoc committees or workgroups | October 2021 with Council | In Process |
| 2 | Exec. Committee will present racial equity representation targets to Council and subcommittees | Executive Committee | Clear targets allows us to increase accountability and track progress. | Targets set for FY 22 – 23. | February 10, 2022 | In Process |
| 3 | Encourage people of color to apply as citizens at large or self-advocates representatives for Autism Council and let Executive Committee know of their application to Boards & Commissions; encourage people of color to engage with the KYACA and its subcommittees as volunteers and advocates and to attend KYACA meetings | Executive Committee | To increase diversity representation on Council & subcommittees and to provide a diverse perspective while we work toward our goals | Compare baseline data of Council and subcommittees at Executive Committee meetings and report to Council | Ongoing | In Process |
| 4 | Council and Subcommittee will ensure both Council and Subcommittees are a safe place for all where participants feel welcomed, celebrated, and included. | Council and Subcommittee | Engaging new representatives and participants with respect to create a culture where racial equity is valued. | Orientation prior to meetings as possible. Open communication with Chairs and Office of Autism. | Ongoing | In Process |

**KYACA/Office of Autism Goal #3: Goals and objectives aligned with Racial Equity Commitments across the subcommittees.**

| # | Objective | Who | Why | Checkpoint/KPI | When Completed | Status |
|---|---|---|---|---|---|---|

| | | | | | | |
|---|---|---|---|---|---|---|
| **1** | Discussion on the racial equity commitments with each subcommittee. | Tal Curry & Subcommittee Chairs | Integration among 3 subcommittees | Added as agenda item and recorded in meeting notes; shared with public for input | October 31, 2020 | Complete |
| **2** | Each subcommittee chair will review current work tasks and highlight potential areas to strengthen racial equity prior to next subcommittee meeting | Subcommittee Chairs & Tal Curry | Leadership continues to be key in setting the tone for urgency and importance of this effort. | Subcommittee chairs to lead presentation & discussion at January 2021 subcommittees | January 15, 2021 | Complete |
| **3** | Add Racial Equity Update/Discussion as a regular agenda item of subcommittees | Subcommittee Chairs | Regular and effective communication is a critical component of any initiative. | Evidenced by agenda and meeting minutes at each quarterly meeting | January 31, 2021 | Complete |
| **4** | Subcommittees will review current work plans to align with racial equity commitments. | Subcommittee Chairs & Tal | Racial equity analysis should occur in places where we are making decisions. | Documented in updated Subcommittee work plans and future meeting minutes as well as on the website and in printed materials | June 2021 | Complete |
| **5** | Provide racial equity commitment update (TBD: based on state approval) and launch regular racial equity communications. | Executive Committee | Leadership continues to be key in setting the tone for urgency and importance of this effort. Diversity in public engagement and input is essential | Utilize DBHDID communications as well as other partners to be sent at least quarterly | May 2022 | In Process |
| | | | | | | |
| | | | | | | |

# 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. The **National Center of Excellence for Integrated Health Solutions**[1] offers technical assistance and resources on value-based purchasing models including capitation, shared-savings, bundled payments, pay for performance, and incentivizing outcomes.

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 for the efficacy and value of various mental and substance use prevention, SUD 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/NASEM 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 (EBPRC) 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 EBPRC 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 used with individuals with mental illness and substance use disorders, including youth and adults with substance use disorders, adults with SMI, and children and youth with SED. The recommendations build 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[2], The New Freedom Commission on Mental Health[3], the IOM, NQF, and the **Interdepartmental Serious Mental Illness Coordinating Committee** (ISMICC)[4].

One activity of the EBPRC[5] was 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."[6] SAMHSA and other HHS federal partners, including the 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 innovative and promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, evidence is collected to determine their efficacy and develop a more detailed understanding of for who and in what circumstances they are most effective.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[7] 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)**[8] 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. Each 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, for educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is interested with what additional information is needed by SMHAs and SSAs to support their and other purchasers' decisions regarding value-based purchase of M/SUD services.

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[1] **https://www.thenationalcouncil.org/program/center-of-excellence/**

[2] 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

[3] 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 use disorder and Mental Health Services Administration.

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

[5] **https://www.samhsa.gov/ebp-resource-center/about**

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

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

[8] **https://store.samhsa.gov/?f%5B0%5D=series%3A5558**

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**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, ACO, 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?

The Department sets aside a portion of funding for Community Mental Health Centers (CMHC) which can be earned based on achievement of certain performance indicators. The indicators are developed by the Quality Management and Outcomes Team (QMOT). The team includes Department staff, staff from each CMHC, and representatives from the University of Kentucky. Recommendations from QMOT provide direction for the collection of information relevant to desired outcomes, methods of measurement, and design of processes for continuous outcomes management across the department. QMOT evaluates outcomes that support the provision of quality services and explore areas for improvement. The core values of QMOT are to insure that services are provided in accordance with clinical practice guidelines that are supported by evidence and knowledge of best practices. Valid and reliable outcome information is used by stakeholders to identify opportunities for improvement.
Also, in conjunction with CMS and the Department of Medicaid Services, KY was one of the first 10 states selected for CCBHC demonstration. KY currently has four (4) CCBHCs. EBPs were specified and required for use by the CCBHCs. Quality measures are in place to assess the CCBHCs. If quality measures are promising, the state will pursue further expansion of CCBHC or possible state plan amendments. CCBHC provides for an enhanced payment structure to reimburse actual costs more closely in the provision of integrated physical and behavioral healthcare.

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

Value Based Purchasing Options for Housing

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**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.** Please name the model(s) that the state implemented including the number of programs for each model for those with ESMI using MHBG funds.

| Model(s)/EBP(s) for ESMI/FEP | Number of programs |
|---|---|
| Coordinated Specialty Care, the Early Assessment and Support Alliance (EASA) model | 9 |
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**2.** Please provide the total budget/planned expenditure for ESMI/FEP for FY 24 and FY 25 (only include MHBG funds).

| FY2024 | FY2025 |
|---|---|
| 1293000 | 1293000 |

**3.** Please describe the status of billing Medicaid or other insurances for ESMI/FEP services? How are components of the model currently being billed? Please explain.

Kentucky iHOPE teams bill Medicaid and other private insurances for services provided to iHOPE participants. There is no group rate for CSC in Kentucky. iHOPE teams can bill Medicaid for a variety of SCS services, including screening, assessment, person-centered treatment planning, individual/group/family therapy, peer support, targeted case management, and prescriber services. While Kentucky Office of Vocational Rehabilitation funds some short term services for supported employment, Kentucky Medicaid does not cover supported employment/education services, thus the longer term supports needed for this population have no insurance coverage. Kentucky Medicaid is currently working on a 1915i waiver that may permit some coverage of supported employment/education in the future. Kentucky Medicaid covers Occupational Therapy services, but NOT through the behavioral health network. Advocacy work is happening in this area, and there is some hope that at least the teams located in agencies identified as CCBHCs will be able to bill for Occupational Therapy in the near future. Kentucky has implemented Multi Family Group Therapy (MFG) as the family psychoeducation model for CSC teams. This evidence-based practice blends components of psychoeducation with family/group therapy models. While Family Psychotherapy is a covered service through Kentucky Medicaid, iHOPE teams are mostly providing MFG and billing through individual/group/family therapy.
Most private insurances only cover therapy and prescriber services. iHOPE teams are encouraged to utilize MHBG funds as needed to cover any needed services not covered under Medicaid/private insurance.

**4.** Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI/FEP.

Kentucky is utilizing implementation science as outlined by the National Implementation Research Network throughout the execution of first episode of psychosis programming. Kentucky is implementing the Early Assessment and Support Alliance (EASA) model of Coordinated Specialty Care (CSC). Oregon's EASA program has been providing CSC services longer than anyone else in the United States and were chosen to be Kentucky's consultants from the beginning. EASA continues to provide monthly consultation to each Kentucky CSC team as well as to the state FEP team, EASA also host a multi-state learning collaborative with all the states they provide with CSC consultation. Kentucky's practice guidelines, that are embedded into each provider contract, are modeled directly from EASA's practice guidelines for CSC. In addition to a public website that includes detailed information for providers, states and participants, EASA provides virtual training opportunities for all CSC programs. Kentucky partnered with EASA to create several introductory CSC training modules that are available on the EASA website to all providers. In addition, EASA has provided Structured Clinical Interview for DSM 5 (SCID-5) training, Multi Family Group Therapy training, and other offerings via virtual formats.
Several evidence-based practices are being utilized in the implementation of ESMI/FEP programming, including:
-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. 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;
-Targeted Case Management – each CSC team is required to have a full-time case manager to assist with identifying strengths and needs for participants;
-Peer Support – each CSC team is required to have a peer support specialist, preferably a Youth Peer Support Specialist, to assist with participant engagement and goal identification. Some CSC teams also have Family Peer Support Specialists to assist with family engagement when working with young people;
-Specialized Screening and Assessment Tools – training and support specific to first episode of psychosis programming continues to be provided to designated staff across the state. These tools include the PRIME Screen, the Structured Clinical Interview for DSM-5 (SCID-5), 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) –This provides CSC teams as well as other outpatient clinicians, specific skills to utilize when providing treatment to youth and young adults that experience psychosis;
Recovery Oriented Cognitive Therapy (CT-R) – This model is in the beginning stages of implementation in Kentucky. It is a treatment approach designed to promote empowerment, recovery and resiliency in individuals with serious mental illness, including early serious mental illness; and
-Multi Family Group Therapy (MFG) – educational and supportive sessions with several families at one time, focusing on specific diagnostic categories. Can be modified to work with one family at a time.

**5.** Does the state monitor fidelity of the chosen EBP(s)?

(●) Yes ( ) No

**6.** Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI/FEP?

(●) Yes ( ) No

**7.** Explain how programs increase access to essential services and improve client outcomes for those with an ESMI/FEP?

The Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) contracts with 8 CMHCs to provide CSC through the iHOPE program. Contract deliverables for these agencies include requirements for rapid access to care within the team (within 48 hours of referral) as well as rapid access (within 7 days of admission) to a prescriber. DBHDID's traditional client/event data set does not include a good way to track early access for this population. During SFY 2023, DBHDID collaborated with the University of KY Human Development Institute (UK/HDI) to create a new data platform, specific for iHOPE teams, that will be utilized to collect client related demographic and outcomes data. This data platform will more accurately track early access and will be used to provide data that will inform additional training needs and increase access to appropriate care for young people with ESMI/FEP.

**8.** Please describe the planned activities for FY 2024 and FY 2025 for your state's ESMI/FEP programs.

SFY 2024:

Increase Cognitive Behavior Therapy (CBT) clinical competency on iHOPE teams by requiring more clinical staff on each team complete foundational CBT training courses in a virtual format;
Increase competency for non-clinical members of iHOPE teams through additional training/consultation efforts;
Continue ongoing consultation and training for all iHOPE teams, as well as for agencies without iHOPE to increase capacity for this population;
Strengthen diagnostic skills through the full implementation of SCID-5 training and the use of the NetSCID;
Continue collaboration with the Kentucky Occupational Therapy Association (KOTA) to increase access to local occupational therapists for iHOPE teams, including continued advocating surrounding Medicaid billing and best practices for this modality;
Providing specialized training and consultation for iHOPE prescribers;
Begin actual data collection (starts July 1, 2023) with the new data tool created by UK/HDI and begin to analyze data and inform on access and outcome issues;
Continue virtual/possibly in person learning opportunities for this specific population to a broader audience to enhance statewide capacity;
Continue regular statewide meetings with iHOPE teams and with all agencies;
Continue regular consultation with EASA and other partners;
Continue regular trainings on screening/assessment tools;
Provide additional training and consultation on CT-R and CBTp treatment models, specific to CSC;
Increase specific CBTp clinical competency for iHOPE teams; and
Provide additional consultation and technical assistance to one CMHC that has expanded to a second iHOPE team.

SFY 2025:

Kentucky allocates funds and plans accordingly per fiscal year. The plans above will be continued through SFY 2025, and additional plans will be created as needed following funding updates and as identified through data analysis and consultations/statewide meetings.

**9.** Please list the diagnostic categories identified for your state's ESMI/FEP programs.

Kentucky has chosen to provide targeted Coordinated Specialty Care to youth and young adults between the ages of 15 – 30 with ESMI/FEP, including individuals with the diagnoses of schizophrenia spectrum and other psychotic disorders, and other psychotic and affective diagnoses that include psychosis as identified in the DSM-5. (Delusional Disorder, Brief Psychotic Disorder, Schizoaffective Disorder, Schizophreniform Disorder, Unspecified Schizophrenia Spectrum and Other Psychotic Disorder, Other Schizophrenia Spectrum and Other Psychotic Disorder, Major Depressive Disorder with psychotic features, and Bipolar I with psychotic features. Kentucky's CSC criteria focuses on youth and young adults who have experienced a first episode of psychosis within the last year.

**10.** What is the estimated incidence of individuals with a first episode psychosis in the state?

Kentucky estimated the FEP incidence rate by using 2020 Census data and utilizing the incidence rate of .03% of the general population, the incidence rate for FEP established through the OnTrack NY study and published on September 1, 2013. (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 https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201300186
Kentucky has the following estimates of FEP incidence:

Statewide: 1,340 individuals per year.

Regionally by CMHC:
Four Rivers: 61 individuals per year
Pennyroyal: 61 individuals per year
River Valley: 65 individuals per year
LifeSkills: 93 individuals per year
Communicare: 84 individuals per year
Seven Counties: 302 individual per year
NorthKey: 139 individuals per year
Comprehend: 17 individuals per year
Pathways: 65 individuals per year
Mountain: 42 individuals per year

Kentucky River: 39 individuals per year
Cumberland River: 69 individuals per year
Adanta: 63 individuals per year
New Vista: 249 individuals per year

**11.** What is the state's plan to outreach and engage those with a first episode psychosis who need support from the public mental health system?

Kentucky's state FEP team will continue to provide ongoing technical assistance in this area with assistance of EASA and other partners. Effective outreach initiatives will be targeted with a focus on larger scale efforts including utilizing social media, billboards, etc.

While the state FEP team will continue to focus on outreach and engagement efforts statewide with both child (including transition age youth) and adult systems of care, immediate plans include outreach and engagement efforts within the adult system of care to include state psychiatric hospitals and local hospitals with psychiatric units. iHOPE teams will have support in creating consistent points of contact with the state and local hospitals in their regions and to streamline the identification and referral process for individuals with FEP in their areas.

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

N/A

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

# Environmental Factors and Plan

### 5. Person Centered Planning (PCP) - Required for 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.

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. Resources for assessing and developing PCP systems can be found at the National Center on Advancing Person-Centered Practices and Systems **https://ncapps.acl.gov/home.html** with a systems assessment at **https://ncapps.acl.gov/docs/NCAPPS_SelfAssessment_201030.pdf**

**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.

**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. By regulation, membership must be comprised of at least 51% of individuals or their family members 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 and receives input and guidance on needs.

Kentucky also has a very active State Interagency Council (SIAC) that consists of partners from child serving agencies and organizations across the state, a parent representative, and a youth representative (full description in Criterion 1). This group meets monthly and has four standing subcommittees that work on goals and activities identified in the SIAC multi-year strategic plan. Family members and youth with lived experience are members of not only the SIAC but also each of the standing committees, as well as ad hoc committees that are established based on need. The SIAC serves as the governing body of Kentucky's System of Care, so youth and parent leaders have an active voice in policies, budgets, services, and supports for those with behavioral health disorders in Kentucky.

In addition, DMH employs several individuals with lived experience who are involved in programming decisions and bring a wealth of knowledge regarding engagement, treatment, and recovery for youth and adults with behavioral health disorders. DBHDID also contracts with multiple consumer and family advocacy organizations to provide leadership training and coaching for adults, families, and youth as well as professional development opportunities around family and youth engagement for both agency staff and persons with lived experience. They also provide and consultation regarding services and programming across the state.

The DBHDID expects CMHCs to develop person-centered treatment and recovery plans for individuals with SUD, SMI, and SED and includes definitions of this process along with expected deliverables in its contracts. CMHC staff are trained in the PCP model and is expected to utilize it with all service recipients. Additionally, peer 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 PCP model, clients are encouraged to include family members, supporters, and other community members in their treatment planning process. In accordance with the PCP 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 PCP 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 PCP 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. For children,

youth, and families, providers and other contracted entities are expected to operate in accordance with the System of Care framework.

In addition to requiring person-centered planning for treatment services, High Fidelity Wraparound (HFW) is available to children with SED who have the most complex needs, and Targeted Case Management (TCM) for children with SED is delivered in accordance with the principles of wraparound. Both HFW and TCM incorporate values and processes that are similar to those of PCP. Finally, core values and guiding principles of the System of Care framework align with person-centered planning.

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

During SFY 2015, DBHDID hired national consultant to train CMHC/DBHDID 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 DBHDID chose to educate and train all providers. The Division of Mental Health (DMH) 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. A Person Centered Planning fidelity tool was created and DMH staff monitors the person centered planning process across the state, by reviewing plans utilizing this tool. 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, other partners were trained 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 person centered plan that honors the person AND satisfies requirements of payors.

For individuals receiving services for SUD, the Division of Substance Use Disorder (DSUD) provides training and technical assistance to enhance client care by focusing on the key concepts inherent in a Recovery Oriented System of Care. Those concepts include ensuring service planning is person-centered, self-directed, strengths- based and participatory involving family members, caregivers, significant others, friends and community partners identified by the client.

**5.** What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as SAMHSA's **A Practical Guide to Psychiatric Advance Directives**)?"

Kentucky has a state statute, Advance Directives in Mental Health Treatment (KRS 202A.420 – 432) https://apps.legislature.ky.gov/law/statutes/statute.aspx?id=50016, governing the use of advance directives for this population. This statute was enacted in 2003 as a result of an advocacy movement led by individuals with lived experience and a statewide legislative advocacy group. During that time, the Division of Mental Health (DMH) partnered with the individuals who championed this effort and created a brief video, explaining the new law and providing information about the process of creating advance directives for mental health care. This video was created in a partnership with Kentucky’s Protection and Advocacy as well as the National Alliance on Mental Illness and a statewide consumer organization. As peer support became a recognizable service, peers and providers across the state were educated about psychiatric advance directives utilizing this video, and adult peer support certification training includes a curriculum requirement for education regarding psychiatric advance directives.
In addition, as DMH implemented Wellness Recovery Action Planning (WRAP) for individuals with SMI, training included teaching peer specialists how to assist in creating these advance directives, which in WRAP planning is very similar to a WRAP crisis plan. Since that time, language encouraging providers to assist individuals receiving behavioral health services has been included in many Medicaid and DBHDID regulations. The law stipulates that a provider for an individual cannot be listed as a surrogate or witness an advance directive. However, providers are encouraged to assist adults in creating these plans, primarily through the assistance of peer support specialists. Even though the title of the statute is Advanced Directives for Mental Health Treatment, many adults with co-occurring SUD have been able to utilize the forms and process to assist with their treatment as well.

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 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 SUPTRS BG 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 SUPTRS BG 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 SUPTRS BG 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 SUPTRS BG funds are allocated to support evidence-based, culturally competent programs, substance use primary 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 SUPTRS BG. 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:**

**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 work 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

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**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?

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

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

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

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**Footnotes:**

Kentucky has no federally recognized tribes.

# Environmental Factors and Plan

### 8. Primary Prevention - Required SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not 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 primary 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 SUPTRS BG 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 Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

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

## 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)

- **a)** ☑ Children (under age 12)
- **b)** ☑ Youth (ages 12-17)
- **c)** ☑ Young adults/college age (ages 18-26)
- **d)** ☑ Adults (ages 27-54)
- **e)** ☑ Older adults (age 55 and above)
- **f)** ☑ Cultural/ethnic minorities
- **g)** ☑ Sexual/gender minorities
- **h)** ☑ Rural communities
- **i)** ☑ Others (please list)

Service Members, Veterans and Family members

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

**a)** ☐ Archival indicators (Please list)

**b)** ☑ National survey on Drug Use and Health (NSDUH)

**c)** ☑ Behavioral Risk Factor Surveillance System (BRFSS)

**d)** ☑ Youth Risk Behavioral Surveillance System (YRBS)

**e)** ☐ Monitoring the Future

**f)** ☐ Communities that Care

**g)** ☑ State - developed survey instrument

**h)** ☑ 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 have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? ◉ Yes ○ No

**a)** 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 RPC and DBHDID prevention professionals with more than 100 combined years prevention experience. The group is coordinated by a Department of Behavioral Health Prevention Branch state employee. 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. Each program, practice or policy included in the list of approved state approaches is identified as evidence-based plus, evidence-based, evidence-informed, or insufficient evidence using a process developed by REACH Evaluation, our contracted evaluator. These categories help 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.

Every year the Regional Prevention Centers, our contracted prevention providers, conduct a needs assessment for one-third of the counties in their regions using a standardized template to guide local assessments for consistency and accuracy. Those are rolled up together to create a state level guide for work. In State Fiscal Year 22, this process was redesigned to include provision of data related to incidence and prevalence through a dashboard that helps establish a uniform guide for county-level assessments. RPC staff conduct key stakeholder interviews and focus groups for 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 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.
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 and American Rescue Plan Act funds). Most of the regular Block Grant funding is allocated to Kentucky's fourteen (14) Regional Prevention Centers (RPC) based on a historical DBHDID funding formula. Each RPC is required to conduct needs assessments for one-third of their counties each year. Local priorities are identified for each county. Allocations for funding other than the regular Block Grant 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 statewide needs assessment but is working on improving submitted activity data and identifying disparities to develop allocations and fee-based reimbursement processes.
The Division of Substance Use Disorder 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 increasing protective factors that can influence substance use/misuse and related consequences. 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 usable 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 Substance Use Disorder and any other relevant organization or entity.

The SEOW consists of a Chair and Co-Chair from the DBHDID Division of Substance Use Disorder (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.

Current SEOW members are:
• Paula Brown Branch Manager, Prevention & Promotion Branch, DSUD
• Steve Cambron Program Administrator/Synar Coordinator, DSUD
• Nikki Milward Assistant Director, DSUD
• Van Ingram Executive Director, Kentucky Office of Drug Control Policy
• Dr. Teresa McGeeney Epidemiologist, REACH of Louisville
• Dr. Vestena Robbins Executive Advisor, DBHDID
• 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
• Stephanie Bunge School Health Consultant, KY Department of Education
• Ben Birkby Director of Policy, Evaluation, and Consultation Services, REACH
• Dr. Michelyn Bhandari Associate Dean, Eastern KY University Dept. of Health Sciences
• John Broadus RPC Liaison/DBHDID
• Dr. Ashley Bush KIPRC – KY Safety and Prevention Alignment Network
• Jacqueline Seals Project Manager, KY Violent Death Reporting System
• Tiffany Quarles Alcohol PES Program Administrator, DBHDID
• 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
• Beck Whipple KY State Suicide Prevention Coordinator, DBH
• Camille Croweak Cannabis PES Program Administrator, DBHDID
• Patty Gregory Director, Seven Counties Regional Prevention Center
• Amy Hutchinson Director, LifeSkills Regional Prevention Center

**b)** If no, (please explain) how SUPTRS BG funds are allocated:

**6.** Does your state integrate the National CLAS standards into the assessment step? ○ Yes ◉ No

**a)** If yes, please explain in the box below.

**b)** If no, please explain in the box below.

The Substance Use Disorder Prevention and Promotion Branch (Branch) has not formally used the CLAS Standards as in our assessment process. The Branch is working to ensure that health disparities are included in the assessment process. Efforts are made to ensure that assessments are conducted in ways that address communication and language barriers by offering language assistance and providing materials in the most commonly spoken languages in the region. We plan to integrate the National CLAS Standards into all steps of the SPF as we move forward.

**7.** Does your state integrate sustainability into the assessment step? ◉ Yes ○ No

**a)** If yes, please explain in the box below.

The Branch integrates sustainability into the assessment step by requiring the Regional Prevention Centers (RPCs), the contracted prevention providers, to utilize a standard needs assessment process developed by the Branch. Part of the process is utilizing existing data sources when possible, including tracking trends for substance use and related consequences. RPCs are also required to keep records of the focus group and key informant interview questions, so those can be utilized in future assessments. Multiple staff members at each RPC facilitate the assessments, so that knowledge of the assessment process and the identified issues for each community are not lost when there is staff turnover. Needs assessment data are shared with community partners and other stakeholders to promote understanding of the local substance use related issues, the importance of assessment, to get additional feedback on the results, and to create buy-in for future assessments.

**b)** If no, please explain in the box below.

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not 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 primary 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 SUPTRS BG 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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2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

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

## Capacity Planning

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

**a)** 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 through the International Certification and Reciprocity Consortium (IC& RC). 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 primary prevention workforce? (●) Yes ( ) No

**a)** 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, KY 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. The training needs of prevention providers are assessed on an annual basis and a plan is developed to ensure that delivery of training matches the needs of the community-level providers. We also access national level technical assistance through the Prevention Technology Transfer Center. online courses and webinars. 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 an annual, in-person training which included a prevention track for 46 years prior to being cancelled in 2020, 2021, and 2022 because of COVID-19. For 2023, it will be a series of online trainings for 2023 with plans for it to return as an in-person training with a dedicated prevention track in 2024.

o DBHDID has developed an onboarding system that includes the Kentucky Substance Use Prevention Skills (KSUPS) training, a four-day comprehensive, hands-on prevention training facilitated by Branch staff as well as Prevention Academy (formerly Substance Abuse Prevention Skills Training). Prevention Academy consists of a series of online training courses focusing on various prevention topics, such as the history of prevention, substance specific information, brain development, environmental strategies, and the 6 CSAP strategies. The trainings were developed specifically for Kentucky and feature national prevention experts as well as Branch subject matter experts. All new prevention staff members must complete both KSUPS and Prevention Academy within 18 months of hire.
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 is held in the fall of each year and focuses on evidence-based prevention strategies and emerging issues in substance use. The statewide prevention network also offered three (3) virtual trainings focused on alcohol in the spring of 2023 to support prevention providers.
o Prevention Ethics is delivered virtually twice a year to prevention providers to support certification. DBHDID has internal trainers for the curriculum.

• Internal Technical Assistance: In addition to technical assistance from the PTTC, Kentucky state-level staff members provide one-on-one and system-wide training and technical assistance including training on the 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

**a)** If yes, please describe mechanism used.

All Regional Prevention Centers are required to assess community readiness for each community they serve. Each local provider completes a readiness assessment during the needs assessment process utilizing the Tri-Ethnic Community Readiness Model. 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.

**4.** Does your state integrate the National CLAS Standards into the capacity building step? ( ) Yes (●) No

**a)** If yes, please explain in the box below.

**5.** Does your state integrate sustainability into the capacity building step? (●) Yes ( ) No

**a)** If yes, please explain in the box below.

Sustainability underlies all capacity building efforts. Training for prevention providers and community partners is designed to increase their knowledge and capacity to do evidence-based prevention. Efforts by prevention providers to recruit new coalition members and community partners, obtain additional funding sources, publicize both the substance related issues and the results of prevention efforts all increase capacity of the providers and community to address substance use/misuse issues in the future.

**b)** If no, please explain in the box below.

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not 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 primary 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 SUPTRS BG 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 Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

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

## Planning

**1.** Does your state have a strategic plan that addresses substance use primary 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.

The Branch staff is currently revising the previous strategic plan which was completed in early 2018.

**2.** Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG? ○ 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 SUPTRS BG primary prevention funds
- **b)** ☐ Timelines
- **c)** ☐ Roles and responsibilities
- **d)** ☐ Process indicators
- **e)** ☐ Outcome indicators
- **f)** ☐ Cultural competence component (i.e., National CLAS Standards)
- **g)** ☐ Sustainability component
- **h)** ☐ Other (please list):

The Branch staff is currently revising the previous strategic plan which was completed in early 2018.

- **i)** ☐ Not applicable/no prevention strategic plan

**4.** Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG 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 SUPTRS BG primary prevention funds? ◉ Yes ○ No

**a)** 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 RPC and DBHDID prevention professionals with more than 100 combined years prevention experience. The group is coordinated by a Department of Behavioral Health Prevention Branch

state employee. 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. Each program, practice or policy included in the list of approved state approaches is identified as evidence-based plus, evidence-based, evidence-informed, or insufficient evidence using a process developed by REACH Evaluation, our contracted evaluator. These categories help 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.

**6.** Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? (●) Yes ( ) No

**7.** Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? (●) Yes ( ) No

**a)** 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 RPC and DBHDID prevention professionals with more than 100 combined years prevention experience. The group is coordinated by a Department of Behavioral Health Prevention Branch state employee. 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. Each program, practice or policy included in the list of approved state approaches is identified as evidence-based plus, evidence-based, evidence-informed, or insufficient evidence using a process developed by REACH Evaluation, our contracted evaluator. These categories help 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.

**8.** Does your state integrate the National CLAS Standards into the planning step? ( ) Yes (●) No

**a)** If yes, please explain in the box below.

N/A

**b)** If no, please explain in the box below.

The Branch has not integrated the National CLAS Standards into the planning step. The RPCs are required to address health equity in their workplans and provide communication and language assistance based on local needs. They are also required to work to be culturally responsive and ensure that they are addressing all parts of the population in the communities with their workplans. The Branch plans to work on incorporating the CLAS Standards in the planning step moving forward.

**9.** Does your state integrate sustainability into the planning step? (●) Yes ( ) No

**a)** If yes, please explain in the box below.

The Branch requires prevention providers to address sustainability as they develop their strategic plans. This includes determining the feasibility of sustaining prevention strategies and outcomes beyond specific funding streams, looking at cross-training for strategies to ensure they can continue even if there are changes in staff at the RPC or community partner level, and developing comprehensive plans that help to produce lasting community change.

**b)** If no, please explain in the box below.

N/A

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not 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 primary 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 SUPTRS BG 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 Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

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

## Implementation

**1.** States distribute SUPTRS BG 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 SUPTRS BG primary prevention dollars in at least one 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:
a. 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:

b. Education: Too Good for Drugs, Prime for Life, Tobacco Retail Underage Sales Training, Positive Alternatives

**c)** Alternatives:

c. Alternatives: Project Prom

**d)** Problem Identification and Referral:

d. Problem Identification and Referral: Prevention providers currently conduct the Zero Tolerance program – a youth DUI screening program, to increase awareness of the harmful effects of substance use. If the screening reveals that a youth may need services beyond education, they are referred to treatment providers. Otherwise, the youth participate in the evidence-based program, Prime for Life.

**e)** Community-Based Processes:

e. Community-Based Processes: 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:

f. Environmental: Social host ordinances, smoke and vape- 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, Sources of Strength.

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

**a)** 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.
In addition, each provider contract includes the federal requirements for the use of block grant funds.

**4.** Does your state integrate National CLAS Standards into the implementation step? ( ) Yes (●) No

**a)** If yes, please describe in the box below.

**b)** If no, please explain in the box below.

The Substance Use Disorder Prevention and Promotion Branch (Branch) has not formally used the CLAS Standards as in the implementation process. The Branch is working to ensure that health disparities are addressed in all prevention implementation. Efforts are made to ensure that strategies are implemented in ways that address communication and language barriers by offering language assistance and providing materials in the most spoken languages in the region. Prevention providers are also supposed to include all segments of the community in prevention implementation efforts. We plan to integrate the National CLAS Standards into all steps of the SPF as we move forward.

**5.** Does your state integrate sustainability into the implementation step? (●) Yes ( ) No

**a)** If yes, please describe in the box below.

The Branch requires all prevention providers to address sustainability in their implementation efforts by including multiple people at the RPC and community levels in implementation, utilizing braided funding when appropriate and available, implementing strategies at all levels of the socio-ecological model, and including the six CSAP strategies to increase the possibilities to create lasting change.

**b)** If no, please explain in the box below

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not 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 primary 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 SUPTRS BG 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;
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5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

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

## Evaluation

**1.** Does your state have an evaluation plan for substance use primary 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 SUPTRS BG 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 SUPTRS BG funded prevention services:

- **a)** ☑ 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** ☐ Heavy use
- **c)** ☑ Binge use
- **d)** ☑ Perception of harm
- **e)** ☑ Disapproval of use
- **f)** ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- **g)** ☑ 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

**5.** Does your state integrate the National CLAS Standards into the evaluation step? ○ Yes ◉ No

**a)** If yes, please explain in the box below.

**b)** If no, please explain in the box below.

The Substance Use Disorder Prevention and Promotion Branch has not formally used the CLAS Standards as in our evaluation process. The Branch is working to ensure that health disparities are included in the evaluation process. Efforts are made to ensure that evaluation efforts are conducted in ways that address communication and language barriers by offering language assistance and providing materials in the most commonly spoken languages in the region. We plan to integrate the National CLAS Standards into all steps of the SPF as we move forward.

**6.** Does your state integrate sustainability into the evaluation step? ◉ Yes ○ No

**a)** If yes, please describe in the box below.

The Branch works to ensure that sustainability is integrated into the evaluation step by encouraging our contracted prevention providers to use established evaluation measures and to share the results of the evaluations with the communities served by those strategies as well as funders and other stakeholders. Providers are required to use those evaluation results to shape their work in all the other steps of the SPF process.

**b)** If no, please explain in the box below.

**Footnotes:**

# 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, youth and transition aged youth, including those with serious 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."

CMHCs 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, youth and transition aged youth, including those with SED, and for adults with SMI, 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: individuals in recovery/family involvement; continuity of care; targeted case management; co-occurring M/SUD services; mental health and aging; mental health services for deaf and hard of hearing; housing options; physical health interface; rural outreach; rehabilitations services such as assertive community treatment, peer support, individual placement and support supported employment, comprehensive community supports, therapeutic rehabilitation programs, and supportive housing services; and behavioral health treatment services, including intensive outpatient programs for those with mental health disorders.

For children, youth and transition aged youth, including those with SED, these key components based on the System of Care framework include: promotion of well-being/prevention of behavioral health disorders; supporting youth/family voices across the system of care; ensuring culturally responsive care, regional summary of the system of care; children and transition age youth service array; best practices; training needs; best practices; supportive services; early interventions for first episode psychosis; Service Members, Veterans and Family Members; integrated care, workforce development and youth/young adult engagement, support and leadership.

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.)

Children with SED
In Kentucky, services for children, youth, transition age youth, and their families that are delivered through Kentucky's public behavioral health safety net (14 regional Community Mental Health Centers) have been provided in accordance with the system of care (SOC) framework since the late 1980s. A system of care is comprised of three (3) equally important components: Philosophy, Infrastructure, and Services & Supports.
The System of Care philosophy includes a Definition, a set of Core Values, and Guiding Principles that operationalize the definition and guiding principles. Kentucky has adopted the recently updated SOC framework, including the components of the philosophy listed here.
SOC Philosophy

1. Definition.
A System of Care is a spectrum of effective community- based services and supports for children and transition-age youth (TAY), with or at risk of behavioral health needs or other challenges, and their families that...
• Is organized into a coordinated network,
• Builds meaningful partnerships with families and youth, and
• Addresses their cultural and linguistic needs
...in order to help them function better at home, in school, in the community, and throughout life.

2. Values.
A System of Care Is:
• Community-based
• Family- and Youth-driven
• Culturally- and Linguistically-responsive

3. Guiding Principles.
Children, Youth, and Families Have Access to:
A comprehensive array of services and supports that are:
• Individualized, strength based
• Trauma-informed
• Developmentally appropriate
• Provided in the least restrictive, natural environment
Utilizing:
• Evidenced-informed practices and practice-based evidence
• Partnerships with families and youth at all levels
• Interagency collaboration at the system level
• Care coordination at the service delivery level
• Health-mental health integration
• Public health approach
• Mental health equity
• Data driven and accountability
That protect their rights protection and advocacy.

SOC Infrastructure
Infrastructure includes but is not limited to processes and structures for:
• establishing a point of accountability for policy and system management and administration (governance);
• developing and implementing strategic planning, including for communications and social marketing.
• financing for infrastructure and services;
• building and sustaining partnerships among family organizations and leaders, youth organizations and leaders, child serving agencies, and community based organizations;
• coordinating outreach, information, and referral efforts
• recruiting and retaining a competent workforce

Governance. Kentucky is fortunate to have a long-standing governance structure in place. The State Interagency Council (SIAC) for Services and Supports to Children and Transition-Age Youth was established by statute in 1990 to serve 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 served as the governing body for all past and present SAMHSA SOC and adolescent CSAT grants, as well as other federal grants (suicide prevention; healthy transitions; Children's Bureau trauma; and others) and state-level initiatives focused on these populations and their families. The SIAC members include:

• Commissioner-level representatives from 12 state agencies (across five Cabinets) that serve children, transition-age youth, and their families;
• Nonprofit Family Organization;
• Youth Representative;
• Parent Representative; and
• Subcommittee for Equity & Justice for All Youth (SEJAY).

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 standing committees that support the work of the SIAC. The standing committees are: Social and Emotional Health and Wellbeing; Racial, Ethnic, and Equity Disparities; Service Array, and Disabilities. The SIAC meets monthly and works in alignment with its two-year strategic plan. Standing Committees meet monthly and complete tasks identified on SIAC's multi-year strategic plan. Eighteen (18) Regional Interagency Councils (RIACS) with similar membership serve as regional loci of accountability for the system of care by:

• Conducting regional system of care planning and operations
• Coordinating system-level continuous quality improvement
• Identifying and developing system of care expansion opportunities
• Promoting system of care awareness
• Initiating and adopting interagency agreements as necessary for providing services & supports to children and transition-age youth with behavioral health needs by agencies on the RIAC
• Advising the SIAC regarding the system of care within the region

RIAC membership is similar to that of the SIAC, with the flexibility to add members based on identified regional needs.

These statutorily mandated bodies craft policy aimed at providing services and supports with children, youth, and transition age youth with or at risk of developing a SED, and their families, that align with the system of care philosophy, comprised of a definition, core values, and guiding principles. This approach ensures that an individualized, collaborative, and integrated approach to planning, coordinating, delivering, and evaluating services and supports for children, youth, and transition age youth with or at risk of developing a SED and their families.

Integration with Physical Health

The system of care framework is built around guiding principles that include the integration of physical and mental health, as well as the adoption of a public health model of care, prioritizing equitable access, services, and outcomes across the continuum of promotion, prevention, early intervention, treatment, and recovery so that services and supports can be put in place to ameliorate symptomology as early in the course of treatment as possible. The interface between the physical healthcare system and the behavioral healthcare system is of growing importance to service providers as well as families. A significant amount of behavioral health care is provided via the physical health provider network, particularly for children. Historically, data has indicated that of Kentucky's children with SED, approximately 50% have a co-occurring chronic physical health condition (i.e., asthma; diabetes; obesity). Given the complexity of these co-occurring conditions, screening, early identification, referral to treatment when indicated, and collaborative of care across the continuum and multiple systems is critical to ensure that providers are not working at cross purposes and that children and families receive timely, appropriate, and effective care.

Community Mental Health Centers (CMHCs) are required to conduct physical health screening of all clients served. Department staff assist contracted providers in improving tools used to screen for and identify potential physical health concerns and to encourage further assessment and integration of physical and behavioral healthcare as well as referral for services elsewhere, when indicated. Four (4) of Kentucky's fourteen CMHCs are participating in a Center for Medicaid and Medicare Services Certified Community Behavioral Health Clinic Demonstration (CCBHC) project. As part of the demonstration, demonstration sites are exploring best practices for integrating primary care screening and monitoring into their service arrays.

Kentucky Strengthening Families

Kentucky is using a nationally recognized strategy, Strengthening Families: A Protective Factors Framework. This approach is coordinated nationally by the Center for the Study of Public Policy. Kentucky Strengthening Families (KYSF) is supported by the Governor's Office of Early Childhood, the Kentucky Department for Public Health, and other state agencies. KDBHDID staff serve on its Leadership Team, subcommittees, and training cadre. KYSF represents a multi-disciplinary partnership of more than 20 national, state, and local, and public and private organizations dedicated to embedding six research-based Protective Factors into services and supports for children and their families and fits well within the system of care (SOC) framework, particularly with promotion and prevention efforts. Supporting families is a key SOC and KYSF strategy to promote school readiness, social-emotional well-being, and preventing child abuse and neglect. All families experience stress and research demonstrates that children grow and learn best in families who have the supports and skills to deal with stress in healthy, effective ways. KYSF protective factors have been embedded into CMHC contracts and DBHDID's approved Trauma Informed Care training curriculum to support their adoption by provider agencies, programs, and staff.

SOC Services and Supports

Mental Health and Rehabilitation Services. All CMHCs have a designated Children's Service Director. These Directors, along with

other leaders, seek to ensure that the mental health and substance use service and support needs of children and families within their regions are evaluated and addresses in a structured, yet flexible manner. Reflective of the system of care framework, services and supports are designed to meet the holistic needs of children with a SED, as well as those of all children served within their respective regions, and their families.

A review of the information from the CMHC Annual Plan and Budget applications submitted in April 2023 reveals that CMHCs strive to address barriers and meet the clinical service needs of children and families. Some examples include:

• All CMHCs offer off-site therapy services in home, school, other community settings;

• The CMHCs employ 160 Service Coordinators to provide targeted case management to children and adolescents with SED and another 26 Service Coordinators are trained and serve as High Fidelity Wraparound Facilitators;

• All CMHCs have positions for 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. The regions reports employing 105 additional staff who have experience serving this population;

• All CMHCs employ clinicians who are trained to and routinely serve transition aged youth, with a total of 505 staff trained;

• All regions employ clinicians who are trained and routinely serve youth with substance use concerns with a total of 335 staff trained;

• Eleven (11) CMHCs employ Youth Peer Support Specialists (YPSS) with a total of 51 YPSS employed; and

• Twelve (12) regions employ Family Peer Support Specialists (FPSS) with a total of 25 FPSS employed.

Kentucky's Medicaid State Plan includes the Rehabilitation Option for mental health and substance use, including statewide coverage for therapeutic rehabilitation and targeted case management for children with SED. Kentucky Interagency Mobilization for Progress in Adolescent and Child Treatment (IMPACT) programs within each CMHC offer targeted case management services that adhere to the values of wraparound, as well as the more intensive care coordinator approach of High Fidelity Wraparound to children with more complex needs, to ensure that children with SED and their families receive needed services and supports. More than $5 million in state general funds is allocated to support Kentucky IMPACT. These funds are used to support program operation, including staff administrators, high fidelity wraparound support, and flexible funds to meet the needs of children, youth, and families. Many CMHCs offer comprehensive community support services in their IMPACT programs and in traditional outpatient services. Community Support Associates serve as mentors and coaches who support children and youth in improving life skills such as organization; impulse control; socialization; coping strategies; job seeking; and budgeting. Services may occur on or off site to allow for more practical experiences in natural environments. Peer Support Specialists, both Family and Youth, are also available through IMPACT and traditional outpatient services. The majority of IMPACT services occur in the home, school, or community setting. Some regional IMPACT and outpatient programs also offer after-school and/or extended summer programs at which children receive individual and group therapeutic services, as well as mentoring and other supports, allowing for continued clinical and supportive services during less structured times.

A list of community-based services available through for children, youth, and families through the CMHCs is provided below. This grid is updated annually based on required Plan and Budget submissions from the fourteen (14) CMHCs. Information was taken from SFY 2024 plan submissions, received in April 2023.

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 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 X
Outpatient Clinical: Family 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 X
Intensive In-Home Services X X X X X
Intensive Outpatient Program X X X X X X X X
After School Program X X X X X X
Day Treatment Program X X X x X X
Partial Hospitalization 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
Comprehensive Community Support Services X X 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 X
Parent/Family Peer Support-individual X X X X X X X X X X X X
Parent/Family Peer Support-group X X X X X X X X X
Respite Care X X X X
Service Planning 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 X

Therapeutic Foster Care X X
Recovery Supports X X X X X X X
IPS Supported Employment X X X X X X X X X X X
Drop-in Center for Transition-age Youth X X X X X X X
Early Childhood Consultation X X X X X X X X X X X X
Coordinated Specialty Care for Early Psychosis X X X X X X X

Employment Supports. 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/first episode psychosis (iHOPE), the Kentucky Partners for Youth Transitions, and collaboration with IPS supported employment training and coaching for the adult population. Recently, Kentucky was chosen to be part of a National Institute of Disability, Independent Living and Rehabilitation Research (NIDILRR) Field Initiated Research Grant to evaluate the effectiveness of IPS Supported Employment for young adults aged 16-24 with behavioral health issues in five different states. This has led to incorporating specialized youth/young adult focused IPS staff within two CMHCs. It is expected that this model will continue to develop throughout other areas of the state in order to better serve the employment and education needs of youth and young adults. In May 2023, a SAMHSA Supported Employment grant was submitted that will focus on young adults with SMI who are in need of supported employment and education supports. This opportunity will increase the potential to provide specialized supports to this population and increase their potential at success in young adulthood.

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 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 SIAC as an 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 issues will have earlier, faster, and easier access to the developmentally appropriate care that they need. The KPYT presently provides state level oversight over the Healthy Transitions grant through SAMHSA.

Housing Supports. The CMHCs 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 the Department for Juvenile Justice (DJJ) to maintain children in their own homes and communities whenever possible and when in the best interest of the child.

TAYLRD Drop-in Centers operate in 12 counties within Kentucky. These Centers are operated through the CMHCs and act as an access points for youth and young adults in the communities they serve. Young people can call or come into these Drop-in Centers during open access hours to receive behavioral health support such as peer support and clinical services in addition to assistance in finding housing and other resources to meet their needs.

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 CMHCs, under contract with the DBHDID, do offer a limited amount of residential care. Therapeutic foster care is offered in two of the 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 state agencies to ensure that the behavioral health needs of children are appropriately identified and addressed. DCBS and DJJ contract with CMHCs and private providers to meet the behavioral health needs of children in their custody.

Education Supports. (Including services provided by local school systems under IDEA)

DBHDID staff collaborate extensively with state and local educational agencies in support of the Individuals with Disabilities Education Act (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 both the CMHCs and school districts on approaches to school-based behavioral health delivery options and models. These have been well attended and partnerships between school districts and CMHCs continue to grow statewide.

As in other states, Kentucky educators are reporting an increase in the behavioral health needs of students. Kentucky's Lt. Governor is using her platform to bring attention and resources to this challenge. Lt. Governor Coleman worked with the KY Student Voice Team to have students in KY schools inform her office's student behavioral health efforts. The DBHDID supported this work by providing clinical and other supports for those meetings and also have used members of the Student Voice Team to inform its work. The Lt. Governor recently announced $40 million in funding to build our state's behavioral health workforce and to provide services for P-12 students. The funds were secured by state education cooperatives through federal funders.

Kentucky's Department of Education (KDE) was awarded federal grants to address violence prevention and behavioral health promotion. Both Project AWARE (Advancing Wellness and Resilience in Education) and School Climate Transformation grants have resulted in efforts designed to train school staff to identify students' behavioral health needs and to increase effective

communication between school staff and behavioral health providers. KDE's Project AWARE is being implemented in three of the state's largest school districts. One Kentucky educational cooperative was recently awarded a Project AWARE grant and three additional counties will be covered through that initiative. A state-level behavioral health program administrator located within DBHDID is staff on both of those initiatives. However, collaborative efforts are not limited to those six districts. Kentucky's programs include emphasis on Trauma-Informed Care, Resilience Building, and educating school staff regarding Secondary Traumatic Stress, promoting these via learning collaboratives. In addition, DBHDID collaborated with KDE to expand student access to TARGET (Trauma Affect Regulation Guide for Education and Therapy) statewide. The multi-disciplinary management team includes members from several different agencies including DBHDID and also includes young adults and family members with lived experience.

The DBHDID is also working with KDE to address educational inequity via a Data for Truth and Action Collaborative. Kentucky participates in a three-state effort to use different data sources to address systemic inequities. KY has identified racial inequities in substance misuse discipline responses and is working with The Center to Improve Social and Emotional Learning and School Safety team at WestEd to formulate a plan to call attention to this issue and to disseminate information regarding best practices to address the challenge.

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.

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 for Juvenile Justice
• Department for Community Based Services
• Department for Behavioral Health, Developmental and Intellectual Disabilities
• KY School Boards Association
• 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 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.

Chaired by the Division of Exceptional Children within KDE, the Kentucky Interagency Transition Council for Persons with Disabilities is made up of more than 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. The Council was at the forefront of meeting accessibility, using a hybrid (virtual and in-person) meeting format prior to the pandemic, which allowed more participation from a much broader audience.

Substance Misuse Prevention and SUD Treatment. Substance use among youth and their caregivers is often identified by CMHC clinicians as a contributing factor to the poor mental health and overall wellbeing of individuals they serve. Funding for substance use treatment for youth has improved in recent years and the use and misuse of nicotine, alcohol, inhalants, prescription and illegal drugs are addressed in the treatment provided. While outpatient clinicians and case managers continue to collaborate with service providers, each CMHC also receives funding to support a full-time Youth Co-Occurring Treatment Coordinator (YTC). The YTCs are tasked with partnering with local 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. The YTCs have more flexibility than outpatient clinicians as they are considered a hybrid of a direct service provider as well as a community-based employee; they are hired with the intention of maintaining their status as subject matter experts on youth co-occurring mental health and substance use, and evidence-based modalities to support these youth and their families.

Additionally, each CMHC includes a Regional Prevention Center that provides community-based promotion and prevention supports and works in collaboration with CMHC treatment staff to ensure a continuum of evidence-based/informed promotion, prevention, early intervention, treatment, and recovery services and supports is available.

Services and supports are provided primarily through contracts with CMHCs and their subcontractors, local governmental agencies, and other community-based organizations. The following are available include:

• Prevention programming in communities offered through 14 Regional Prevention Centers;
• Juvenile diversion programs, under age 21 DUI assessment and education programs;
• Consultation with businesses on the development of a drug-free workplace and employee assistance programs;
• Social setting withdrawal management; residential treatment; intensive outpatient; outpatient treatment; targeted case management; peer support
• Specialized treatment services for pregnant women, youth; and persons who inject drugs; and

• Medications for Opioid Use Disorder (MOUD) for opiate dependent persons who are high-risk for HIV due to injecting drugs.
The DBHDID 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 guiding DBHDID services 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 wellbeing of every Kentuckian. From peer pressure of youth to use illicit substances to the risks of being involved in a drunk driving accident, all Kentuckians are at risk for substance use related problems. The DBHDID has statewide responsibility for providing leadership and program direction for implementation of primary prevention, early identification (intervention), treatment, and recovery services and supports for children, youth, and adults with or at risk of developing substance use disorders.
Medical, Dental and Vision Care
Physical Health Care. CMHCs are required to complete physical health screenings for all new clients and to update this information at least annually. Combined data for 2020 and 2021 show that 25.5% of Kentucky children age 10-17 have a Body Mass Index (BMI) at or above the 95th percentile, thus meeting criteria for obesity, compared to 17% nationally. Kentucky children and youth (age 0-17) also rank lower than average in overall health status, with 88.6 percent of children being in "very good or excellent health" compared to 90.2 nationally (Data Resource Center for Child and Adolescent Health). Additionally, Kentucky children have high rates of asthma (10.6% of children 11 years old and younger, 13.6% of middle school students, and 11.8&% of high school students. Kentucky Department of Education (KDE) 2020 data lists asthma as the most common chronic disease in schools with more than 46,000 students diagnosed.
Community Health Centers (CHCs) have school-based clinics located in thirty-eight (38) counties across Kentucky. These clinics provide primary health care as well as oral health, substance use, and mental health services, to children and youth who may not otherwise be able to access health care. In 2022, Kentucky received federal funding to expand this network in order to improve access and decrease health disparities among youth.
As previously mentioned, four of Kentucky's fourteen CMHCs are part of a Center for Medicaid and Medicare Services Certified Community Behavioral Health Clinic Demonstration (CCBHC) project and are integrating primary care screening and monitoring into their service arrays. Additional CMHCs have expressed interest in becoming CCBHCs.
The Kentucky Department for Medicaid Services (DMS) is engaging school districts to become certified as providers of School-Based Health Services (SBHS). Certification for SBHS authorizes local education agencies in Kentucky, including Kentucky School for the Deaf and Kentucky School for the Blind, to enroll as Medicaid Health service providers for children who are eligible under the Medicaid program and under the Individuals with Disabilities Education Act (IDEA). The program is designed specifically to allow school districts to act as health care providers and be reimbursed under Medicaid. District participation in SBHS will increase student access to physical health as well as services and supports aimed at treating mental health and substance use.
Oral Health Care. A 2005 report produced by the nonprofit group Kentucky Youth Advocates revealed that half of the state's children between ages two and four had cavities and that only a third of those children covered by Medicaid had used dental services in the past year. Oral health can impact behavioral health in several ways. Discomfort from untreated dental issues can result in inattentiveness, anxiety, fatigue, and acting out among children and youth. Children and youth may be self-conscious of unhealthy teeth and smiles, leading to anxiety, embarrassment, and withdrawal. Finally, chronic pain may result in overuse of prescription pain medication or illicit substances, increasing the risk of substance misuse among youth. Thus, it is important that CMHCs and other behavioral health providers strive to connect children and youth to accessible, affordable, high quality oral health care.
Of equal importance is collaboration at the state level. Two (2) agencies co-located in the Cabinet for Health and Family Services with DBHDID are working to improve oral health care for children, youth, and families. The Kentucky Department for Medicaid services (DMS) contracts with managed care organizations to provide oral health 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. The Kentucky Department for Public Health (DPH) 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.
University Colleges of Dentistry are also committed to improving the oral health of Kentucky's children and youth. The University of Kentucky College of Dentistry in coordination with other agencies provides myriad 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 elementary schools in three 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 months and 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.
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. The Coalition is focusing on two primary areas through 2025: improve oral health awareness and improve access to oral health care.
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, four, five, or six 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. Addressing dental health care needs has been found to reduce the number of school days that Kentucky's students miss due to pain associated with dental problems.
Vision Health 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. The 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 14 CMHCs offer consultation and education regarding behavioral health care and services for children, youth, and families within their communities, as well as connections to services and supports available through partner agencies. This is in addition to the ancillary support services that CMHCs directly provide as part of the children's array and indicated in the service/support array grid provided above. These non-clinical supports include, but are not limited to:
• Respite;
• Intensive in-home;
• After school programs;
• Family peer support;
• Youth peer support;
• Specialized summer programs;
• Comprehensive community support;
• IPS Model of Supported Employment;
• Transition planning for transition age youth; and
• Youth and Family Engagement and Leadership support.
Family and Youth Voice. Across all regions of Kentucky, parent and youth voices are most consistently heard through their membership on Local and Regional Interagency Councils (LIACs and RIACs) and through leadership opportunities provided by Kentucky's Statewide Family Network grantee, Kentucky Partnership for Families and Children Inc., (KPFC). The DBHDID has maintained contracts with multiple funding sources with KPFC aimed at elevating the voices of youth and families at all levels of the SOC. KPFC works to ensure "that all families raising youth and children affected by behavioral health challenges will achieve their fullest potential." KPFC's mission is to empower families affected by behavioral health challenges to initiate personal and systems change. The board of directors consists of 21 to 31 members: 12 parent representatives from various community mental health center regions, two transition-age youth representatives, seven child-family serving agency representatives, and 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.
KPFC's programs and/or activities include:
• Dissemination of a quarterly newsletter to more than 3,000 members;
• Participation on numerous 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 and youth to access information about KPFC and resource information statewide;
• Provision of an infrastructure for Kentucky Youth MOVE, a chapter of Youth MOVE National, 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 CMHCs to establish and support Regional Youth Councils and to assist in the identification of youth leaders;
• Distribution of resource information and learning opportunities for families raising young children from birth to five that have an emotional-social delay;

• Opportunities for youth (13-26 year old) with behavioral health challenges and their parents to learn, connect and network as part of the youth and parent movement; and
• Strengthening of Kentucky's family- and youth-driven system of care.
Early Childhood Mental Health. DBHDID and the Department for Public Health (DPH) have co-administered Kentucky's statewide Early Childhood Mental Health (ECMH) Program since its inception in 2003. Funds are contracted to the CMHCs for regional program administration. he 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 and their families.
The ECMH program is funded with Master Tobacco Settlement Funds awarded to DPH for maternal and child health. Funds support one full-time equivalent ECMH Specialist position in each of the 14 CMHC regions. The Specialists' time is devoted solely to their regional ECMH programs, aimed at building the capacity of regional providers to better meet the social, emotional, and behavioral needs of children birth through age five and their families. In recent years, State Opioid Response funds were utilized to establish Early Childhood Consultant (ECCs) positions in each CMHC. The 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. Consultant positions are being sustained with tobacco settlement funds for pregnant and parenting women.
Treatment 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 is located within the CMHCs children's services division and serves as the regional subject matter expert in youth substance use and co-occurring substance use and mental health disorder treatment. The coordinator collaborates and coordinates 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. The coordinator keeps 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.
Resources.
Stroul, B.A., Blau, G.M., & Larsen J. (2021). The Evolution of the System of Care Approach. Baltimore: The Institute for Innovation and Implementation, School of Social Work, University of Maryland.
Adults with SMI
Physical Health and Oral 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, 2021, from the Center for Disease Control (CDC), analyzed health data through 2018. This report acknowledges that 37.3 million Americans have diabetes, and 96 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.
CMHCs 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 2024 Plan and Budget submissions indicated six of the 14 CMHCs are currently providing primary care services to individuals they are serving in their programs while three provide minimal services such as physicals or contract out to physical health providers. Four (4) of those CMHCs are now credentialed as Certified Community Behavioral Health Clinics (CCBHC).
All 14 CMHCs reported having some type of formal agreement with a least one 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" is co-located in the lower level of the CMHC outpatient clinic in Johnson County, a very rural location in Kentucky, and provides 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 Homeplace Clinics, one that focuses specifically on 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.

Northern Kentucky (NorthKey) operates three 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 are not able to afford dental care but who earn too much money to qualify for Medicaid assistance). There are four dental vans from the University of Kentucky. Several faith-based organizations have provided the financial support needed to start these services and to keep them operating. In addition, some faith-based groups have opened free clinics in church buildings, which are staffed by volunteer dentists who come to the region from all over the state for weeklong mission trips. 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 CMHCs. The grid is updated annually based on required Plan and Budget submissions. This grid is populated from April 2023 submissions as plans for SFY 2024.

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 X |
| Consumer Operated Services Program (COSP) | X X X X X X X X X |
| Social-Club Drop-In | X X X X X X X |
| Local NAMI Kentucky Affiliates | X X X X X X X |
| Consumer Conferences | X X X |
| Crisis Services | |
| Emergency-Help Line | 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 |
| Mobile Crisis Services | 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 X X |
| Intensive Outpatient Program for MH | X 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 X |
| Flexible Funds for SMI (Wraparound Funds) | X X X X X X X X X X X X X |
| Payee Services | 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 X |
| Educational Services (Supported Education) | X X |
| Illness, Management and Recovery (IMR) | 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 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 |
| Housing Development | X X X X |

Mental Health Disorder Treatment

Each regional board provides a full array of outpatient services including, but not limited to, screening, assessment, person centered treatment planning, individual psychotherapy, group psychotherapy, psychiatric evaluations, walk-in emergency appointments, psychopharmacology, assertive community treatment, targeted case management, and peer support. 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 missed appointments;

• Assuring medication continuity within the agency when level of care changes;

• Addressing shortages and turnover of professional staff, especially prescribers, increasing waiting periods for appointments;

• Assuring continuity of care between CMHCs and inpatient settings or other community providers, thereby ensuring quality, holistic care;

• Screening adequately for substance use disorders/co-occurring disorders/early psychosis; and

• Providing opportunities for staff training in co-occurring mental health and substance use disorders (screening, assessment, and treatment).

Substance Misuse Prevention and SUD Treatment

Kentucky Medicaid reimburses for a variety of SUD services including but not limited to screening, assessment, Brief Intervention and Referral to Treatment (SBIRT), targeted case management, MOUD, individual/group/family therapy, and peer support. In addition, an array of crisis services including Crisis Intervention, Residential Crisis Stabilization Services, and Mobile Crisis Services are Medicaid reimbursable for individuals with SUD.

Additionally, each CMHC includes a Regional Prevention Center that provides community-based promotion and prevention supports and works in collaboration with CMHC treatment staff to ensure a continuum of evidence-based/informed promotion, prevention, early intervention, treatment, and recovery services and supports is available.

Additional substance use specific services provided through contracts with CMHCs include:

• 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 additional outpatient services;

• Specialized treatment services for pregnant women, adolescents and persons who inject drugs, and

• Medication for opioid use disorder (MOUD) to opiate dependent persons who are high-risk for HIV disease due to injecting drugs.

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 DBHDID 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) and10 (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), treatment and recovery for persons who are affected by substance use.

Services for Persons with Co-Occurring Mental Health/Substance Use Disorders

It is well known that a large percentage of individuals with mental health disorders also have substance use disorders. Traditional silos have been challenging in the quest for integrated evidence-based care for these individuals. Efforts by Kentucky to support integrated care 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 disorders;

• Utilization of the Dual Diagnosis Capability in Addiction Treatment (DDCAT) and the Dual Diagnosis Capability in Mental Health Treatment (DDMHT) tools in reviewing local programming;

• Including administrative staff for co-occurring substance use and mental health disorders in both the Division of Substance Use Disorder and the Division of Mental Health;

• Requiring in contracts with CMHCs 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;

• Supporting the creation and maintenance of support groups such as Double Trouble in Recovery (DTR) through advocacy organizations staffed by individuals with lived experience in co-occurring disorders;

• Encouraging the use of Integrated Dual Diagnosis Treatment (IDDT) in ACT teams and outpatient service settings;

• Providing training and consultation to Coordinated Specialty Teams regarding how to identify co-occurring substance use disorder, and how to treat it in tandem with first episode psychosis; and

• Providing workshops at Kentucky School (which has traditionally been designed for substance use disorders) that focus on integrated treatment and mental illness.

Division of Mental Health staff have begun reviewing service data for individuals with co-occurring disorders in an effort to identify intervention points that will assist with statewide implementation of integrated care. One data point identified is that although 11 CMHCs currently report providing integrated care through the mental health system (including individuals with SMI), there is no service code for "integrated treatment" thus treatment provided cannot be captured adequately. Treatment is shown as individual or group therapy, but it is unknown if evidence-based integrated treatment is truly being provided to individuals

identified as having co-occurring disorders. Work continues to be done in this area.

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 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 principles 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 CMHCs, 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;
• Permanent supportive housing; 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 CMHCs in a variety of ways:

• The Division of Mental Health designates a statewide Community Support Program (CSP) coordinator;
• Contracts with CMHCs 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 provided to regional programs in how to incorporate psychiatric rehabilitation technology into daily programming. As of SFY 2023, 12 CMHCs provide therapeutic services for individuals with SMI;
• The Division of Mental Health (DMH) designates a statewide Individual Placement and Support (IPS) Supported Employment coordinator;
• Collaboration between the DMH 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. In addition to a DMH program administrator, a full time IPS coordinator, and several additional fidelity reviewers, coaches and trainers are available to work on IPS implementation, within an infrastructure that was developed with a steering committee. Growth continues with IPS in Kentucky;
• The DMH, 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 CMHCs require all regions to provide access to ACT, IPS Supported Employment, and Peer support services for adults with SMI. As of SFY 2023, all CMHCs across the state are providing ACT services to adults with SMI, IPS Supported Employment and adult peer support services to adults with SMI;
• Eight (8) CMHCs are providing access to Illness, Management and Recovery (IMR) services, an evidence-based practice for adults with SMI;
• Twelve (12) CMHCs 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) CMHCs 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. 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. Several initiatives are in progress regarding supported education in Kentucky.

One of the key components to rehabilitation services is housing. It is difficult to focus on anything except where you will live if you do not have a place to live. DBHDID requires via contract for CMHCs to provide supportive housing services in accordance with the SAMHSA Permanent Supportive Housing Toolkit, and to conduct an annual self-assessment of supportive housing services using the SAMHSA Permanent Supportive Housing fidelity scale. Additionally, DBHDID contracts with other community partners to provide supportive housing services.

Twelve (12) of the 14 CMHC's have developed housing units covering the wide range of those they serve. As of the plans submitted in April of 2023, the total units owned and operated by CMHC's across the Commonwealth is 967. Many of these units are embedded in local mainstream housing that is owned and/or operated by the CMHC.

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

Quality, timely service 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;

• Most funding sources other than Medicaid do not reimburse for TRP, ACT or peer support services, 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 separate Managed Care Organizations (MCOs), has led to numerous difficulties with authorizations for TRP, ACT and other rehabilitation services. Each CMHC must have contracts with each of the six MCOs and negotiate for each service;

• 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.

**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 a separate Kentucky' 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/titles/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/titles/907/015/060/

• Reimbursement provisions and requirements regarding TCM for individuals with SMI and children with SED. https://apps.legislature.ky.gov/law/kar/titles/907/015/065/

• Coverage provisions and requirements regarding TCM for individuals with SUD. https://apps.legislature.ky.gov/law/kar/titles/907/015/040/

• Reimbursement provisions and requirements regarding TCM for individuals with SUD. https://apps.legislature.ky.gov/law/kar/titles/907/015/045/

• 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/titles/907/015/050/

• 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/titles/907/015/055/

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 56% (44,178 of 79,196) of the estimate number of individuals with SMI and 7.4% (5,847) of those individuals receiving TCM services, during SFY 2022. Based on an estimated prevalence rate of 5% of the child (under age 18) population in Kentucky, the CMHCs served approximately 43% (21,441 of 49,756) of the estimated number of those individuals with SED and 7.9% received TCM (3,910) services, during SFY 2022 (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.

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 14 CMHCs, DBHDID

requires each region to provide an outpatient appointment for adults with SMI within 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 14 calendar days. Since SFY 2013, CMHC 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 14 calendar days of release.

The CMHCs and the state operated/contracted psychiatric hospitals must work closely together to assure continuity of care. All contracts with these entities 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. 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, are agenda items.

• 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 more than 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 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".

DBHDID, through contracts with CMHCs, has been strengthening the system of care for adults with SMI by enhancing 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 co-occurring substance use disorders. 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.

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

N/A

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 | 79,196 | 44,178 |
| 2.Children with SED | 49,756 | 21,441 |

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 serious mental illness were based on national research. In 1980, the U.S. Department of Health and Human Services 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.

In 1962, as Kentucky was writing statutes and regulations for the creation of the Community Mental Health Centers, the first Kentucky statute was written that outlined a definition for chronic mental illness (CMI) as serious mental illness was first known in Kentucky. That statute, KRS 210.005, https://apps.legislature.ky.gov/law/statutes/statute.aspx?id=54182 still exists and has the following broad definition for SMI for Kentucky:

"Chronic" means that clinically significant symptoms of mental illness have persisted in the individual for a continuous period of at least two (2) years, or that the individual has been hospitalized for mental illness more than once in the last two (2) years, and that the individual is presently significantly impaired in his ability to function socially or occupationally, or both.”

During the 1990s a work group comprised of consumers, family members, and providers reviewed the federal definition and Kentucky's statutory definition of “chronic mental illness” and assisted in creating Kentucky’s definition of “adult with serious mental illness,” as currently operationalized. This definition is narrower than the definition promulgated in the federal register for “Adult with Severe and Persistent Mental Illness”, and uses the following criteria for age, diagnosis, disability, and duration:

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

Historically, stakeholders have supported the Department's desire to focus limited funding on adults who meet the state's narrower definition. Kentucky's mental health planning has historically focused on this subset of the population in development of its Community Support Program system of care.

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).

Kentucky uses the federal SPMI prevalence rate of 2.6% and the 2020 census data to estimate the percentage of the population of focus served by the Regional Boards during SFY 2022.

The following denotes the adult population and the estimated number of adults with serous mental illness (SED), thus percentage served:

2020 Adult Census – 3,045,985
Estimated number of adults with SMI (2.6% of Kentucky's adult population) – 79,196

Number of Adults with SMI served in SFY 2020 – 43,410 or 50%
Number of Adults with SMI served in SFY 2021 – 43,326 or 55%
Number of Adults with SMI served in SFY 2022 – 44,178 or 56%

Estimate of Prevalence – Children's Mental Health

Using 2020 census data and the state's agreed upon prevalence rate estimate of five (5%) percent, CMHCs are aware of the number of children in potential need of services. The CMHCs 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 is experiencing 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 serious emotional disturbance (SED) and thus percentage served:

2020 Child Census – 995,111
Estimated number of Children with SED (5% of Kentucky's child population) – 49,756

Kentucky Children with SED Served SFY 2020 – 24,094 or 47% (of the 5% SED population)
Kentucky Children with SED Served SFY 2021 – 20,082 or 40% (of the 5% SED population)
Kentucky Children with SED Served SFY 2022 – 21,441 or 43% (of the 5% SED population)

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

N/A

## 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 IDEA | 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 systems | Yes No |

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

N/A

**A system of care is: A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.*
***https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf***

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. **See SAMHSA's Rural Behavioral Health page for program resources**

Children with SED and their families. A primarily rural state, 102 of Kentucky's 120 counties are considered Rural or Designated Eligible Census Tracts in Metropolitan Counties by the Health Resource Service Administration HRSA). Rural counties are disproportionately impacted by poverty and families living in rural areas frequently do not have access to reliable transportation, and with few exceptions, public transportation is non-existent. As a result, many children are not able to travel to service providers, and service reimbursement rates do not include travel time, so home-based services are not consistently available across the state. In addition to challenges faced by families, provider agencies in rural areas also experience challenges in serving children and families in the communities that they serve. Rural county offices often have a minimal number of staff with clinicians who serve all ages of service recipients; access to clinicians who specialize in services for children and families is often limited. To better meet the needs of children and their families, Community Mental Health Centers (CMHCs) employ Targeted Case Managers, High Fidelity Wraparound Facilitators, Community Support Associates, and Family and Youth Peer Support Specialists to assist with outreach to and engagement of families in rural areas. These staff have more flexibility in their schedules that allows them to travel to meet families in locations that are easy for them to access. These staff can access limited amounts of flexible funding are available to children with SED and their families to provide necessary goods and services for which there is no other source of payment. They also collaborate closely with other community agencies and non-profit organizations that may offer transportation, childcare, and other types of assistance to families. School-based clinicians and supportive staff collaborate with Local Education District Directors of Pupils and Personnel, District Homeless Coordinators, and Family Resources/Youth Services Center staff to identify children with SED. They work together with families and other community and natural supports to identify and prioritize needs, including mental health and substance use issues, and connecting with those who can support the safety, health, and wellbeing of children with SED and their families.

KY River Community Care provides youth crisis housing support for youth and young adults in nine counties within rural eastern Kentucky (Perry, Letcher, Knott, Knox, Whitley, Bell, Clay, Harlan, and Leslie Counties). The McDaniel House is an emergency housing option for youth 18-24 years old. Each home provides stable short-term housing as youth are placed on a voucher list for longer term housing support. They offer case management, behavioral health services, and community support services. They are open 7 (seven) days per week to guide young people in setting and achieving goals to support their transition to long term independent housing. The Host Home Program allows individuals 14-24 to be housed in a stable home environment with host families. The program provides financial assistance in the form of a monthly grocery and travel stipend as well as behavioral health supports such as case management and clinical services. Host Homes are typically extended family, friends, teachers, or other adult support people who take in a young person to keep them from experiencing homelessness.

Adults with SMI. Three of the most common barriers to mental health services in rural areas of Kentucky 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. Adult peer support specialists are critical in the continuum of rural behavioral health care, to enhance meaningful access, engagement and outcomes.

Transportation barriers remain one of the greatest concerns among providers, service recipients 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 transportation regions statewide operate 24 hours a day/seven days a week with a single broker or broker/provider established in each region. Service recipients access transportation services through a toll-free phone number. Eleven of the fourteen CMHCs report engaging in initiatives to better coordinate transportation services for adults with SMI in their regions. When no other source of funding is available, flexible funding for individuals eligible for targeted case management services may be utilized for transportation costs.

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 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 14 CMHCs now report delivering or accessing services through the telehealth network. Examples of how the CMHCs 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 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 addition, 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 the pandemic, outpatient therapy services are being offered/delivered via telehealth or telephonic platforms, in addition to traditional service methods. Involuntary psychiatric hospitalization petition 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 10 counties to increase access to providers with therapy services, medication 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 rural counties in their region.
• Seven Counties Services sites all have a telehealth room for clients who walk in and need to be seen by providers at other sites.
• NorthKey continues to utilize telehealth for all clinical services when needed or requested. Clients are contacted by phone and asked if they would like to be seen via telehealth.
• Comprehend provides the majority of 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 pandemic, they provided telehealth services to as many clients as possible for all of their services. In addition, an Accessing Telehealth Through Local Area Stations (ATLAS) site was recently established to assist with telehealth access during times of natural disasters.
• 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. In addition, an ATLAS site was recently established to assist with telehealth access during times of natural disasters.
• 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 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.
• New Vista provides telehealth as a method for most services as needed or as requested.
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 people experiencing homelessness. **See SAMHSA's Homeless Programs and Resources for program resources**

Children with SED and their families. For the 2021-2022 school year, the Kentucky Department of Education (KDE) reported that 21,062 unduplicated children and youth from age 3-21 enrolled in public schools met the definition of being homeless. The KDE provides the most comprehensive definition and data for children experiencing homelessness. The KDE has adopted the McKinney-Vento definition of homelessness that is used by the US Department of Education. This definition is broader than the HUD definition, defining homeless students as 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.

McKinney-Vento Definition of Homelessness: https://nche.ed.gov/mckinney-vento-definition/

Each CMHC prioritizes services and supports to individuals experiencing homelessness and connecting with children who have SED and are experiencing homelessness (and their families) tends to be coordinated by children's mental health staff who work in accordance with the system of care framework and take a whole child/family approach to their work. In Kentucky, children experiencing homelessness can be found in both 'traditional' locations such as cities and larger metropolitan areas and in rural parts of the state, where they often stay with friends and family members for short, impermanent periods of time or in other non-home locations and are often transitory. Connecting with children who move frequently is difficult. Identification, outreach, and engagement strategies for children and youth experiencing homelessness are similar to those described above for those living in rural areas. CMHC staff also rely on teachers, child welfare staff, and community influencers to assist with location and engagement of children who are experiencing homelessness, with priority being given to ensuring the children's safety and basic needs.

Recently, DBHDID added funding to support a regional Transition Age Youth (TAY) Coordinator full time position in every CMHC. This peer group has been instrumental in identifying transition age youth and young adults with SED and SMI who experience homelessness and connecting them to services and supports aimed at stabilizing their living arrangements along with education, vocational, benefit, and employment supports.

Transition Aged Youth Launching Realized Dreams (TAYLRD) Drop-in Centers operate in 12 counties within Kentucky. These Centers are operated

through the CMHCs and act as an access points to youth and young adults in the communities they serve. Young people can call or come into these Drop-in Centers during open access hours to receive behavioral health support such as peer support and clinical services in addition to assistance in finding housing and other resources to meet their needs.

Adults with SMI, KDBHDID recognizes the importance of system coordination among the numerous agencies and programs involved with services to Kentucky's population experiencing homelessness. At the state level, KDBHDID participates in the Kentucky Interagency Council on Homelessness (KICH), a group of state and local providers, individuals with lived experience 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 supportive housing production.
The Council's Plan to Prevent and End Homelessness, 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 people experiencing homelessness, 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) have continued to collaborate on the SSI/SSDI Outreach, Access, and Recovery (SOAR) Initiative, developed a Case Management Manual for service providers for those experiencing homelessness and a Homelessness Rights Manual (both available on the KICH website), and have promoted education and training for discharge planning in public institutions. Efforts are also underway to increase access and availability of housing options for individuals experiencing homelessness through the promotion of the "Housing First" model.
Most Community Mental Health Centers offer individualized services designed to alleviate homelessness as well as to provide mainstream mental health treatment to persons who are experiencing homelessness and have a mental illness. Of the 14 Community Mental Health Centers in Kentucky:
• All CMHCs give a service priority to individuals experiencing homelessness;
• 10 CMHCs do consultation with local shelters;
• 10 CMHCs have staff dedicated to individuals experiencing homelessness;
• 10 CMHCs have staff that regularly visit local homeless shelters;
• 4 CMHCs have a walk-in clinic; and
• 3 CMHCs 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., provides outreach, case management and training in the Bowling Green / Warren County area.
• NorthKey Community Care utilizes a multidisciplinary outreach team employed by the CMHC to provide screening, treatment, and case management, and subcontracts with Welcome House of Northern Kentucky, a private non-profit shelter and homeless service provider, for case management and payee services. The program serves the northern region of Kentucky, just south of Cincinnati, Ohio. The majority of clients served in the PATH program come from Boone, Campbell, and Kenton counties, which are the urban areas.
• Seven Counties Services, 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 Behavioral Health provides outreach, case management and housing support services in Laurel County.
• Kentucky River Community Care provides outreach, case management, housing support services, and support for six emergency apartments for individuals experiencing homelessness who have a mental illness located in Hazard / Perry County, but which also includes individuals 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 CMHCs attempt to provide a statewide system of outreach, community support, and mental health services for persons with serious mental illness who are experiencing homelessness. The role of the State PATH Contact (SPC) is central to supporting local PATH providers throughout Kentucky. The SPC prepares the annual PATH application in collaboration with local providers, ensures that annual data collection requirements are met, and ensures 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, Adanta, LifeSkills, New Vista, the Housing and Homeless Coalition of Kentucky (HHCK) 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 Kentucky Housing Corporation (KHC) in the operation of local homeless planning boards ("Continuum of Care Committees") in Kentucky's area development districts (which correspond to the fourteen CMHC regions). CMHCs are encouraged to participate in this process for the benefit of individuals with serious mental illness who are experiencing homelessness or who 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 CMHC area, funded by Mental Health Block Grant funds. The goal of this program is the identification of individuals with serious mental illness who are experiencing homelessness and linkage with mainstream mental health services. Consultation and training for service providers of those experiencing homelessness is also provided under this initiative.

**c.** Describe your state's targeted services to the older adult population. **See SAMHSA's Resources for Older Adults webpage for resources.**

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 estimated to have a serious mental illness. Based on the 2020 Census population numbers, and utilizing the 2.6% federal formula, there is an estimated 26,493 Kentuckians over the age of 60 with SMI. In SFY 2022, Kentucky's CMHCs served 6,935 individuals over the age of 60 with a serious mental illness (SMI), accounting for 26% of the state's total estimate.
The diagnosis and treatment of serious mental illness can be more complex with older adults due to the presence of other health diagnoses. Additionally, there is an on-going concern regarding healthcare providers underdiagnosing depression, and other mental illnesses in older adults, 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 have not been adequately treated for their mental health issues due to lack of recognition of the problem, ageism, stigma, and lack of trained professionals who can identify and treat these mental health disorders.
Another issue affecting care for older adults with SMI is that they often have Medicare insurance coverage only, and many of the behavioral health services they need are not part of that benefit package. For services that are reimbursable, Medicare often will not reimburse for all available professional provider types. This is especially challenging in areas where workforce shortages and staff turnover have limited available provider types. There is a need for additional flexible funding to support the behavioral health services required for older adults.
Older adults with SMI have access to the full range of evidence-based services including permanent supportive housing, supported employment, assertive community treatment, peer support, targeted case management, crisis services, and others. Mental Health Block Grant and State General Funds support services for these individuals who might not have a payor for a service they need.
In Kentucky there are fifteen (15) Area Development Districts (Area Agencies on Aging), which focus on the needs of older adults and cover all 120 counties in Kentucky. The Area Agencies on Aging are under the umbrella of the Department for Aging and Independent Living (DAIL), a sister agency to DBHDID. DBHDID and DAIL collaborate on several initiatives including educational campaigns and conferences, the Interim Settlement Agreement and subsequent settlement agreements, and grant proposals related to aging.
A state-level Mental Health and Aging Coalition was created many years ago through partnerships with DAIL, the University of Kentucky Sanders Brown Center on Aging, the 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. DMH has traditionally 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 certification training for local coalition members in Mental Health First Aid for Older Adults.
The pandemic negatively impacted the state-level Mental Health and Aging Coalition through staff turnover, decreased meeting participation and decreased statewide program activities. Kentucky DMH is committed to addressing the behavioral health and wellness needs of older adults with serious mental illness. DMH is currently hiring a program administrator for mental health and aging programming and a team of staff from across the Department collaborate to address the needs of this population. Existing DMH staff have already created plans for revitalizing the state Coalition. The following goals for SFY 2024 were identified:
1. Revitalize the state Mental Health and Aging Coalition and include representatives from state and local government agencies, institutes of higher education, medical and behavioral health organizations, caregivers, persons with lived experience, faith based community members, and other stakeholders;
2. Develop a five-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, Question, Persuade, and Refer (QPR) Suicide Prevention, Whole Health Action Management (WHAM), behavioral health equity, cultural humility, Trauma Informed Care and Resiliency, Wellness Recovery Action Plan (WRAP), 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/start up grants for current and prospective local Mental Health and Aging Coalitions.

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

N/A

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.

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic for SAMHSA is increasing access to treatment for SMI and SUD using telehealth modalities. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client-provider interactions. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural or underserved areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access, the SAMHSA Evidence Based Resource Guide, **Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders**.

## Criterion 5

**a.** 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 as of April of 2023, approximately 663,176 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 for the first time.

As a result of these changes, DBHDID evaluated purchasing options, redesigned CMHC contracts and implemented performance-based contracting. In addition, the Cabinet for Health and Family Services (CHFS) contracts with Managed Care Organizations (MCOs) to coordinate behavioral health services for individuals with Medicaid across the state. As of SFY 2023, there are six MCOs coordinating these services. Providers 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. Providers are adjusting to the rollback of some of those relaxed requirements.

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.

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 use prevention, treatment, and recovery services block grant funds, to CMHCs 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 sheet with planned expenditures of mental health block grant funds outlines exactly how the funds are allocated for SFY 2024. State allocations work on an annual basis, so the exact allocations for SFY 2025 will be determined at a later date.

Component 2: Staffing

DBHDID contracts directly with each CMHC to provide direct services and each CMHC 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 includes 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.

With a broader array of behavioral health services reimbursable by Medicaid, and with the expansion of Medicaid provider types in Kentucky to others beyond CMHCs, staff retention remains an important issue for most CMHCs. In addition, the pandemic led to staff shortages and additional challenges in staff retention. DBHDID has provided support to CMHCs in efforts to assist with staff issues.

Component 3a: Training for Mental Health Service Providers

DBHDID strives to provide access to ongoing 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. When the pandemic shut down offices, DBHDID staff quickly adapted to Zoom technology and virtual connection software (Zoom, Teams, etc.) were purchased for DBHDID staff. Since early 2020, most meetings and staff trainings have occurred utilizing virtual means.

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 includes 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 the 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 paraprofessionals.

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 CMHC staff, to attend training events. Funds are also used to support technical assistance for the development and maintenance of adult and children's programming. (e.g., Targeted Case Management). The listing below shows DMH training and technical assistance initiatives.

Training/Technical Assistance for Providers and DBHDID Staff

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

Advancing Wraparound: Training 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.

American Sign Language Interpreter Peer Supervision Groups on Mental Health Interpreting training: 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.

Assertive Community Treatment (ACT) team leader technical assistance: DMH 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.

Behavior Institute: A two-day conference sponsored by the Kentucky Council for Children and Behavior Disorders, the Kentucky Department of Education, Kentucky's System of Care Five grant through DMH, Kentucky Autism Training Center and the Central Kentucky Special Education Cooperative.

Child and Adolescent Needs and Strengths (CANS): Functional assessment used for children with child welfare involvement through the Department for Community Based Services (DCBS). It is the outcomes management tool for High Fidelity Wraparound.

Cognitive Behavior Therapy for Psychosis (CBTp): Training for clinicians, regarding building skills to provide CBT with individuals experiencing psychosis, in particular with those experiencing their first episode of psychosis. This intense training includes follow up coaching and consultation with national experts for teams serving individuals with early psychosis.

Community Support Program (CSP) meetings: These meetings are hosted by DMH and held quarterly and are open to all CMHC CSP directors as well as other community partners who serve adults with SMI.

Creating Community Connections: A DBHDID sponsored statewide event focusing on educational opportunities for targeted case managers (SMI/SED/SUD), peer support specialists, community support specialists, and their supervisors across the state. This event is not offered every year but is well attended when offered.

Crisis Director's meetings: DMH 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.

DBHDID Orientation: Provided to all new staff hired by DBHDID. Enhances staff knowledge of the mission and vision of the agency, programs and services administered by the agency, and staff who lead those initiatives.

Deaf and Hard of Hearing Services Provider Symposia: Trainings that are offered quarterly to bring together Deaf and Hard of

Hearing service specialists as well as other CMHC staff who serve these individuals. Due to the lack of training in adjoining states, Ohio and Indiana usually attend as well.
Deafness 101: An 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: A set of eleven online modules that provide 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, including Coordinated Specialty Care (CSC).
Engagement in the Wraparound Process: Training 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.
First Episode Psychosis (FEP) Consultation: Monthly calls with national experts for each FEP team across the state to offer implementation support for CSC and guidance in serving this population.
Hearing Voices that are Distressing: Training 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 for those working with this populations. This training is provided by request.
Individual Placement and Support (IPS) Supported Employment: Quarterly IPS supervision meetings are held with IPS supervisors led by state IPS training/fidelity/coaching staff, regarding IPS services for adults with SMI and other populations. In addition, state IPS training staff offer IPS training regarding education and technical assistance with topics such as documentation, career profiling, recovery and self-care. Once a year, a statewide conference is held that includes IPS employment specialists, supervisors, the Office for Vocational Rehabilitation (OVR) staff, DMH staff, and others who seek information on IPS in Kentucky.
Introduction to Wraparound: Training provided 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.
Kentucky Behavioral Health Planning and Advisory Council Member Orientation: An annual orientation provided for all new Council members, including state agency representatives, or other interested parties. Led by members of the Council.
Kentucky Registry of Interpreters for the Deaf (RID): Training for interpreters for individuals who are Deaf or Hard of Hearing across the state.
Kentucky School of Alcohol and Other Drug Studies: An annual, weeklong event, sponsored by DBHDID, providing education from national and state experts regarding up and coming theories of practice in the field of behavioral health. This training has been held for over 40 years until the pandemic but is on track to occur again. Traditionally, this conference has had very large (over 800 people) attendance, and providers from Indiana and Ohio have attended. This event includes a track focused on services and supports for youth with SUD and co-occurring MH/SUD and their families, as well as additional sessions on co-occurring mental health disorders for adults.
Kentucky- System Transformation Advocating Recovery Supports (KYSTARS) conference: Annual statewide conference provided by DMH via contract with local NAMI affiliate. This conference provides an opportunity for peer support specialists, targeted case managers, and community support associates to receive annual education on recovery issues related to individuals with SMI/SED/SUD. This is event is low cost/no cost and provides continuing education credits to these providers. An annual award ceremony recognizing outstanding peer specialists in the community, is part of this event.
Mental Health Interpreting Peer Supervision Groups: Training provided in Northern Kentucky and Louisville areas (statewide as requested) providing support to interpreters. This peer supervision group is the only ongoing training of its kind in the country.
Multi Family Group Therapy: An evidence-based family psychoeducational/therapy model, particularly effective when working with families of individuals experiencing their first episode of psychosis. This training is offered virtually, several times each year, through national FEP partners. In addition, FEP programs in Kentucky also participate in monthly consultation calls with the national experts, specifically focused on implementing this practice.
Olmstead Housing Initiative (OHI) training: Provided by DMH in collaboration with the statewide housing agency to educate providers on processes to secure housing assistance in the form of OHI vouchers that can be used for some flexible housing needs for individuals with SMI who fit the Olmstead criteria.
Olmstead meetings: Statewide meetings held quarterly and hosted by DMH to provide education and technical assistance to all providers across the state who provide DIVERTS to individuals with SMI.
Parent and Youth Cafes: Based on Kentucky's Strengthening Families initiative, the Parent and Youth Cafes are offered by DMH in collaboration with Kentucky Partnership for Children and Families (KPFC). These offerings focus on the protective factors specific to families with children and behavioral health challenges.
Peers In the Know training series: Virtual training series designed to build peer knowledge and capacity, provided by DMH via a contract with an agency that houses the Center for Peer Excellence and provides education and support to all peer support specialists across the state, through these training events, newsletters and regular calls.
Projects for Assistance in Transition from Homelessness (PATH) briefings: Quarterly meetings hosted by DMH with all PATH recipients to strengthen collaboration efforts to assist individuals with SMI experiencing homelessness.
Regional Interagency Council (RIAC) learning series: A learning series that supports the regional system of care efforts. Topics are drive by RIAC and training is free and open to all RIAC members and system of care partners.
Structured Clinical Interview for Diagnostic and Statistical Manual 5 (SCID-5): This is an assessment tool used to more accurately diagnose behavioral health conditions as categorized in the DSM-5. Virtual trainings are offered several times per year through national First Episode Psychosis (FEP) partners, and FEP team staff receive this training.

Supported Housing Coordinator briefings: Quarterly meetings hosted by DMH with all CMHC housing coordinators providing a forum for statewide collaboration on efforts to attain and maintain housing for individuals with SMI.
System of Care Academy: Event sponsored by DBHDID that brings 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 topic that emerges throughout the year and is the focus of the plenary session.
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.
Transition Aged Youth Launching Realized Dreams (TAYLRD): A training that provides an overview of barriers, developmental issues, cultural issues and best practices when providing services and supports to transition age youth.
Trauma Informed Care: 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 that creates community partner trainers that will be able to provide general overview training on Trauma Informed Care for their local agencies.
Suicide Prevention Training/Technical Assistance Provided to the General Public and/or Providers:
Applied Suicide Intervention Skills Training (ASIST): Training to learn how to prevent suicide by recognizing signs, providing a skilled intervention, and developing a safety plan to keep someone alive.
Assessing and Managing Suicide Risk Outpatient (AMSR OP) : Teaches best practices in suicide risk assessments and how to determine the level of suicide risk for individuals. Focuses on clinicians and other healthcare professionals in outpatient settings.
Assessing and Managing Suicide Risk Direct Care (ASMR-Direct Care): Prepares non-clinical staff working in outpatient settings to provide confident and empathetic care to individuals at risk of suicide.
CODE Red: A universal safety planning intervention for suicide prevention.
Collaborative Assessment and Management of Suicidality – Educational (CAMS): Provides an overview of data and theories regarding suicide rates, information about the field of suicidology and suicide prevention. Used for large audiences of healthcare providers and administrators, as well as school districts.
Collaborative Assessment and Management of Suicidality (CAMS): Evidence-based assessment and treatment model regarding individuals at risk of suicide. Can be applied across treatment settings and with various clinical populations.
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.
Question, Persuade and Refer (QPR): A 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 suicide crisis. This program is 90 minutes in length and each participant receives a booklet containing the basic program information.
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.
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 Emergency Support Function (ESF) 8 – Public Health and Medical Services group. ESF is led by the Department of Public Health, a sister agency to DBHDID, within the Cabinet for Health and Family Services (CHFS). The ESF group assists with coordination of public health and medical related preparedness, response, and recovery activities for any incident/event (emergency, disaster, exercise, or planned event) that requires state-level coordination. One of the primary support organizations for the ESF is the Kentucky Community Crisis Response Team (KCCRT). This organization falls under DBHDID per statute approved during the 2023 legislative session and was created under Kentucky Revised Statutes Chapter 36 and Chapter 42. In the case of natural or manmade disasters, KCCRT is activated by a Governor's Disaster Declaration to provide psychological first aid to survivors. KCCRT also deploys upon request Rapid Assessment and Response Teams to first responders, and communities which are to mitigate stress reactions to critical incidents and traumatic events. In the past, the responsibilities for these services have been housed outside DBHDID. The movement of the entity to the Department for Behavioral Health, where it sits in most other states, allows for a synergistic response with other services provided through DBHDID, as well as the leveraging of additional resources to support survivors.
DBHDID, through KCCRT, is the state's designated entity to apply for and implement the SAMHSA/FEMA Crisis Counseling and the Disaster Case Management Grant funded programs. In FY 2022 and FY 2023, DBHDID managed the Immediate Services Program (ISP) and Regular Services Program (RSP) for Western Kentucky (KY-4630; record strong tornadoes) and the ISP and RSP for Eastern Kentucky (KY-4663; 1,000-year flooding). The Crisis Counseling Program for Western Kentucky has wrapped up. The Eastern Kentucky project is moving into a three-month No Cost Extension period before wrapping up in November. In addition, both locations also received the Disaster Case Management (DCM) grant, which DBHDID is currently administering. In the case of the DCM grant for Eastern Kentucky, DBHDID wrote and submitted the grant in a single day and the grant represented the first for FEMA using "the new modern approach" for DCM services that ensures that disaster case management services are available to survivors early in the disaster period.
DBHDID has hired two staff members to oversee the Disaster Services Implementation. In addition, a team of 10 staff across the department are being trained to provide on-call services to support the KCCRT when volunteers are deployed to the community. Policies, processes, and procedures are being updated to reflect the new structure within DBHDID and volunteers are being retrained, recredentialed, reactivated, and recruited to increase capacity of the team. Additional teams are being considered, including a School Response Team that will be specifically equipped to respond to schools on the death of a student or staff from suicide, or other significant traumatic event, such as a disaster or in-school shooting situation.
DBHDID requires the fourteen (14) CMHCs via contract, to maintain a community-level behavioral health disaster plan and a Continuity of Operations Plan (COOP plan). The statewide Disaster Behavioral Health Plan outlines expected regional response in the case of a crisis or disaster in order to ensure that survivors and their behavioral health needs are met. It also ensures

collaboration with local community partners. The COOP plan ensures that the CMHC has a roadmap for the continuation of services to its clients during an emergency situation. Each CMHC is required to review their plans annually with DBHDID 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.

KCCRT 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. Others are first responders, including law enforcement, firefighters, emergency medical services and dispatchers. As a part of the KCCRT effort, Psychological First Aid trainings are offered across the Commonwealth. 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. The trainings are offered online, free of charge through the National Child Traumatic Stress Network (NCTSN).

DBHDID was also required by 2022 legislation to develop and convene a public safety peer task force and offer recommendations on best practices related to the development of peer counseling groups for first responders. The team met throughout the winter and spring of 2023 and released its report to the General Assembly in July 2023. The report provides overall guidance on the definition of a public safety peer support team, steps in creating a new team within a first-responder or public safety agency, guidelines on ethics, confidentiality, and appropriate interventions; as well key trainings that should be utilized to equip members.

DBHDID also offers Mental Health First Aid (MHFA) training to first responders, emergency health service providers, emergency dispatchers, state guardians, police officers and other community members in order to increase capacity to meet the needs of individuals in the community with behavioral health issues. MHFA is a public education program that provides members of the community with skills, knowledge, and abilities to help identify, understand and respond 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 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. DBHDID collaborates with Community Mental Health Centers, and other entities who have trained providers to offer 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. DBHDID 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 as well as through CMHCs and internal trainings. In addition, DBHDID has provided funding over the years, through the statewide 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 made available 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, DBHDID staff coordinates additional MHFA trainings as well as Question, Persuade and Refer (QPR) training and Applied Suicide Intervention Skills Training (ASIST).

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 Committees. The Advisory Committees 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. Crisis Intervention Team (CIT) 2 is a new offering that provides refresher training for law enforcement officers who have already received CIT training. This refresher training focuses on training needs that are identified through the regional Advisory Committees and includes current trends for law enforcement. During SFY 2022, 11 CIT trainings occurred across the state, and three CIT 2 classes. For SFY 2023, 11 CIT trainings, in 9 CMHC regions have been scheduled, as well as two CIT 2 classes.

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, developmental 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 (eight 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.

**b.** Describe your state's current telehealth capabilities, how your state uses telehealth modalities to treat individuals with SMI/SED, and any plans/initiatives to expand its use.

The advantages of establishing telehealth capability 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. Kentucky has had regulations governing the use of telehealth for many years. However, until recently this guidance only covered prescribers and some categories of licensed clinicians. During the pandemic, access to telehealth services greatly expanded across the state, with most services and service providers now allowed to provide telehealth, and all 14 CMHCs now report delivering or accessing services through the telehealth network. Examples of how the CMHCs utilize telehealth

equipment for providing services to individuals with SMI/SED are outlined below:
• Four Rivers Behavioral Health currently utilizes the telehealth network for psychiatric screening and services in three 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 addition, 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 the pandemic, outpatient therapy services are being offered/delivered via telehealth or telephonic platforms, in addition to traditional service methods. Involuntary psychiatric hospitalization petition 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 10 counties to increase access to providers with therapy services, medication 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 rural counties in their region.
• Seven Counties Services sites all have a telehealth room for clients who walk in and need to be seen by providers at other sites.
• NorthKey continues to utilize telehealth for all clinical services when needed or requested. Clients are contacted by phone and asked if they would like to be seen via telehealth.
• Comprehend provides the majority of 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 pandemic, they provided telehealth services to as many clients as possible for all of their services. In addition, an Accessing Telehealth Through Local Area Stations (ATLAS) site was recently established to assist with telehealth access during times of natural disasters.
• 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. In addition, an ATLAS site was recently established to assist with telehealth access during times of natural disasters.
• 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 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.
• New Vista provides telehealth as a method for most services as needed or as requested.

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

N/A

**Footnotes:**

Updated: 5/3/23

## MENTAL HEALTH (TPAV) BLOCK GRANT ALLOCATIONS FOR FISCAL YEAR 2024

**CONTRACTED TO THE REGIONS FOR SERVICES:**

| | Region | Crisis Services | 988 Implementation/ Follow-Up | DIVERTS | Consumer Operated Options | Reintegration Services | Children with SED | IPS-SE MHA | ECMH Specialist | FEP | DHoH Services | DHoH Language Access | Atlas Stations | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Four Rivers | 12,076 | 100,000 | 209,936 | 50,000 | | 91,944 | | 25,000 | 150,000 | | | | 638,956 |
| 2 | Pennyroyal | 10,730 | 100,000 | 252,530 | | | 81,739 | | 25,000 | 3,000 | | 6,000 | | 478,999 |
| 3 | River Valley | 10,410 | 100,000 | 260,569 | | | 87,581 | | 25,000 | 3,000 | | | | 486,560 |
| 4 | LifeSkills | 15,574 | 100,000 | 265,171 | 50,000 | | 93,825 | | 25,000 | 150,000 | | | | 699,570 |
| 5 | Communicare | 15,193 | 100,000 | 212,444 | 50,000 | | 102,578 | | 25,000 | 150,000 | | | | 655,215 |
| 6 | Seven Counties | 30,201 | 100,000 | 677,556 | 50,000 | 100,000 | | | 25,000 | 150,000 | | 84,900 | | 1,217,657 |
| 7 | North Key | 13,436 | 100,000 | 309,375 | 50,000 | | 121,563 | 50,000 | 25,000 | 3,000 | | 6,000 | | 678,374 |
| 8 | Comprehend | 7,348 | 100,000 | 81,795 | | | 76,811 | | 25,000 | 3,000 | | | | 293,954 |
| 10 | Pathways | 13,650 | 100,000 | 254,434 | | | 100,340 | | 25,000 | 150,000 | | | | 643,424 |
| 11 | Mountain | 12,811 | 100,000 | 198,952 | 50,000 | | 83,144 | | 25,000 | 150,000 | | | 37,500 | 657,407 |
| 12 | Kentucky River | 8,265 | 100,000 | 124,842 | 15,000 | | 85,031 | | 25,000 | 3,000 | | | 37,500 | 398,638 |
| 13 | Cumberland River | 14,254 | 100,000 | 288,263 | 15,000 | | 102,686 | | 25,000 | 150,000 | 34,500 | 12,000 | 37,500 | 779,203 |
| 14 | Adanta | 11,642 | 100,000 | 175,183 | | | 82,495 | | 25,000 | 3,000 | | | | 397,320 |
| 15 | New Vista | 21,804 | 100,000 | 252,988 | | | 148,507 | | 25,000 | 150,000 | 33,500 | | | 731,799 |
| **TOTAL** | | **197,394** | **1,400,000** | **3,564,038** | **330,000** | **100,000** | **1,258,244** | **50,000** | **350,000** | **1,218,000** | **68,000** | **108,900** | **112,500** | **8,757,076** |

**OTHER CONTRACTS:**

| | | |
|---|---|---|
| Bridgehaven | 143,000 | **143,000** |
| Wellspring | 50,000 | **50,000** |
| Independence Place | 50,000 | **50,000** |
| KPFC | 393,000 | **393,000** |
| NAMI Lexington | 175,190 | **175,190** |
| NAMI Louisville | 55,000 | **55,000** |
| REACH | 83,420 | **83,420** |
| UK HDI | 630,221 | **630,221** |
| IPOP/IBI | 100,000 | **100,000** |
| | | **$1,679,831** |

**TOTAL MH TPAV BLOCK GRANT ALLOCATIONS** **$10,436,907**

Audit Reserve **$0**

**TOTAL MH TPAV BLOCK GRANT AVAILABLE** **$10,436,907**

# Environmental Factors and Plan

### 10. Substance Use Disorder Treatment - Required SUPTRS BG

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/residential) | (•) 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:

| | | |
|---|---|---|
| **i)** | Prioritized services for veterans? | (•) Yes ( ) No |
| **ii)** | Adolescents? | (•) Yes ( ) No |
| **iii)** | Older Adults? | (•) Yes ( ) No |

## 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.

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, recovery housing, and other community-based recovery supports. DBHDID has a Division of Program Integrity that includes a Program Support Branch that monitors provider compliance with all contract deliverables and contract performance indicators. Funding for contracted providers is contingent upon satisfactory completion of contract deliverables and performance indicators. The Program Support Branch coordinates reviews of all PWWDC contract deliverables with specific program administrators in the Division of Substance Use Disorder that oversee the PWWDC programming. Monitoring reports are created during the third quarter of each fiscal year for the DBHDID Commissioner. Any issues are discussed with contracted entities, and plans of correction are developed and monitored through the Program Support Branch.

Kentucky continues to expand its Plan of Safe Care (POSC) initiative with pilot sites at 10 of the 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 for pregnant and parenting individuals and their families. From SFY 2016 to SFY 2022, it is estimated that more than 5,000 individuals and their children/families have received treatment and utilized services from over twenty-two (22) selected providers across the state supported by these funds.

As part of the KY-Moms Maternal Assistance Towards Recovery (MATR) the Adult Substance Use Treatment & Recovery Services Branch, within the Division of Substance Use Disorder, 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. 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 to educate 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 six months after delivery. Prevention and case management services are designed to reduce harm 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, LGBTQI+, 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. DBHDID has a Division of Program Integrity that includes a Program Support Branch that monitors provider compliance with all contract deliverables and contract performance indicators. Funding for contracted providers is contingent upon satisfactory completion of contract deliverables and performance indicators. The Program Support Branch coordinates reviews of all PWID contract deliverables with specific program administrators in the Division of Substance Use Disorder that oversee the PWID programming. Monitoring reports are created during the third quarter of each fiscal year for the DBHDID Commissioner. Any issues are discussed with contracted entities and plans of correction are developed and monitored through the Program Support Branch.

### 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. DBHDID has a Division of Program Integrity that includes a Program Support Branch that monitors provider compliance with all contract deliverables and contract performance indicators. Funding for contracted providers is contingent upon satisfactory completion of contract deliverables and performance indicators. The Program Support Branch coordinates reviews of all TB contract deliverables with specific program administrators in the Division of Substance Use Disorder that oversee the TB programming. Monitoring reports are created during the third quarter of each fiscal year for the DBHDID Commissioner. Any issues are discussed with contracted entities and plans of correction are developed and monitored through the Program Support Branch.

### 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 such 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 SUPTRS BG 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 SUPTRS BG funds to support elements of a Syringe Services Program? ○ Yes ◉ No

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

## 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)** MOUD — (●) 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.

**a)** Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

Kentucky contracts with 14 CMHCs for MH/SUD services. Of the 14 CMHCs, seven currently have CARF accreditation and four are currently accredited by the Joint Commission, resulting in 79% of the CMHCs having independent peer reviews by these two external accreditation bodies. In addition, four of these CMHCs are also Certified Community Behavioral Health Clinics.

**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)

## 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.

https://apps.legislature.ky.gov/law/statutes/chapter.aspx?id=38158 KRS 210

Kentucky Administrative Regulations DBHDID https://apps.legislature.ky.gov/law/kar/titles/908/

Kentucky Administrative Regulations Medicaid https://apps.legislature.ky.gov/law/kar/titles/907/

The 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 https://apps.legislature.ky.gov/law/statutes/statute.aspx?id=53678 KRS 194A.030.

If the answer is No to any of the above, please explain the reason.

Kentucky has not requested a waiver for any of the block grant priority population requirements, Kentucky is expecting to meet all current block grant requirements.

**Footnotes:**

# 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 2022-FFY 2023? ○ Yes ◉ No

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

N/A

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**Footnotes:**

# Environmental Factors and Plan

### 12. Trauma - Requested

Narrative Question

**Trauma**[1] is a common experience for adults and children in communities, and it is especially common in the lives of people with mental and substance use disorders. For this reason, the need to address trauma is increasingly seen as an important part of effective behavioral health care and an integral part of the healing and recovery process. It occurs because of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful and/or life-threatening experiences. Trauma has no boundaries regarding age, gender, socioeconomic status, race, ethnicity, geography, ability, or sexual orientation. 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 and children and families in the child welfare system have high rates of mental illness, substance use disorders and personal histories of trauma. Similarly, many individuals in primary, specialty, emergency, and rehabilitative health care also have significant trauma histories, which impacts their health and responsiveness to health interventions. Also, schools are now recognizing that the impact of traumatic exposure among their students makes it difficult for students to learn and meet academic goals. As communities experience trauma, for some, these are rare events and for others, these are daily events. Children and families living in resource scarce communities remain especially vulnerable to experiences of trauma and thus face obstacles in accessing and receiving M/SUD care. States should work with these communities to identify interventions that best meet the needs of their 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 how practices are conducted. These public institutions and service settings are increasingly adopting a trauma-informed approach distinct from trauma-specific assessments and treatments. Trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma, 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 with a focus on equity and inclusion. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[2] paper.

[1] 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.*

[2] *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 guides 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 provide training on trauma-specific treatment and interventions for M/SUD providers? | (•) Yes ( ) No |
| **4.** | 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 |
| **5.** | Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? | (•) Yes ( ) No |
| **6.** | Does the state use an evidence-based intervention to treat trauma? | (•) Yes ( ) No |

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

The Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) engages in numerous activities to promote integration of trauma-informed practices within the department and among our partner agencies.
Internal activities are supported by the DBHDID Trauma and Resilience Team (TR Team), comprised of representatives from each of the DBHDID's branches as well as several at-large members. This team meets to discuss, plan, and implement opportunities to enhance staff wellbeing and workplace resilience and promote the implementation of trauma-informed approaches in the

programs it supports. The TR Team has conducted staff surveys and focus groups to understand staff perspectives, provides opportunities for learning and awareness, promotes resilience-building activities in the workspace, and monitors staff well-being as part of a process of system change. The DBHDID Trauma & Resilience Team created five short, animated videos on professional well-being that were disseminated to all CHFS staff that were very well received.

DBHDID also serves as the content expert for trauma-informed and resilience-oriented practice within the larger Cabinet for Health and Family Services and Kentucky State Government, providing leadership, technical assistance, training and coaching support to other offices, departments, and cabinets. DBHDID facilitates the CHFS Trauma and Resilience Roundtable (TR Roundtable), an open group of champions from across all 17 of Departments and Offices in the Cabinet for Health and Family Services. The TR Roundtable facilitates cabinet-wide activities to enhance awareness and promote a culture and climate that is actively and intentionally trauma-informed and resilience-oriented to promote a resilient workforce, a resilient organization, and trauma-informed and resilient services and programs for all Kentuckians. DBHDID also serves to lead and provide technical assistance to Resilience Teams in each CHFS department/office through the CHFS Resilience Community of Practice. The Resilience Community of Practice facilitates department/office-level teams to assess, understand, plan, implement and sustain changes in organizational practices to promote resilience in the workplace and enhance trauma-informed approaches in all services. The work of the Trauma & Resilience Team, the Trauma & Resilience Roundtable and the Resilience Community of Practice is closely integrated with department and cabinet work to address racial equity, to address and raise awareness of the intersectionality of trauma, race and resilience.

DBHDID provides a number of supports and technical assistance to the larger community regarding trauma-informed care and systems. Since 2012, DBHDID has facilitated the Trauma-Informed Care (TIC) Steering Committee which brings together public and private behavioral health agencies and providers to discuss federal, statewide, and regional trauma-informed and resilience-oriented efforts. These meetings allow these agencies to highlight various activities and new efforts being conducted, identify gaps in knowledge and services, and enhance awareness of new research and current best practices. DBHDID supports each of Kentucky's 14 Community Mental Health Centers (CMHCs). The TIC Key Contacts meet semi-annually to share, learn and brainstorm to ensure they are aware of current research and best practices and can learn from one another. DBHDID also continually revises CMHC contract language to enhance integration and implementation of trauma-informed practice and policy. CMHC standard practice now ensures all staff are trained in trauma-informed care, trauma-informed care training is part of onboarding, each agency has designated TIC trainers, and clinicians are trained in trauma-focused evidence-based interventions relevant to their area of practice such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Trauma Affect Regulation Guide for Education and Therapy (TARGET), Race-Based Trauma Therapy, Eye Movement Desensitization Reprocessing (EMDR), Cognitive Behavior Intervention for Trauma in Schools (CBITS), and Seeking Safety.

DBHDID seeks to build TIC content expertise and training capacity across the state through the Trauma-Informed Care Training of Trainers (TIC-TOT). The TIC-TOT is a free, one-day session held three times a year preparing participants to lead a 3-hour training in basic components of trauma-informed care for their agencies and communities. The TIC-TOT provides participants with slides, background resources, training activities and tips, and quarterly support calls. As of June 2023, 320 participants have been trained, with more than 187 subsequent trainings logged by those participating in the TOTs.

DBHDID fosters numerous partnerships across the state to promote trauma-informed and resilience-oriented practice, including but not limited to Kentucky Department of Education, Department of Public Health, Department for Community Based Services, Department for Medicaid Services, Office of Family Resource and Youth Service Centers, Kentucky AmeriCorps, Department of Juvenile Justice, Kentucky Center for School Safety, Kentucky colleges and universities, and Kentucky 4-H. These partnerships include professional development, conference and webinar training, developing resources, consultation on program development, implementation support, and sustainability planning related to building and sustaining staff well-being and resilience, implementing trauma-informed practices in all programs and services, crisis response and recovery, and expanding current models for practice to include best practices for addressing positive and adverse childhood experiences and building resilience. In response to lessons learned during the COVID-19 pandemic, DBHDID has collaborated with the Department of Public Health to integrate trauma-informed and resilience-building approaches into the training and work of Community Health Workers, and also supports DPH staff working exposed to trauma in programs to address the opioid epidemic. DBHDID also partners closely with the Kentucky Department of Education (KDE) to promote trauma-informed practices in educational settings by co-sponsoring training, coaching and development of resources including KDE's Trauma Toolkit required by the School Safety and Resiliency Act.

Between July 1, 2021 and June 30 2023, the DBHDID Trauma & Resilience Advisor provided 55 training sessions to providers including educators, judges, court personnel, behavioral health professionals, health care and public health workers, peer support specialists, child protective workers, 4-H agents and parents and other caregivers, within and beyond Kentucky. Topics included resilience-building strategies to enhance staff wellness, incorporating positive childhood experiences into program services, implementing trauma-informed practices, trauma-informed supervisory strategies, trauma-informed school disciplinary response systems, and more. In addition, there were 19 monthly 1-hour resilience programs hosted by DBHDID and open to all CHFS 7000 employees live and via recording.

In 2022, in partnership with several state agencies, DBHDID created Partnership for a Resilient Kentucky (PaRK), to serve as a network of providers across the range of health, human and education services to promote integration of practices that promote positive childhood experiences (in addition to addressing adverse childhood experiences), protective factors and strengths-based healing approaches to preventing and responding to trauma and building resilience. PaRK has held three virtual meetings to highlight conceptual and service models and connect providers to one another, has more than 100 providers and agencies across the commonwealth connected through the network, and has launched a website for information and resources for Kentucky providers.

For several years, DBHDID has focused on raising awareness in two additional areas: secondary traumatic stress and racial trauma. Partnerships with the University of Kentucky Center on Trauma and Children (UK CTAC) have enabled regional community mental

health centers (CMHCs) to participate in Secondary Traumatic Stress-Breakthrough Series Collaboratives to understand and address staff secondary trauma exposure. During the COVID-19 pandemic, DBHDID also funded the UK CTAC to establish the Well@Work website of online resources, short videos, and online self-assessment tools related to workforce well-being. Well@Work also offered several short ECHO training series for various professional providers (health care, behavioral health, education). The Well@Work project has been so successful it will be sustained by the UK CTAC for the foreseeable future. DBHDID has also sponsored training for clinical providers on evidence-based assessment and intervention for racial trauma with treatment developer Dr. Steven Kniffley.
In response to a series of natural disasters, DBHDID also facilitated the implementation of several Disaster Mental Health grants to serve populations (including professional providers) impacted by tornadoes in Western Kentucky in December 2021, and severe flooding in Eastern Kentucky in July 2022. While these grants were not specifically led by the TIC and Trauma & Resilience staff, there was collaboration to ensure that all approaches were trauma-informed and resilience-oriented. DBHDID was critical in not only coordinating and overseeing the disaster behavioral health response on the ground through disaster response staff, but the Trauma & Resilience Advisor worked to connect schools with CMHC crisis response and youth service providers. DBHDID coordinated development of a set of resources for the Kentucky Department of Education and the impacted regions that included a training for school staff, a guide to tiered response by schools to natural disaster, other resources and examples. Schools were connected to disaster behavioral health services for non-English speaking families.

Tornado Resources: https://drive.google.com/drive/folders/1H2sHSloJOnhFYdrsOJyXhE3rAyG-yBcU?usp=drive_link

Flooding Resources: https://drive.google.com/drive/folders/1hd1KPPYobqvvtY3pa2rgAMPcO4lSBBhg?usp=drive_link

Ongoing support to disaster and first responders continues with training and technical assistance to prevent and mitigate secondary trauma, compassion fatigue and burnout. The Kentucky Community Crisis Response Team (KCCRT) provides the entire spectrum of critical incident stress management (CISM) services from pre-incident training, acute crisis response, and post-incident support to emergency services personnel who have encountered a traumatic event. Traumatic events include: line of duty deaths, multi-casualty incidents, use of deadly force, suicide of a first responder, events involving children, prolonged incidents, terrorism, and any other overwhelming event.
Additionally, KCCRT coordinates acute multi-component crisis support services and specialized training to schools, communities and organizations outside the emergency services field.
These services are provided at no cost in attempts to prevent the destructive effects of emotional trauma, job related stress, and accelerate recovery from critical incidents before stress reactions can negatively impact an individual’s career, health and family.

Populations served by KCCRT include:

Emergency Services Personnel
Emergency services personnel face stressful events every day. It is the extraordinary events that can result in stress responses that interfere with even an experienced individual's ability to function. Most of our services are provided to emergency services personnel after a critical incident. Critical incidents impacting emergency services personnel include line-of-duty injuries, line-of-duty deaths, prolonged incidents, incidents involving children, mass casualty incidents, suicide of a co-worker, and any other overwhelming event.

School Communities
Tragic events may elicit strong emotional and psychological reactions among administrators, teachers, support staff, students, and parents. The traumatic events that may impact a school community include the death or serious injury of a student, teach or staff member, a bus accident, fires or explosions, natural or man-made disasters, and violent or hostage situations.

Business and Industry
Employees and leadership staff may experience strong emotional and psychological reactions after experiencing or learning of a traumatic event. These events may be the sudden death of a co-worker, a suicide or homicide, a serious workplace injury, and violent or hostage situations.

Disaster Survivors
The overall range of stress goes far beyond the immediate impact of the initial destruction. Some may experience reactions that will cause enough distress to interfere with adaptive coping. These reactions may affect individuals emotionally, impact relationships, disrupt work and cause financial worry.

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 a third of people in prisons and nearly half of people in jail have a history of mental health problems.[1] Almost two thirds of people in prison and jail meet criteria for a substance use disorder.[2] As many as 70 percent of youth in the juvenile justice system have a diagnosable mental health problem.[3] States have numerous ways that they can work to improve care for these individuals and the other people with mental and substance use disorders involved in the criminal justice system. This is particularly important given the overrepresentation of populations that face mental health and substance use disorder disparities in the criminal justice system.

Addressing the mental health and substance use disorder treatment and service needs of people involved in the criminal justice system requires a variety of approaches. These include:

- Better coordination across mental health, substance use, criminal justice and other systems (including coordination across entities at the state and local levels);
- Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups;
- Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system;
- Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community;
- Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems);
- Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, at booking, jails, the courts, at reentry, and through community corrections);
- Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system;
- Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met;
- Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges;
- Partnering with the judicial system to engage in cross-system planning and development at the state and local levels;
- Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system; and
- Supporting court-based programs, including specialty courts and diversion programs that serve people with M/ SUD.
- Addressing the increasing number of individuals who are detained in jails or state hospitals/facilities awaiting competence to stand trial assessments and restoration.

These types of approaches can improve outcomes and experiences for people with M/SUD involved in the criminal justice system and support more efficient use of criminal justice resources. The MHBG and SUPTRS BG may be especially valuable in supporting a stronger array of community-based services in these and other areas. SSAs and SMHAs can also play a key role in partnering with state and local agencies to improve coordination of systems and services. This includes state and local law enforcement, correctional systems, and courts. SAMHSA strongly encourages state behavioral health authorities to work closely with these partners, including their state courts, to ensure the best coordination of services and outcomes, especially in light of health disparities and inequities, and to develop closer interdisciplinary programming for justice system involved individuals. Promoting and supporting these efforts with a health equity lens is a SAMHSA priority.

[1]Bronson, J., & Berzofsky, M. (2017). Indicators of mental health problems reported by prisoners and jail inmates, 2011–12. Bureau of Justice Statistics, 1-16.

[2]Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2017). Drug use, dependence, and abuse among state prisoners and jail inmates, 2007–2009. Washington, DC: United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[3]Vincent, G. M., Thomas Grisso, Anna Terry, and Steven M. Banks. 2008. "Sex and Race Differences in Mental Health Symptoms in Juvenile Justice: The MAYSI-2 National Meta-Analysis." Journal of the American Academy of Child and Adolescent Psychiatry 47(3):282–90.

**Please respond to the following items**

**1.** Does the state (SMHA and SSA) engage in any activities of the following activities:

- [x] Coordination across mental health, substance use disorder, criminal justice and other systems
- [x] Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups
- [x] Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system, including those related to medications for opioid use disorder
- [x] Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- [x] Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- [x] Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community
- [x] Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems)
- [x] Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, booking, jails, the courts, at reentry, and through community corrections)
- [x] Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system
- [x] Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met
- [x] Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges
- [x] Partnering with the judicial system to engage in cross-system planning and development at the state and local levels
- [x] Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system
- [x] Supporting court-based programs, including specialty courts and diversion programs that serve people with M/SUD
- [x] Addressing Competence to Stand Trial; assessments and restoration activities.

**2.** Does the state have any specific activities related to reducing disparities in service receipt and outcomes across racial and ethnic groups for individuals with M/SUD who are involved in the criminal justice system? If so, please describe. (●) Yes ( ) No

The KDBHDID has a dedicated Executive Staff Advisor position that provides this specific training across the Department, CMHC's, state psychiatric hospitals and other community organizations. DBHDID also has small workgroups made up of staff members from every branch that coordinate with the dedicated staff advisor to analyze data and provide TA to our community partners for better outcomes.

**3.** 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

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

Law Enforcement recognizes that police and/or emergency services are the first responders for people experiencing a behavioral health crisis or emergency, which can be an intervention point to avoid formal entry to the criminal justice system. Crisis intervention team (CIT) training, mobile crisis outreach teams staffed by law enforcement agencies and mental health providers, training of 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 more than twenty-two (22) years and has

successfully diverted thousands of individuals into care. more than 5,378 Kentucky law enforcement officers statewide (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 2022, 285 Kentucky Police Officers received the 40-hour CIT certification and there were 11,952 statewide law enforcement responses to persons with either mental illness, substance use disorders, intellectual disabilities, or co-occurring disorders. There have also been more than 57 CIT "Train the Trainer" certifications awarded since the program's implementation. In July 2017, Lexington Metro Police began their own CIT certification for all new recruits. Beginning in 2021, Bowling Green, Hopkinsville and Owensboro have begun 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 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 began 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. In 2022 24 officers attended CIT 2. The CIT 2 training course is currently being revised to a 40-hour training, with additions of face-to-face scenarios, liability topics and extensive testing for completion.

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, developmental 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.

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 was increased in FY23 and is expected to increase in FY24, depending on availability of state general funds, which cover the costs. In SFY 2004, the program served just under 5,000 individuals in jails statewide. In SFY 2022, the program served 19,988 clients in the jails. 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 CMHS provide. Funding is 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 $1,200,000 for SFY 2022 and SFY23 and added an additional $406,000 to the program for SFY23. Providers have requested $1.8 million in SFY24, to keep up with demand.

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. 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 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 program paused during COVID-19 because the prisons curtailed outsiders from entering the facilities. Staffing was reduced as a result. However, a new reintegration specialist has been rehired and the intiative that utilizes case managers and peer support specialist to form a bridge of services between the prison system and the individual's home community will be restarted in SFY24. This will enable the connection to behavioral health services and provides a "warm hand off" to the local community mental health center. In addition, Department of Medicaid Services has requested a waiver that would allow them to begin the benefit process within 6 months of an individual being ready for release to ensure connection to community-based services upon release. The waiver is awaiting CMS approval.
In July 2020, DBHDID was awarded an Assisted Outpatient Treatment (AOT) grant from SAMHSA in the amount of $4 million dollars ($1 million per year for four years). AOT is defined as a civil court-ordered community-based treatment for individuals with serious mental illness (SMI) designed to assist individuals who have had difficulty sustaining engagement in outpatient services, and who have shown a history of repeated hospitalization, arrest, or acts or threats of injury to self or others. Under AOT, individuals receive regular monitoring of progress by the court along with a wide range of community mental health services, including but not limited to medication, therapy, person centered recovery planning, case management, and peer support. The AOT program was implemented in two (2) initial pilot sites, through two (2) state psychiatric hospital catchment areas. The first was the Central State Hospital catchment area, which incorporates two (2) Community Mental Health Centers, one covering Kentucky's largest populated area. The AOT program then expanded to the Western State Hospital catchment area, which includes four (4) additional

Community Mental Health Centers. The AOT program is designed to improve outcomes for individuals with serious mental illness, demonstrate cost savings, develop a sustainable model for statewide implementation and continuation, and reduce inpatient psychiatric hospital utilization and involvement in the criminal justice system.

As of March 2023, 80 individuals have been served through Kentucky's AOT program and 51 individuals are currently active participants in the Central State Hospital and Western State Hospital catchment areas. Assisted Outpatient Treatment programs are currently being implemented in the Eastern State Hospital catchment area (five Community Mental Health Centers) and in the Appalachian Regional Hospital catchment area (three Community Mental Health Centers) through state funds. Program data is being evaluated regularly by the University of Kentucky evaluation team for all phases of the AOT program throughout Kentucky.

Stettin, B., Lukes, A., Snook, J. & Johnson, B. (2019). Implementing assisted outpatient treatment: Essential elements, building blocks and tips for maximizing results: Retrieved June 2023 from:
https://www.treatmentadvocacycenter.org/storage/documents/backgrounders/White_Paper_FINAL_1.pdf

Children with SED

The DBHDID recently submitted an application to SAMHSA in response to its Notice of Funding Opportunity for System of Care (SOC) Expansion and Sustainability. If funded, this will be Kentucky's sixth consecutive SOC grant. The overall mission of the grant is to expand existing infrastructure and service delivery to children/youth at risk for or with SED who have child welfare and/or justice involvement. Justice involvement includes those involved with the Administrative Office of the Courts (AOC) and/or the Department for Juvenile Justice (DJJ). While not excluded from previous SOC grants, this will be the first time that youth with justice involvement are intentionally included in the population of focus. This decision was based on challenges currently being faced in identifying and appropriately meeting the mental health needs of the population; the crisis currently being experienced by Kentucky's DJJ and resultant reform efforts; increasing numbers of children with mental health needs who are involved with both the DJJ and the Department for Community Based Services (DCBS), Kentucky's Child Welfare agency. The DJJ is also collaborating with the State Interagency Council (SIAC) for Services and Supports to Children and Transition-Age Youth to implement diversion efforts to establish a diversionary program to identify and provide treatment for any youth identified as suffering from mental illness, including any youth currently detained and will be transferred as soon as practicable to a secure facility for treatment. The SIAC has served as the governing body for Kentucky's system of care since its statutory creation in 1990; this is the first time it has been specifically included in juvenile justice legislation and presents an exciting opportunity to better serve youth with justice involvement and who have SED. Finally, in SFY 22, the DJJ partnered with Kentucky's SAMHSA Statewide Family Network grantee, the Kentucky Partnership for Families and Children (KPFC), to provide intensive leadership training to youth detained it its residential Youth Development Centers. This training is aimed at youth with lived experience receiving services for an SED or SUD and is the first step required to seeking certification as a Kentucky Youth Peer Support Specialist. The training was a success, and DJJ has requested that KPFC make this a regular leadership development event for youth in its care.

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

N/A

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**Footnotes:**

# Environmental Factors and Plan

## 14. Medications in the Treatment of Substance Use Disorders, Including Medication for Opioid Use Disorder (MOUD) – Requested (SUPTRS BG only)

Narrative Question

In line with the goals of the Overdose Prevention Strategy and SAMHSA's priority on Preventing Overdose, SAMHSA strongly request that information related to medications in the treatment of substance use disorders be included in the application.

There is a voluminous literature on the efficacy of the combination of medications for addiction treatment and other interventions and therapies to treat substance use disorders, particularly opioid, alcohol, and tobacco use disorders. This is particularly the case for medications used in the treatment of opioid use disorder, also increasingly known as Medications for Opioid Use Disorder (MOUD). The combination of medications such as MOUD; counseling; other behavioral therapies including contingency management; and social support services, provided in individualized, tailored ways, has helped countless number of individuals achieve and sustain remission and recovery from their substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based, or non-medication inclusive, treatment for these conditions. The evidence base for medications as standards of care for SUDs is described in SAMHSA TIP 49 Incorporating Alcohol Pharmacotherapies Into Medical Practice and TIP 63 Medications for Opioid Use Disorders.

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 offer MOUD and medications for alcohol use disorder or have collaborative relationships with other providers that can provide all FDA-approved medications for opioid and alcohol use disorder and other clinically needed services.

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. States should use Block Grant funds for the spectrum of evidence-based interventions for opioids and stimulants including medications for opioids use disorders and contingency management.

In addition, SAMHSA also encourages states to require equitable access to and implementation of medications for opioid use disorder (MOUD), alcohol use disorder (MAUD) and tobacco use disorders within their systems of care.

SAMHSA is asking for input from states to inform SAMHSA's activities.

**Please respond to the following items:**

**1.** Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding the use of medications for substance use disorders? (●) Yes ( ) No

**2.** Has the state implemented a plan to educate and raise awareness of the use of medications for substance disorder, including MOUD, within special target audiences, particularly pregnant women? (●) Yes ( ) No

**3.** Does the state purchase any of the following medication with block grant funds?

- **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 treatment with the use of FDA-approved medications for treatment of substance use disorders is combined with other therapies and services based on individualized assessments and needs? (●) 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 Department of Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) employs the State Opioid Treatment Authority (SOTA). The SOTA oversees NTPs to ensure compliance with relevant federal and State laws and regulations, including conducting announced and unannounced visits, and monitoring the methadone central registry. They consult with and make recommendations to SAMHSA and the DEA concerning new and renewing applications for NTPs and medication units, and on patient complaints.

Kentucky also maintains comprehensive legislative regulations to support access to all formulations of buprenorphine. For example, Kentucky Medicaid has removed most prior authorizations for buprenorphine products for the treatment of opioid use disorder, including the extended release injectable, Sublocade.

Additionally, DBHDID coordinates the annual Kentucky School for Alcohol and Other Drug Studies, an education and training resource developed for healthcare providers and professionals throughout the Commonwealth's behavioral health continuum of care. The objective of Kentucky School for Alcohol and Other Drug Studies is to provide the most effective evidence-based clinical practices in prevention, treatment, harm reduction, and recovery supports. Continuing education classes are provided and designed to enhance provider knowledge and skills in evidence based treatment practices. 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 (CMHCs) are required by DBHDID contract to provide access to MOUD for 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, DBHDID has provided funding opportunities to expand access to MOUD services at the CMHC's.

DBHDID also supports specialized medication services for pregnant and parenting persons with an opioid and/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, DBHDID has facilitated a grant process for providers to expand services to those persons affected by neonatal abstinence syndrome (NAS), encouraging innovative residential and recovery support service programs for pregnant and parenting persons;
• Encouraging and supporting Community Mental Health Centers (CMHCs) and other residential programs across the state to increase residential treatment capacity for pregnant and parenting persons and their children that supports MOUD services into their programs;
• Funding services at two (2) publicly funded Narcotic Treatment Programs to target services to pregnant persons 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 the implementation of plans of safe care activities that includes the use of MOUD.

DBHDID utilizes the SOR grant to increase utilization of MOUD in a wide variety of treatment settings including:
• Hospital bridge clinics and inpatient consultation services
• Federally qualified health clinics and rural health clinics
• Primary care clinics
• Jail and prison based OUD treatment
• Drug courts
• Community pharmacies
• Mobile treatment

DBHDID 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 Self-Management and Recovery Training (SMART) Recovery
• Reentry support
• Transformational employment programs
• Recovery community centers
• Regional prevention centers

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**Footnotes:**

# Environmental Factors and Plan

### 15. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress to set aside 5 percent of the Mental Health Block Grant (MHBG) allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *....to support evidenced-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to expend some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expanding 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

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-intervention 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, stabilization service to support reducing distress, promoting skill development and outcomes, manage costs, and better invest resources.

SAMHSA developed **Crisis Services: Meeting Needs, Saving Lives**, which includes "**National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit**" as well as an **Advisory: Peer Support Services in Crisis Care** and other related National Association of State Mental Health Programs Directors (NASMHPD) papers on crisis services. SAMHSA also developed "**National Guidelines for Child and Youth Behavioral Health Crisis Care**" which offers best practicies, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by this new 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

**1.** Briefly narrate your state's crisis system. For all regions/areas of your state, include a description of access to the crisis call centers, availability of mobile crisis and behavioral health first responder services, utilization of crsis receiving and stabilization centers.

Kentucky CMHCs provide a safety net of crisis services in their designated regions using state general funds, Block Grant funds, and discretionary grant funds. Three crisis services are Medicaid billable (mobile crisis, crisis intervention, and residential crisis stabilization). The following shows the number of CMHCs that provide each crisis service for adults and children:

Adult Peer Support: 14 for adults; not collected for children
Criminal Justice Drop-Off Sites: five for adults; five for children

**2.** In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

*a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
*b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the SAMHSA guidance. This includes coordination, training and community outreach and education activities.*
*c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the SAMHSA*

*guidelines.*

*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*

*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

*Other program implementation data that characterizes crisis services system development.*

*1. Someone to talk to: Crisis Call Capacity*

- *a. Number of locally based crisis call Centers in state*
  - *i. In the 988 Suicide and Crisis lifeline network*
  - *ii. Not in the suicide lifeline network*
- *b. Number of Crisis Call Centers with follow up protocols in place*
- *c. Percent of 911 calls that are coded as BH related*

*2. Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)*

- *a. Independent of first responder structures (police, paramedic, fire)*
- *b. Integrated with first responder structures (police, paramedic, fire)*
- *c. Number that employs peers*

*3. Safe place to go or to be:*

- *a. Number of Emergency Departments*
- *b. Number of Emergency Departments that operate a specialized behavioral health component*
- *c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis)*

**a.** Check one box for each row indicating state's stage of implementation

| | Exploration Planning | Installation | Early Implementation Less than 25% of counties | Partial Implementation About 50% of counties | Majority Implementation At least 75% of counties | Program Sustainment |
|---|---|---|---|---|---|---|
| Someone to talk to | ☐ | ☐ | ☐ | ☐ | ☑ | ☐ |
| Someone to respond | ☐ | ☐ | ☑ | ☐ | ☐ | ☐ |
| Safe place to go or to be | ☐ | ☐ | ☐ | ☑ | ☐ | ☐ |

**b.** Briefly explain your stages of implementation selections here.

Someone to Talk to
Majority Implementation: Kentucky has 14 CMHCs that operate 24/7 regional crisis call centers; those centers responded to more than 302,000 crisis contacts in SFY 2022. Nine CMHCs provide warmline services for children and eight provide warmline services for adults. NAMI Lexington's Participation Station, a local mental health advocacy organization, provides peer-operated warmline services seven days a week and a second statewide advocacy organization is developing the service.

**3.** Based on SAMHSA's National Guidelines for Behavioral Health Crisis Care, explain how the state will develop the crisis system.

988 projects
Kentucky's 988 program has a designated 988 Program Administrator at DBHDID and an active coalition that meets monthly to direct implementation. It has five committees (Marketing, Quality Assurance, Policy and Advocacy, Lived and Loss Experience, and Emergency Services) that meet on a regular basis. Kentucky's 988 program is working on the following projects:
• 988 Workforce Development: The 988 Program Administrator and partners are working to standardize and expand 988 call counselor capacity.

**4.** Briefly describe the proposed/planned activities utilizing the 5 percent set aside.

The 5% crisis set aside is allocated to the 14 regional CMHCs for expansion of crisis services, including increasing training, technology, staff, and services to individuals who do not have a payor, including individuals with SED and SMI. A portion of the 5% crisis set aside has also been utilized to assist with 988 implementation. The CMHCs are engaged in the following initiatives to enhance crisis services in their region:
• Expansion of Services: CMHCs have been and are opening 23-hour crisis receiving facilities, co-occurring capable crisis

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

N/A

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

N/A



**Footnotes:**

# Environmental Factors and Plan

### 16. Recovery - Required

Narrative Question

Recovery supports and services are essential for providing and maintaining 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- guided the approach to person-centered care that is inclusive of shared decision-making, culturally welcoming and sensitive to social determinants of health. The continuum of care for these conditions involves psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder, and services to reduce risk related to them. Because mental and substance use disorders can become chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management recovery and personal success over the lifespan.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. 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)** | Use 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.

Children/youth with SED, SUD, and co-occurring SED/SUD
While many of the services and supports listed in #4 below are available to children/youth, they are not necessarily specific to this age group and may not be developmentally appropriate for children/youth with SED, SUD, or co-occurring SED/SUD. To better meet the developmental and treatment needs of children/youth, recovery services and supports for this age group are provided primarily through children's services divisions of the Community Mental Health Centers (CMHCs) rather than through substance use treatment services divisions, where services and supports are more appropriate for adults. Child, youth, and family programs within the CMHCs operate in accordance with the system of care framework that takes a collaborative, strength-based approach to supporting the whole child/youth and family throughout a continuum of promotion, prevention, early intervention, treatment, and recovery. To that end, each of the 14 regional CMHCs has funding to support a full time Youth Treatment Coordinator (YTC). The YTCs are dedicated to raising awareness of the prevalence and possible indicators of youth substance use and co-occurring mental health concerns; educating the community and child-serving agencies about youth co-occurring mental health and substance use issues; and how to screen and make referrals for further assessment. Additionally, they are charged with educating CMHC clinicians on the unique treatment needs these youth have, connecting them to training opportunities in evidence-based/informed prevention, assessment, treatment, and recovery practices for this population, and supporting collaboration across and within CMHC divisions (i.e., substance use treatment, substance use prevention, children's behavioral health).

Based on annual reporting information, CMHCs offer the following services and supports to children/youth with SED, SUD, SED/SUD. Screening; assessment; outpatient treatment (individual, family and group sessions); intensive outpatient; school based services; group sessions for court involved individuals; aftercare support; medication management; peer support (youth and family); targeted case management (for SED and SUD); community support; transition-age youth drop-in centers; interventions for first episode of psychosis and clinical high risk for psychosis; and two counties offer flexible beds for residential services.

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, mental health and addiction challenges. DBHDID also contracts with Young People in Recovery (YPR), a national advocacy group that 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).

Evidence-based/informed practices specific to youth with SUD are available through CMHCs and include: Adolescent Community Reinforcement Approach; Functional Family Therapy; Motivational Interviewing; Nurturing Parent Programs; Seven Challenges; Seeking Safety; Matrix Model; SMART Recovery; Young People in Recovery (YPR); YPR My Recovery is EPIC

Additionally they can connect individuals with services and supports from other agencies within their communities if they are not available through the CMHC (i.e., residential, intensive outpatient, partial hospitalization; mutual aid/self-help groups, medication for opioid use disorder).

DBHDID and the CMHCs partner with other community-based agencies for the provision of additional services and supports for youth with SED, SUD, SED/SUD. These include but are not limited to Kentucky's SAMHSA Statewide Family Network grantee (Kentucky Partnership for Families and Children); the National Alliance on Mental Illness;; Department for Community Based Services (Kentucky's child welfare agency) Department for Juvenile Justice; Kentucky Department of Education; Administrative Office of the Courts, and Young People in Recovery.

Finally, Kentucky's State Interagency Council (SIAC) for Services and Supports to Children and Transition-Age Youth serves as the statutorily created governing body for Kentucky's system of care (SOC). The SIAC is comprised of:
• Commissioner-level representatives from twelve state agencies (across five Cabinets) that serve children, transition-age youth, and their families;
• Nonprofit Family Organization;
• Youth Representative;

• Parent Representative; and
• Subcommittee for Equity & Justice for All Youth (SEJAY).
In its role as SOC governing body, the SIAC provides opportunities for cross-agency collaboration to improve availability of and access to a continuum of evidence-based/informed practices for children/youth with SED, SUD, SED/SUD and creating policies that align with the SOC core values and guiding principles.

Individuals with SMI
Currently, Kentucky's Division of Mental Health (DMH) offers, though contract 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, 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 early SMI who are experiencing First Episode Psychosis, and a full array of Crisis services including Mobile Crisis. DMH 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 employ 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.

**4.** Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations

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, supervised, 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 some areas 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.

Using regulatory compliance measures, the State Opioid Treatment Authority (SOTA) monitors provision of MOUD at state approved Narcotic Treatment Programs (NTPs), offering primarily methadone and other federally approved medications.

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.

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, which 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. Employed 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 several years have been challenging due to increased isolation and decreased access to necessary supports to establish and sustain recovery, as a result of the COVID-19 pandemic. Despite these challenges, Kentucky continued to see success in assisting those in recovery. During SFY 2022, eleven (11) new community-based recovery homes were 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).

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.

Kentucky Division of Substance Use Disorder (DSUD) became the state affiliate of the National Alliance for Recovery Residences (NARR) on April 1, 2020. Since then, DSUD has operated the Kentucky Recovery Housing Network (KRHN), a voluntary certification program for recovery housing. To date, KRHN has certified 54 recovery residences with 566 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. The KRHN advisory board has also worked with community partners, providing input on HB 248, which mandates that all recovery houses operating in Kentucky because certified through KRHN. The bill allows for the exception of Oxford Houses, Recovery Kentucky Centers operated by the Kentucky Housing Corporation, or religious non-profits directly affiliated with a religious organization in their county. In addition, KRHN worked with the Kentucky Injury Prevention Research Center (KIPRC) at the University of Kentucky to develop FindRecoveryHousingNowKY.org, a recovery housing directory that helps potential residents and community partners locate quality recovery housing.

During SFY 2022, 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. Eleven (11) providers received funding awards during SFY 2022. 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. PPW funds focused on recovery housing that met the needs of parents with children, including easier access to telehealth services and recovery support services.

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?

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, across mental health and substance use disorder programming. Each type of peer support is representative to individuals with lived experience in either mental health disorders, substance use disorders 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 includes 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;

• Agencies are required to submit names and numbers of peer support specialists who successfully complete training requirements; and
• All certified peer support specialists are required to obtain and provide documentation of continuing education each year.

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. DBHDID contracts with a variety of advocacy partners to support recovery programming.

DBHDID partners with 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. PAR's leadership is an individual in long term recovery.

This past year the Kentucky Division of Substance Use Disorder (DSUD), which has operated a revolving loan fund in partnership with Kentucky Housing Corporation since the early 1990s, transitioned operational control of that loan fund to Oxford House, Inc. The evidence-based Oxford House model was chosen to establish new recovery homes utilizing that loan fund. Since 2016, when DSUD began working with Oxford House, Inc., Kentucky's network has grown from four (4) houses in Northern Kentucky providing 32 recovery beds, to 112 houses with 877 beds across the state including housing for men with children and houses for women with children. The contract with Oxford House, Inc., provides Kentucky with Oxford House outreach workers who identify, open, and sustain community-based recovery housing, as well as establish relationship with service providers to ensure linkages with the existing continuum of care and an Oxford House women's resource coordinator who is responsible for targeting services directly for women and women with children.

DBHDID contracts with the National Alliance on Mental Illness (NAMI) Lexington affiliate and initially required the development of a Technical Assistance Center for individuals with lived experience in mental health disorders and co-occurring mental health/substance use disorders 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, and designated as a Consumer Operated Services Program (COSP) according to the SAMHSA toolkit. DBHDID contracts with KYSTARS to provide technical assistance in the development and support of 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.

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 eight (8) 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 2023 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 Double Trouble in Recovery (DTR) groups in certain identified high-risk regions;
• Launch six 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.

DBHDID contracts 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 employed;
• Providing conference calls, newsletters, webinars, for peer specialists who are working and others, regarding issues related to recovery; and
• Provide advocacy training, which targets individuals who have lived experience and want to learn leadership skills to contribute in their communities.

A contract was awarded to Kentucky Partnership for Children and Families (KPFC), 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 young people, and family members in participation on councils and attendance at state and national training (stipends, travel, childcare, etc.). 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.

Kentucky DBHDID also contracts with several other statewide advocacy organizations to assist in implementing a recovery oriented system of care, including Young People in Recovery, Mental Health America of Kentucky, National Alliance on Mental Illness, Louisville affiliate, and others.

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

N/A



**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:

**1.** Does the state's Olmstead plan include:

| | |
|---|---|
| Housing services provided | (•) Yes ( ) No |
| Home and community-based services | (•) Yes ( ) No |
| Peer support services | (•) Yes ( ) No |
| Employment services. | (•) Yes ( ) No |

**2.** Does the state have a plan to transition individuals from hospital to community settings? (•) Yes ( ) No

**3.** What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

Kentucky has an Olmstead Compliance Plan in response to the landmark civil rights case of Olmstead v. L.C. in 1999, when the Supreme Court held that it is discriminatory and unlawful for governments to keep persons with disabilities in segregated settings when they are capable and desire to reside in the community. Kentucky's first Olmstead Compliance Plan was in 2002. Kentucky's current Olmstead Plan created in 2019, consists of nine (9) goals:

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.
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.
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.
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.
5. To Increase available, accessible, quality, and affordable community housing.
6. To establish a process that will allow individuals with disabilities to safely and appropriately transition from an institution to a community setting.
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.
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.
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.
The state's current Olmstead plan (created in 2019) will be updated this fall.
In the process of implementing the first Olmstead Compliance Plan, DBHDID developed supports for individuals with serious mental illness. Mental health funding is made available specifically for individuals in institutions who meet the Olmstead criteria. Each of four (4) state psychiatric hospital catchment areas receives $200,000 each year to serve individuals in their area that meet Olmstead criteria. Regional Olmstead committees were formed, consisting of Division of Mental Health (DMH) representatives and staff from CMHCs, state psychiatric hospitals, and other community stakeholders. Currently these committees meet monthly, at each state psychiatric facility to discuss individual needs and resources specific to each catchment area (these monthly meetings have been conducted via zoom and/or hybrid). In addition, a statewide Olmstead committee was developed and is hosted by DMH, and includes representatives from DMH, CMHCs, state psychiatric facilities, state nursing facilities, specialized personal care homes, National Alliance on Mental Illness (NAMI) and other community partners. This meeting allows a structure to discuss systemic issues and possible barriers to implementation of necessary community services.
Housing services are essential in this process. DMH operates the Olmstead Housing Initiative (OHI) in partnership with New Beginnings of the Bluegrass, Wellspring of KY, and the CMHCs. These funds are to serve the Olmstead population and can be used in a variety of ways including for rent, security deposits, furniture, utility deposits, etc. This provides the flexible funding needed to make a transition successful. During SFY 2018 and in each subsequent fiscal year, $400,000 additional dollars were added to fund OHI for a total of $786,000. In addition, the Louisville Metro Housing Authority, in collaboration with DMH, provides set-aside Housing Choice Vouchers for individuals who meet Olmstead criteria in Jefferson County.
Kentucky's Olmstead plan is a collaborative effort, headed by the Cabinet for Health and Family Services (CHFS), and including many of the Departments under CHFS. This plan also includes early intervention for transition age youth and young adults experiencing mental health disorders. The CMHCs 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 the Department for Juvenile Justice (DJJ) to maintain children in their own homes and communities whenever possible and when in the best interest of the child.
Twelve counties across Kentucky operate Drop-in Centers for transition age youth and young adults. These Centers are operated through the CMHCs and act as an access points for youth and young adults in the communities they serve. Young people can call or come into these Drop-in Centers during open access hours to receive behavioral health support such as peer support and clinical services in addition to assistance in finding housing and other resources to meet their needs. KY River Community Care provides youth crisis housing support for youth and young adults in nine counties within rural eastern Kentucky (Perry, Letcher, Knott, Knox, Whitley, Bell, Clay, Harlan, and Leslie Counties). The McDaniel House is an emergency housing option for youth 18-24 years old. Each home provides stable short-term housing as youth are placed on a voucher list for longer term housing support. They offer case management, behavioral health services, and community support services. They are open seven days per week to guide young people in setting and achieving goals to support their transition to long term independent housing. The Host Home Program allows individuals 14-24 to be housed in a stable home environment with host families. The program provides financial assistance in the form of a monthly grocery and travel stipend as well as behavioral health supports such as case management and clinical services. Host Homes are typically extended family, friends, teachers, or other adult support people who take in a young person to keep them from experiencing homelessness.
Twelve of the CMHCs offer intensive care coordination via High Fidelity Wraparound (HFW). This intensive, family- and youth-led teaming process is aimed at allowing families to prioritize their needs, including shelter, food, health care, and connects them to state, community, and natural supports. By meeting families where they and focusing on the families priorities first, HFW teams are able to engage with families and youth and early and focusing on basic needs prior to addressing behavioral health concerns, when indicated.
Kentucky continues to explore and implement programming 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. Kentucky's Coordinated Specialty Care (CSC) programming is one of these programs. In addition, individuals in Kentucky who have intellectual or developmental disabilities are included under the Olmstead plan. Kentucky's service system for this population includes several Medicaid Home and Community Based (HCBS) 1915 (c) Waiver programs.
Kentucky's Olmstead plan touches other agencies that do not sit directly under CHFS. The Department of Corrections and the Department for Juvenile Justice collaborate with DMH and the Cabinet on numerous programs to decrease institutionalization of youth offenders and offenders with SMI, as well as to support reintegration post incarceration. The Administrative Office of the Courts (AOC) has purview over several Mental Health Courts across the state that provide assessments, treatment, and case management for offenders with mental illness at no charge. Some of these Mental Health Courts also include peer support as a service. These programs are all designed to divert individuals with mental illness from institutions.
In August 2013, the Cabinet for Health and Family Services (CHFS) 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 ranged as high as 2,300 individuals, with an original list of 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 600 individuals with SMI out of personal care homes within a three year period. As a result of the ISA, efforts were made by DBHDID to create a new and expanded system of care for these individuals. DBHDID 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 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. DMH 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 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 of the original 133 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 were 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 collaborations 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.

DMH 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 (SASA), 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.

On March 6, 2020, Governor Andy Beshear issued Executive Order 2020-215 declaring a state of emergency in the Commonwealth regarding COVID- 19. As a result of the health crisis and until the time Executive Order 2020-215 is lifted, Kentucky Protection and Advocacy and the Cabinet agreed to an Addendum to the Second Amended Settlement Agreement. The Addendum identified the changes that affect the way in which CMHCs provide services pursuant to the SASA.

These changes included:
1. Suspending all efforts to transition individuals with SMI currently residing in free-standing PCHs, or those with SMI at risk of entry into a PCH, to community-integrated housing.
2. Providing behavioral health services as defined in Sections III. F.1-10 of the SASA only to the extent allowable by Executive Order or other federal and/or state government issued Orders related to COVID-19, and only to the extent by which Community Mental Health Centers are reasonably capable. These services may include:
a. Phone calls to provide follow-up services to individuals who have previously transitioned to community- integrated housing under the SASA.
b. Assistance with gathering documentation related to obtaining or re-certifying for State Supplementation.
c. Other services that can be provided while practicing social distancing or that do not require in-person contact.
3. Suspending all efforts to meet the discharge and transition process provisions of the SASA, including transition milestone timelines.
4. Suspending Regional Transition Committee meetings.

The addendum was lifted On October 26th, 2022, and all aspects of the Settlement Agreement were to continue. As of October 2022, 2,375 individuals had received housing assistance, and the opportunity to receive community-based services and supports.

Beginning July 1, 2023, CHFS entered the Third Amended Settlement Agreement (TASA) to transition 61 unduplicated individuals from personal care homes and an additional 80 individuals who are under state guardianship. Once these numbers have been met the TASA shall be terminated and CHFS will transition to a Sustainability Plan to keep the system of care in place established from the Settlement Agreement efforts continuing to assist individuals in accessing housing assistance with necessary behavioral health supports.

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

N/A

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

# 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 (11th and 12th 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 for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG 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.[1]. 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.[2]. For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3].

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.[4].

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.[5].

According to data from the 2017 Report to Congress[6] 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).

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[1]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[2]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.

[3]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.

[4]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[5]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**

[6] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

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**Please respond to the following items:**

**1.** Does the state utilize a system of care approach to support:

a) The recovery of children and youth with SED? (●) Yes ( ) No

b) The resilience of children and youth with SED? (●) Yes ( ) No

c) The recovery of children and youth with SUD? (●) Yes ( ) No

d) The 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) Health care? ( ) Yes (●) No

c) Juvenile justice? (●) Yes ( ) No

d) 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

c) Is the child serving system connected with the FEP and Clinical High Risk for Psychosis (CHRP) systems? (●) Yes ( ) No

d) Does the state have an established FEP program? (●) Yes ( ) No

Does the state have an established CHRP program? (●) Yes ( ) No

e) Is the state providing trauma informed 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.)

In Kentucky, services for children and their families have been provided in accordance with the system of care framework since the late 1980s. As such, Kentucky has state and regional governing bodies comprised of child-serving agencies; families and youth with lived experience; a family-run organization; and agencies focused on transition-age youth and young adults. These

statutorily mandated bodies craft policy aimed at providing services and supports with children with or at risk of developing a SED, and their families, that align with the system of care core values and guiding principles.

Core Values.

A System of Care Is:
• Community-based
• Family- and Youth-driven
• Culturally- and linguistically responsive

Guiding Principles.

Children, Youth, and Families Have Access to:
A comprehensive array of services and supports that are:
• Individualized, strength based
• Trauma-informed
• Developmentally appropriate
• Provided in the least restrictive, natural environment
Utilizing:
• Evidenced-informed practices and practice-based evidence
• Partnerships with families and youth at all levels
• Interagency collaboration at the system level
• Care coordination at the service delivery level
• Health-mental health integration
• Public health approach
• Mental health equity
• Data driven and accountability
That protect their rights protection and advocacy.

System of Care Framework, modified from: Stroul, B.A., Blau, G.M., & Larsen J. (2021). The Evolution of the System of Care Approach. Baltimore: The Institute for Innovation and Implementation, School of Social Work, University of Maryland.

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

In SFY 22, DBHDID allocated funds to each of the 14 regional Community Mental Health Centers (CMHCs) to support a full time Youth Treatment Coordinator (YTC) position. The YTCs are dedicated to raising awareness of the prevalence and possible indicators of youth substance use and co-occurring mental health concerns; educating the community and child-serving agencies about youth co-occurring mental health and substance use issues; and how to screen and make referrals for further assessment. Additionally, they are charged with educating CMHC clinicians on the unique treatment needs these youth have and assist in connecting them to training opportunities in evidence-based/informed prevention, assessment, treatment, and recovery practices for this population.

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

• Creating and sustaining a children's behavioral health workforce that is trained and supported to deliver evidence-based/informed, integrated treatment practices for youth with SUD, including those with co-occurring MH and SUD.
• Supporting existing substance use treatment providers, typically trained to work with adults with SUD in workforce development opportunities aimed at increasing their competence and confidence is providing youth-oriented, developmentally appropriate services to youth with SUD, including those with co-occurring MH and SUD

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**Footnotes:**

# Environmental Factors and Plan

### 19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death overall, with over 47,000 people dying by suicide in 2021 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:**

**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.

Using the federal State Suicide Prevention Infrastructure, Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities' (DBHDID) Suicide Prevention team is building, unifying, and leveraging community partnerships. Below is a description of the work in Kentucky.

DBHDID is the designated lead organization for suicide prevention in the state and is authorized to create and carry out the state suicide prevention plan. DBHDID is the fiscal agent for the annual state budget line items related to suicide prevention. Although, Kentucky uses braided funding streams to comprehensively address suicide, DBHDID is directly responsible for the following funds.

Block Grants
DHBDID is responsible for two block grant programs, including Substance Use Prevention, Treatment and Recovery Services Block Grant (SUPTRS-BG) and Mental Health Block Grant (MHBG). The SUPTRS-BG program provides funding to use towards to planning, implementation and evaluation of activities that prevent and treat substance use disorders and promote prevention and public health. The MHBG funds provide and monitor comprehensive, community-based mental health services to adults with serious mental illnesses and to children with serious emotional disturbances. These two block grant funding streams drive the work in Kentucky for substance use/misuse and suicide prevention.

Cooperative Agreements for States and Territories to Build Local 988 Capacity
The Suicide and Crisis Lifeline 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. Within Kentucky, the mental health safety net is built upon 14 local Community Mental Health Centers (CMHC) located across the commonwealth. The CMHCs provide support for their respective regions with crisis services, mental health disorder and substance use disorder services, including providing access to 988 for individuals in crisis.
In Kentucky 988 accredited call centers are located within 13 local CMHCs across the state and provide primary 988 access to their respective regions. The 13 centers that are accredited include: Four Rivers, Pennyroyal, River Valley, LifeSkills, Communicare, Seven Counties, NorthKey, Pathways, Mountain, Kentucky River, Adanta, New Vista and Cumberland River. One center, Pennyroyal, provides primary 988 coverage for Comprehend and LifeSkills in addition to its own region. Pennyroyal also provides backup coverage for every region except Comprehend, LifeSkills, its own counties, and Jefferson County within Seven Counties' region. One of the 988 /Lifeline accredited centers, LifeSkills, currently provides backup 988 services to Pennyroyal for its own counties. Additionally, Pennyroyal is the only accredited 988 center in Kentucky equipped and trained to answer texts and chats sent to 988. Chat and texts are received on a limited basis of three (3) hours each weekday. Use of the 988 number in Kentucky is significant and as such ensuring available capacity is imperative.

Current Kentucky data related to 988 usage:
• In 2022, Kentucky was accountable for 25,613 calls of the 2.5 million across the United States.
• Nearly 27% of Kentucky-originated calls to the 988-line accessed services through the Veteran's Crisis Line. Prior to the launch of 988 in July 2022, 20% of the total callers in Kentucky self-selected to be transferred to the Veteran's Crisis Line. That number increased to 21% following the launch of 988.
• Nearly 400 individuals accessed services through the Spanish Language Line in 2022, with a 70% increase in usage after the July 2022 launch. The use of the Spanish Language Line increased 115% in July 2022 with the launch of 988. Calls to the Spanish Language Line accounted for 1.4% of Kentucky-originating calls in April 2023.
• On average, Kentucky residents call the 988 Suicide and Crisis Lifeline more than 730 times each week. The newly approved, national three-digit number, 988, went live in July 2022 and made accessing mental health and suicide prevention resources as easy as calling 911 for physical health care. Calls to the Suicide & Crisis Lifeline from Kentucky based callers increased 35% with the launch of 988, while texts increased 225%. Chat messages to 988 have increased 123% between July 2022 and April 2023.

• In 2018, Kentucky had an in-state answer rate of 44%, which equals to 8,201 incoming calls. With an increase in capacity and advocating, the answer rate increased up to 75% at the end of the calendar year 2021.With continued efforts to increase capacity, the Kentucky 988 system has achieved some progress in answering more calls. The answer rate for in-state calls reached 81% in August 2022 but dipped slightly over the remaining few months in 2022 ending with an average answer rate of 74% for the calendar year 2022.

Garrett Lee Smith (GLS) Suicide Prevention State or Tribal Grant
The Substance Abuse and Mental Health Services Administration (SAMHSA) has awarded DBHDID the 2022 Garrett Lee Smith State Youth Suicide Prevention and Early Intervention Grant (GLS grant). Kentucky's Strategic Allies Fostering Empowerment of Today's Youth (KY SAFETY) GLS grant will support the implementation of evidence-based prevention and early intervention strategies in four rural school districts to:
1. Increase the number of schools and community partners who can identify and work with youth at risk of suicide.
2. Increase the capacity of clinical service providers to assess, manage, and treat youth at risk of suicide.
3. Improve the continuity of care and follow-up of youth identified to be at risk for suicide, including those who have been discharged from emergency department and inpatient psychiatric units.

These efforts enhance, and leverage efforts initiated during Kentucky's three previous GLS grants, a COVID-19 emergency suicide response project, multiple efforts to address the capacity of crisis line staff to answer 988 calls, texts and chats, and projects focused on improving mobile crisis response for those at greatest risk of dying by suicide, especially youth.

Additional Braided Funds
With sister state–level departments, regional and community partners, Kentucky also utilizes the following major sources of funding: CCBHC (Certified Community Behavioral Health Clinic Expansion) Grants, Center for Disease Control (CDC) Injury or Violence Prevention (IVP) Grant, Garrett Lee Smith (GLS) Suicide Prevention Campus Grant, Maternal and Child Health Services Block Grant (MCHB), State Medicaid or Medicare Dollars, and regional Zero Suicide Grants.

DBHDID maintains a dedicated leadership position, as well as core staff positions, to carry out recommendations and create cross-agency and cross-sector collaboration within the state government. Within DBHDID there are three (3) Full Time Equivalent (FTE) employees, listed as the Statewide Suicide Prevention Coordinator, Suicide Prevention Enhancement Specialist and Mental Health Promotion/Problem Gambling Coordinator, who are all housed in the Mental Health Promotion, Prevention and Preparedness (P3) branch, within the Division of Mental Health. Suicide prevention staff receive quarterly technical assistance from their federal partners at the Suicide Prevention Resource Center (SPRC). The DBHDID Suicide Prevention team works to provides technical assistance on the following areas defined by the Framework for Successful Messaging on Suicide Prevention: 1) developing strategic communication campaigns, 2) promoting a positive suicide prevention narrative, 3) following available best practice suicide prevention messaging guidelines, and 4) minimizing unsafe suicide prevention messaging practices.

Lead by the Suicide Prevention Team, the Kentucky Interagency Council for Suicide Prevention (KICSx) state-level advisory board ensures a broad, inclusive public-private partnership that has co-created a shared vision and commitment to suicide prevention. KICSx is made up of four working subgroups and is responsible for the development, implementation, and oversight of Kentucky's State Strategic Plan for Suicide Prevention. Some of the partners working within the interagency council include: Kentucky Department for Public Health (DPH); Kentucky Department of Education (KDE); Kentucky Department for Community Based Services (DCBS); Kentucky Department for Veterans Affairs (KDVA); 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 (KSPAN); Kentucky Prevention Network (KPN); Kentucky Injury Prevention and Research Center (KIPRC); Kentucky YMCA; Kentucky Boys and Girls Clubs; University of Louisville; Eastern Kentucky University; University of Kentucky; Kentucky Faith Based Coalition; and others.

The KICSx sub-groups are listed below along with their respective vision and five-year goals.

Data/Surveillance: Kentucky will be suicide safe. Through analysis, visualization and translation, data are accessible, user-friendly, and actionable to empower all Kentuckians to realize their role in mitigating the consequences of the suicide continuum.

Goals:
• Increase input from those with lived and loss experience to inform analysis and presentation of quantitative data in order to understand and communicate suicide mortality and morbidity data.
• Increase the use of self-harm and suicide data in programmatic decision-making through the creation of an online dashboard to inform suicide prevention, intervention, treatment, and postvention efforts across the Commonwealth.
• Attempt to address identified data gaps to comprehensively articulate the experience of those impacted by suicide in Kentucky.

Prevention: Kentucky's vision is to have coordinated and integrated suicide prevention utilizing best practices from a variety of experts and organizations. Kentucky will work together to promote access to suicide prevention resources in communities, following the principles of diversity, equity, and inclusion.

These services focus on preventing suicide and related consequences. Teaching and supporting communities to move up stream by promoting connectedness between peers and caring adults, encouraging help seeking, building protective factors, and teaching and modeling healthy coping skills. These skills are also taught and included in the delivery of evidence-based prevention curricula.

Goals:
• Create statewide infrastructure by unifying key groups and coordinating suicide prevention education following evidence-informed best practices.
• Increase community outreach efforts, paying special attention to populations of focus in suicide prevention and mental health promotion.

Intervention: Kentucky's vision is to develop and promote compassionate, competent, person-centered care for individuals experiencing suicidal ideation that is multitiered, readily accessible to community members and clinical providers, and engages individuals where they are. Care that is informed by best practices, validated by those with lived and loss experience, and advocates support for care providers.

In addition to preventing suicide, DBHDID Suicide Prevention team supports intervention capacity for those in crisis, including individuals with SMI/SED. Intervention-building efforts include recognition of a suicidal crisis, referral to appropriate care, and then follow-up as necessary. The team provides TA to schools related to appropriate policies and procedures to identify and refer youth at risk of suicidal behavior to appropriate care. The DBHDID team supports capacity building among providers, especially clinicians employed by the Community Mental Health Centers, to ensure that providers are trained to deliver appropriate services and use best practices for those at risk of dying by suicide.

Goals:
• Kentucky will have a clear definition of Suicide Care Pathway best practices among behavioral health providers and agencies to increase competency for more individualized care in safer communities.
• Implementation of Suicide Care Pathways as adapted for consumer cohort and availability of resources at the regional level.

Postvention: Kentucky's vision is that every Kentuckian has access to immediate and ongoing evidence-based support following a suicide loss or attempt. In partnership with communities across the Commonwealth and driven by the voices of people with lived experience of suicide, Kentucky will implement plans to expand and integrate postvention best practices for loss and attempt survivors.

DBH staff supports communities, health departments, and schools after a suicide death by providing best practice resources to address specific needs in the community. Postvention services also include reviewing and developing school and workplace policy and procedures to plan and prepare before a suicide death occurs.

Goals:
• Increase suicide and suicide attempt exposure education and training for individuals, families, groups, and communities.
• Grow and build capacity to enhance immediate and ongoing support for loss and attempt survivors.

DBHDID works through its Community Mental Health Centers (CMHC) clinical, crisis and Regional Prevention Centers (RPCs) teams to deliver clinical and crisis care as well as community prevention efforts across the 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. DBHDID also increased statewide capacity during SFY 2018/2019 by hiring a collaboration specialist at each of the fourteen RPCs. 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.

Statewide Zero Suicide Initiative
Each of the 14 CMHCs are required to conduct a Zero Suicide Assessment each fiscal year and develop workplans 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 workplans and implement the Zero Suicide Framework within their organization.

In 2022, DBHDID in partnership with DPH, hosted a Zero Suicide Academy. Fourteen teams made up of CMHCs and University of Kentucky Health and Owensboro Health completed the two-day workshop as well as attended a nine-month Zero Suicide Community of Learning. This partnering of state and regional teams enhanced efforts to integrate into their structures, policies, and activities suicide risk screenings into systems, incorporating gatekeeper trainings into staff responsibilities, requiring the collection of suicide-related data, and maintaining suicide specific policies and protocols. As a result of the growing number of organizations partnering in the Zero Suicide work, DPH has hired an FTE to provide one-on-one and group technical assistance to current and future Zero Suicide teams.

DBHDID works to ensure that suicide prevention efforts are culturally responsive by working with state-level coalitions listed below that are for and by those populations most at risk for death by suicide. The goal of these collaborative efforts is to empower people with lived experience and professionals across the state to embed suicide prevention activities into their deliverables as appropriate to their mission and vision.

Raising Hope: Rural Suicide Prevention Project (raisinghopeky.com)
Raising Hope is a statewide coalition composed of agricultural, educational, health and governmental partners united to promote

the holistic health of Kentucky farmers. For the past three years, coalition members have focused on diverse projects, including those to reduce the stigma associated with mental illness, raise appreciation of Kentucky farmers, educate rural healthcare providers about the unique stress associated with farming, and promote the health-seeking behaviors of farmers.

The initiative is managed through the Kentucky Department of Agriculture, which partners with regional and state stakeholders, including DBHDID's State Suicide Prevention Coordinator. Additional partners include the University of Kentucky's Southeast Center for Agricultural Health and Injury Prevention, the University of Louisville, Western Kentucky University, the state's fourteen Community Mental Health Centers, Kentucky Department of Public Health, Kentucky Cooperative Extension Service, and the Kentucky Farmer Stress and Suicide Group. The program works to increase awareness of resources available in Kentucky to farmers that address mental health and suicide.

Kentucky's Governors Challenge Team for Suicide Prevention among Service Members, Veterans and Families
Service Members, Veterans, and their families are at higher risk for suicide across numerous data sources and studies. In 2019, a partnership between Veterans Affairs and HHS Substance Abuse and Mental Health Services Administration (SAMHSA) launched the Mayor's and Governor's Challenges, including right here in Kentucky. Kentucky's Governors Challenge team aims to partner with local organizations and local government to prevent suicide among Service Members, Veterans, and their Families (SMVF). The team's vision is to create healthier communities across Kentucky to support Service Members, Veterans and families through education, reducing stigma and promoting connectivity. The purpose is to create sustainable support for SMVF by informing the state-wide Suicide Prevention efforts of the unique needs of this population. The Kentucky team is made up of members from the Governor's Office, Kentucky Departments of Veterans Affairs, Behavioral Health, Defense, Veteran's Affairs VISN office, Community Mental Health Centers, local VA Medical Centers, readjustment counselors, first responders, and higher education.

60+ Suicide Prevention Interdepartmental Taskforce
This taskforce was created in 2022 to address the increased need for suicide intervention and prevention efforts across the state due to an increase of suicide deaths in adults aged 60 and older. Partnerships between Kentucky's Department for Aging and Independent Living (DAIL), DBHDID, and Area Agencies on Aging (AAAs) and National Foundation to End Senior Hunger (NFESH) will be used to implement suicide intervention trainings to home delivered meal (HDM) staff and volunteers.

Goal: Train AAA's HDM staff/volunteers to recognize and act on mental health crisis.
Objectives
1. Train HDM volunteers/staff with skills to recognize mental health crises through training in Question. Persuade. Respond. (Q.P.R.)
2. Utilize HDM visits to recognize signs of crisis and prepare staff/volunteers to follow policy/procedures to provide recipients assistance and resources
3. Build "Crisis Diverters for Our Elderly" program, comprised of two designated staff with each AAA, provide suicide intervention through the Applied Suicide Intervention Skills Training (ASIST) program.

Expected Outcomes include:
• 25% (approximately 7,353 participants) of HDM recipient will have access to trained Gatekeepers and ASIST liaisons for support and resources
• Broadened knowledge of staff/volunteers around mental health
• Reduced stigma and stereotype around mental health by training over 50 staff/volunteers in evidence-based programs Q.P.R. and ASIST
• Development of "Crisis Diverters for Our Elderly" within each AAA
• Develop a sustainability plan that will support the projects

988 Planning Coalition (988.ky.gov)
In July 2022, 988 became the national three-digit dialing code for the Suicide and Crisis Lifeline, while maintaining the existing phone number of 1-800-273-TALK (8255). The new 988 number, serves as 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 has shifted from a predominant law enforcement and justice system response to an immediate response of connecting individuals to care in suicidal, mental health and substance use crises. The number serves as the first step to make a fundamental shift in how people in crisis are engaged in our communities. When you have a police officer, 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.

All efforts to reduce suicides are data-driven and based on a surveillance plan that allows decision-making based on the contexts in the state. Data is collected from several locations/entities, including the state epidemiological outcomes workgroup (subgroup focused on suicidal behaviors and deaths across the state), child fatality review committee (include multiple stakeholders that review death of adolescents together to discuss gaps, needed changes, and work together to support the community) and Regional Prevention Center needs assessments (this data comes from each county the RPC's serve).

DBHDID has a memorandum of understanding with the Department for Public Health (DPH) and contracts directly with an epidemiologist from the Kentucky Injury Prevention and research Center (KIPRC), an agent of DPH. There are currently two state and county-level data dashboards available through partnerships with REACH Evaluation of Louisville and KIPRC's Injury and Prevention grant.

They can be found at:
• Kentucky Behavioral Health Dashboard
• Kentucky Violence and Injury Prevention Program (KVIPP) and Kentucky Safety and Prevention Alignment Network (KSPAN) KVIPP/KSPAN Injury Data

DBHDID has a close working relationship with KIRPC's Kentucky Violent Death Reporting System (KVDRS). KVDRS works with DPH's Vital Statistics and state elected coroners to ensure suicide death data is accurately reported. KDVRS works with CDC's National Violent Death Reporting System to provide an active surveillance on state-level deaths including homicides and suicides.

DBHDID works to create a multi-faceted lifespan approach to suicide prevention across the state and allocates sufficient resources to fully implement and evaluate a comprehensive approach to suicide prevention. The Suicide Prevention Team is working on using the six activities in the SPRC's Strategic Planning Approach to Suicide Prevention: 1) use data or other sources to describe your state's suicide problem and its context, 2) choose short and long-term goals based on available data to guide suicide prevention efforts, 3) identify key risk and protective factors for suicide in your state, 4) select or develop strategies and interventions that address identified risk and protective factors, 5) plan for evaluation of your strategies and interventions and 6) evaluate and improve strategies/interventions over time.

DBHDID supports all state, county, and local efforts in the planning, execution, and evaluation of their efforts, including allocation of needed resources.

Technical Assistance and Training:
RPCs - Each year, the Regional Prevention Centers develop work plans that identify priority substances and mental health needs within their regions. For SFY 23, thirteen RPCs have identified suicide prevention as a priority region wide or in at least three counties 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.

Schools: In addition to supporting implementation of the Sources of Strength, Lifelines, and Too Good for Drugs programs, the Kentucky Division of Substance Use Disorder, through the RPCs, 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.

Schools are required by Kentucky law (KRS 156.095) that states all school district employees with job duties requiring direct contact with students in grades six through twelve fulfill one hour of high-quality suicide prevention training every year. The KRS requirement also includes that every public school in Kentucky provide suicide prevention awareness information and/or training to all students grades sixth through twelve by September 15th of every year. In 2022, DBHDID began working with the Kentucky Student Mental Health Ambassadors from the Team Kentucky Student Mental Health Initiative led by Lt. Governor Jacqueline Coleman. The group assisted in developing the 2023-2024 DBHDID School Recommendations for Suicide Prevention Training Toolkit.

Clinical Staff and State Organizations: The DBHDID Suicide Prevention team coordinates many mental health and suicide-related training for various audiences, including the staff of schools, community organizations, clinicians, healthcare providers, and other behavioral health staff. Training programs provided include Question, Persuade and Refer (QPR), Applied Suicide Intervention Skills Training (ASIST), Assessing and Managing Suicide Risk (AMSR), Code Red, and Collaborative Assessment and Management of Suicidality (CAMS).

DBHDID Funded School Curricula Implementation
DBHDID provides support for the implementation of evidence-based curriculums, including Lifelines, Sources of Strength, 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: Lifelines was first implemented in Kentucky in 2012, through a Garrett Lee Smith suicide prevention grant. Since then, it has been funded through the Kentucky Incentives for Zero Suicide and Kentucky's Substance Use Prevention, Treatment and Recovery Services Block Grant.

Lifelines is a comprehensive youth suicide prevention program that targets the entire school community, and it is designed to be implemented in grades 5-12. 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: Lifelines 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, DBHDID, 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. ARPA (American Rescue Plan Act) funding continues to support implementation of the program in middle and high schools, and SOR 2 provides funding for the SOURCES Elementary program (3 – 5th grades) and the newly developed SOURCES K – 2nd grade curriculum rolled out in summer 2022.

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 K - 5.

Between July 1, 2021, and March 31, 2023, Kentucky has trained an additional 202 adults in Sources of Strength and an additional 1,327 Peer Leaders. Currently, the state has:
• 67 schools implementing the middle and high school Sources program (this is down as some schools could not implement during COVID, but more schools are coming back on board, there are a total of 112 schools trained and more interested).
• 51 people trained as trainers for this program.
• 92 people trained as Sources Elementary coaches.
• 26 elementary schools that are implementing or have ordered curriculum for the coming school year.
• Served 763 people during SFY 22 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 participate in the evaluation process conducted by REACH of Louisville.

Purple Star Award Program: Service Members, Veterans, and their families are at higher risk for suicide across numerous data sources and studies. In Kentucky, one unique identified population is youth with military connections. Military-connected refers to children of Service Members on active duty, the National Guard, Reserves and Veterans. Through self-report (Kentucky Incentives for Prevention Survey), these youth identify as being at a higher risk of substance use, serious psychological distress, and suicidal thoughts and behaviors. Military-connected youth report 3.4% higher rates of serious psychological distress and 3.5% higher rates of suicide attempts compared to non-military-connected youth. Because of this elevated risk, Kentucky's prevention network along with local and state military partners, launched the Purple Star Award program in 2021.

The Purple Star Award Program is a state-sponsored designation for individual schools that are dedicated and committed to military-connected students. The program helps increase protective factors and reduce risk factors for substance misuse and behavioral health issues by providing a caring school climate and increasing school engagement and involvement from parents and other adults in the school and community. Designated staff within the school receive military culture training and provide hands-on support to students and families during transitions and help bring awareness to the needs of military-connected students. Schools host annual recognition events and provide easy access to needed resources.

Since the launch of the Purple Star Award program in 2021, 53 school staff completed Kentucky's military cultural competence training and 42 Kentucky schools received the Purple Star Award. Pre and post training survey data report increased rates of awareness of Kentucky's military presence, ways to engage and support military-connected youth, and knowledge of local military family resources. Purple Star Awarded schools receive resources and information on other evidence-informed programs such as the Dinner Table Project, creative art contests, prescription medication safety, and resiliency trainings. The Purple Star Facebook page reaches over 3,000 Kentuckians a month and bimonthly newsletters share resources and information to over 400 subscribers.

A Purple Star Liaison Facebook group was created for the school liaisons to share ideas, resources and lessons learned. The Purple Star Award Project Directors worked with Advisory Board Representatives, from over twenty state and community level agencies, to create awareness campaigns featuring Kentucky's Governor and First Lady, the Director of Kentucky Military Affairs, a Purple Star Award principal, military youth, and parents.

**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

If yes, please describe how barriers are eliminated.

There are new initiatives through the zero suicide teams (listed above) to work towards addressing and eliminating barriers for individuals who are discharged from inpatient units or emergency departments. To address the barrier of organizational connectedness, the University of Kentucky Children's Hospital Zero Suicide (ZS) team and the New Vista CMHC ZS team have met to work on the process of warm hand offs for youth identified at risk of suicide. These two organizations work within the same geographic region and their connectedness is vital towards improving care transitions.

Another major barrier to smooth transitions is the health and wellbeing of those making referrals to care pathways, the healthcare workers. Assisted by the passage of new nursing board requirements, the Statewide Suicide Prevention Coordinator has been working with the Department of Public Health to train healthcare workers on addressing suicide through two online courses.
1) Addressing Suicide: Treatment and Awareness for Healthcare Workers
2) Addressing suicide: Chronic Stress within the Healthcare Field.

To address barriers in broader way, DBHDID has applied for multiple federal grants to help with this initiative.

**5.** Have you begun any prioritized or statewide initiatives since the FFY 2022 - 2023 plan was submitted? (●) Yes ( ) No

If so, please describe the population of focus?

New Initiatives for populations of focus include efforts to serve:
• Ethnoracially Minoritized Communities and Gender and Sexually Diverse
Communities- In March 2023, DBHDID, in partnership with the University of Louisville and Dr. Ryan Combs, began two Boot Camp Translations (BCT). A BTC is nine-month community-engaged research process for translating medical information and clinical guidelines into concepts, messages, and materials that are understandable, meaningful, and engaging to community members. The objective of the 988 Suicide and Crisis Lifeline Boot Camp Translation Campaigns is to use BCT to engage community members, organizational stakeholders, and researchers to tailor 988 marketing materials to meet the needs of two priority groups (Kentuckians of Color and LGBTQ+ Kentuckians). The results of this project will help us better understand how those at risk perceive 988 messaging and how to tailor suicide prevention lifeline messaging to meet their needs.
• Youth- Garrett Lee Smith Grant, Collaboration with Lt. Governor, Youth Ambassadors, Purple Star Program
• Older Persons (60+)- Partnering with the Department for Aging and Independent Living (DAIL) on a grant
• Substance Using Individuals-Prevention Enhancement Network Collaboration Efforts

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

N/A

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

# Environmental Factors and Plan

### 20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SUPTRS BG 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 State Medicaid Authority 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's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and M/SUD conditions.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- SAMHSA seeks to enhance the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states. In many respects, successful implementation is dependent on leadership and collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

**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?

Celebrate Recovery – faith based recovery organization for individuals with SUD. To assist in revitalization of statewide connections with faith-based recovery groups.

Pacific Institute for Research and Evaluation – to address partner violence in Kentucky by creating a community of practice connecting relevant state organizations. Will provide intersectional, trauma-informed training for Kentucky's SUD providers.

Kentucky Center for School Safety, West Kentucky Educational Cooperative, Kentucky Department of Veterans Affairs, Kentucky School Counselor's Association, Kentucky High School Athletic Association, Kentucky Commission on Military Affairs through the Governor's Office, Kentucky Association of School Administrators, Kentucky Army National Guard Military and Family Services, Humana, U.S. Department of Labor, U.S. Army Garrison Fort Campbell, Kentucky National Guard Child and Youth Program, National Association for Black Veterans, Christian County Chamber of Commerce, Prevent Child Abuse Kentucky – new partners on

the advisory board for the Purple Star Award Program, which is being implemented statewide as a response to documented higher rates of substance use and behavioral health disorders (including suicidal ideation and suicide attempts) among military-connected youth. The Purple Star Award helps increase protective factors and reduce risk factors for substance misuse and behavioral health issues with military-connected youth by providing a caring school climate and increasing school engagement and involvement from parents and other adults in the school and community.

Young People in Recovery – the Kentucky chapter of the national advocacy group for young people with SUD that is partnering with DBHDID to enhance advocacy efforts for young people with SUD.

Seeds of New Leaf, Shepherd's House, Isaiah House, Revive Ministries, Freedom Bridge – community-based recovery and treatment organizations partnering with DBHDID to provide recovery based services for individuals with SUD

Harm Reduction Coalition – an advocacy organization designed to promote health and dignity for individuals with SUD. Working with DBHDID to provides policy making and input on public health strategies for communities regarding harm reduction interventions.

Kentucky River Health Department – partnering with DBHDID to provide access to a local Recovery Community Center for a variety of treatment and recovery-based services to individuals with SUD.

Clark County Health Department – partnering with DBHDID to provide access to a local Recovery Community Center for a variety of treatment and recovery-based services to individuals with SUD.

Drug Free America – a non-profit organization that works to develop strategies and provide educational programs that prevent drug use and promote sustained recovery. Assisting DBHDID in those efforts.

Federation of Appalachian Enterprise (FAHE) – a non-profit organization designed to eliminate persistent poverty in Appalachia. Kentucky partners with FAHE to provide recovery housing for individuals with SUD and to provide support for individuals with behavioral health disorders in Appalachian during natural disasters.

Spalding University – partnering with DBHDID to provide Community Empowerment to Support Jail Diversion programming, particularly for individuals with SMI.

Crisis Text Line – working with DBHDID to create a data dashboard for call center calls related to 988 implementation.

Mental Heath America of Kentucky – state Chapter of the national advocacy organization that is partnering with DBHDID to provide statewide public messaging related to mental health and wellness education, enhancing diversity education, creating and informing warm lines, and providing a Learning Series for providers that assist in identifying and treating First Episode Psychosis.

University of Connecticut – Partnering with DBHDID for strategic planning and other work related to 988 implementation.

**3.** Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

• By instituting planning groups, planning meetings and working through implementation steps based on proven implementation methods;
• By continuing to provide statewide peer group meetings with dedicated state program administrators to offer support and foster communication with providers;
• By creating additional and continuing established learning collaboratives, communities of practice, and other methods of providing feedback regarding implementation of identified programming for populations of focus, including local school districts and school-based behavioral health service providers;
• By enhancing data collection and analysis, including needs assessment processes, to better identify needs through more objective processes;
• To enhance Kentucky's ability to effectively implement necessary statewide programming by working with SAMHSA's Training and Technical Assistance partners to provide implementation training Department-wide, as well as to create an overall training//TA plan for Kentucky;
• By enhancing statewide availability of mobile crisis units, Quick Response Teams, use of technology and telehealth in partnership with shelters for those experiencing homelessness to provide SUD screening and referrals, co-responder efforts with law enforcement, and working early with individuals who are reentering their communities after justice involvement; and
• By collaborating with the Department for Medicaid Services on additional waiver programming for individuals with SED/SMI/SUD.

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

N/A

**Footnotes:**

# Environmental Factors and Plan

## 21. State Planning/Advisory Council and Input on the Mental Health/Substance use disorder 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 SUPTRS BG, 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.**[1]

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.

[1] **https://www.samhsa.gov/grants/block-grants/resources [samhsa.gov]**

### 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? Attach supporting documentation (e.g. meeting minutes, letters of support, etc.)

The Kentucky Behavioral Health Planning and Advisory Council (Planning Council or Council) reviews the state plan during its August quarterly meeting and the report during the November quarterly meeting. Department staff draft the plans and reports; Council members, stakeholders, and the public are encouraged to provide recommendations and feedback. Staff mail and email 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 since 2020; membership and meeting participation are at an all-time high! All Council members with a term (which includes Individuals with Lived Behavioral Health Experience, Family Members, Parents, and Young Adults with Lived Behavioral Health Experience) receive a stipend to support their attendance.

Before all meetings, handouts are mailed to members with a term and to members who request paper handouts, approximately two weeks prior to the meetings. During the August and November Council meetings, staff include a copy of the plan/report and an overview of the drafted plan/report. Time is provided on the agenda for attendees to ask questions and to provide feedback and recommendations. Council members provide verbal or written feedback (written feedback via chat) during the meeting. 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/report. Information is provided on how to submit comments after the meeting via the department website, telephone, email, or US Mail to the Block Grant State Planner. Comments and recommendations are reviewed and incorporated into the documents and system planning as applicable.
Council members have another opportunity annually to provide feedback to the department. The Council's Finance and Data Committee meets in April to review block grant allocations (MHBG and SABG) for the upcoming fiscal year and to prioritize projects/funding. This has occurred for over 15 years to guide system planning. For the past few years, service needs/priorities for funding have been compiled during the April meeting, placed into a survey format, and the full Council has had an opportunity to electronically vote on priorities in May. The link to the survey is shared in the meeting notice, in the chat box during the meeting, and in a follow-up email after the meeting. Members are also able to add additional priorities to the list, and three members did so this year.
In May 2023, 20 service priorities were compiled during the Finance and Data Committee meeting and 18 members completed the survey. The following are the top 10 service needs identified:
1. Permanent supportive housing for adults with SMI
2. Longer length residential treatment for SUD/SMI dual diagnoses. (More than 30 days)

3. More housing and supported employment services
4. Training for crisis interventions (as an addition to law enforcement training)
5. More peer-run services
6. More crisis stabilization units for children
7. Jail transition services for those with SUD/MH getting released
8. More youth mental health services overall
9. Training for emergency responders, healthcare providers regarding compassion for those with BH disorders
10. More/better access to services

This is another way the state receives valuable feedback that impacts the development of block grant plans. The results of the survey will be shared at the August 2023 Council meeting.

Additionally, members of the planning council had the opportunity to provide input to the department's strategic plan development, providing one additional opportunity for members to guide the work of the Block Grants.

**2.** What mechanism does the state use to plan and implement community mental health treatment, substance misuse prevention, SUD treatment, and recovery support 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.
A statewide needs assessment is conducted using a standardized template to guide local assessments for consistency and accuracy, and to create a state level guide for work. Beginning in SFY 2023, local needs assessments will be done for one-third of Kentucky's counties each year rather than for the entire state bi-annually. This will allow for a more complete and accurate process at the local level. At the end of three years, there will be a comprehensive statewide assessment in place. Along with changes in the timeline, data related to incidence and prevalence will be provided through a dashboard that will guide county-level assessments. The dashboard and data will be utilized to examine alcohol, tobacco, marijuana, opioids, stimulants, and mental health issues while taking into consideration incidence, prevalence, morbidity, mortality, community contexts (poverty, lack of housing, discrimination) and health disparities. Once the analysis is done, 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 administrators 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.
DBHDID support the biannual implementation of the Kentucky Incentives for Prevention survey, a Kentucky-specific youth risk behavior survey that measures use, perception of harm, and related consequences for substance use. The survey was traditionally conduced in the odd years but was paused during COVID-19 for safety reasons and moved to even years. It is being paused a second time, in 2023, because of new state legislation that requires active consent versus passive consent for youth participation. DBHDID is working with evaluators to identify active consent protocols as the survey reaches more than 100,000 6th, 8th, 10th and 12th graders during each administration. It is expected to be resumed in 2024. Results from the survey guide both substance use prevention and mental health promotion and prevention services across the state and data is included in the needs assessment for each community.
The Kentucky Prevention Network, in conjunction with DBHDID, holds an annual conference in the fall of each year and provides two (2) substance-specific trainings in the spring, guided by discussions with DBHDID program administrators and identified training needs from the funded programs.
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.
Department staff provide ongoing monitoring and technical assistance for DBHDID-funded substance use disorder treatment programs statewide. Program Administrators maintain a constant contact with CMHCs 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.

Department staff solicits input on mental health treatment from the community mental health centers and other community partners on an ongoing basis. This consultation occurs at regular peer group meetings with children's service directors, community support program directors, and crisis service directors for both adult and children, as well as at commissioner-level Chief Executive Officer (CEO) meetings and other venues.

The Department of Behavioral Health, Developmental, and Intellectual Disabilities (DBHDID) incorporated the Kentucky Treatment Outcome Study (KTOS) as a means of uniformly collecting and analyzing annual outcomes information from federal and state funded treatment programs. This study uses a pre-test/post-test design modeled after several large federally funded research projects examining treatment outcomes among individuals with substance use disorders and co-occurring disorders. Baseline data are collected by community mental health center staff as clients enter treatment (including outpatient, outpatient intensive, and inpatient). A selected sample of clients who agree to participate in the follow-up interview are contacted by the University of Kentucky Center on Drug and Alcohol Research (UK CDAR) staff 12-months later to complete a follow-up interview by telephone. Follow-up interviews are conducted by the UK CDAR Behavioral Health Outcome Studies (BHOS) research team and are independent of the treatment agency in order to confidentially examine client progress in treatment.

The annual collection of baseline and follow-up data is essential to providing up-to-date regional and statewide data on substance use trends and treatment outcomes for Kentucky. Annual data collection is critical in providing rich insights into regional variations and overall treatment outcome trends. Further, key trends in substance use and policy needs fluctuate annually depending on economic and other state-specific sociopolitical issues, making the need for consistent annual data collection even more important. KTOS provides rigorous data that can highlight crucial insights about substance abuse and co-occurring treatment and validate anecdotal evidence of the need for treatment statewide.

The youth version of the Kentucky Substance Abuse Treatment Outcome Study (Adolescent KTOS) is a means of uniformly collecting and analyzing annual outcomes information from federal and state funded treatment programs for clients who are 12-17 years old. Using items adapted from the Teen Addiction Severity Index and the GAIN (Global Appraisal of Individual Needs), a survey developed for Kentucky adolescents (the Adolescent KTOS) was implemented statewide in 2004. This study uses a pre-test/post-test design modeled after several large federally funded research projects examining treatment outcomes among individuals with substance use and co-occurring disorders. Baseline data are collected by community mental health center staff as clients enter treatment (including outpatient, outpatient intensive, and inpatient). Clients who agree to participate in the follow-up interview are contacted by UK CDAR staff 12 months later to complete a follow-up interview by telephone. Collecting client-level data at baseline and follow-up allows for examination of change in substance use, mental health problems, academic performance, employment, justice system involvement, and recovery supports.

In 2006, the Department of Behavioral Health, Developmental, and Intellectual Disabilities (DBHDID) asked the UK CDAR BHOS team to collaborate on the evaluation of Kentucky's opiate treatment programs (OTPs). Following in-depth consultation with OTP providers, DBHDID staff, and other experts, a structured interview was developed in 2007 and statewide use began as the Kentucky Opiate Replacement Treatment Outcome Study (KORTOS). The project has joint oversight of the Kentucky Division of Behavioral Health and Narcotic Treatment Authority and currently includes all Kentucky licensed OTPs.

Follow-up interviews are conducted by the UK CDAR BHOS research team 6-months after the intake assessment and are independent of the treatment agency in order to confidentially examine client progress in treatment. Collection of baseline and follow-up data allow for examination of changes in substance use, employment, education, physical and mental health status, and involvement with the criminal justice systems. KORTOS requires unique procedures and challenges given the characteristics of this population and the needs of the various sites.

The Planning Council's membership also provide rich information about prevention, treatment, and recovery supports needed for individuals in recovery, parents, and family members. The Council and its committees meet approximately eight times per year.

**3.** Has the Council successfully integrated substance misuse prevention and SUD treatment and recovery or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

**4.** 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

**5.** Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The following Council duties are included in the Bylaws and the work of the Council:

• Report directly to the Commissioner of the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID).

• Assist DBHDID in designing a comprehensive, recovery-oriented system of care.

• Advise DBHDID on the use of Substance Abuse Prevention and Treatment Block Grant (SABG) funds and Mental Health Block Grant (MHBG) funds and on the quality of statewide, recovery-oriented behavioral health services.

• Review the annual combined SABG and MHBG Application and annual Behavioral Health Reports pursuant to Public Law 102-321, Section 1915 (a) and to submit recommendations to DBHDID, prior to the September 1 and December 1 due dates, respectively.

• Advocate for individuals in recovery from mental health disorders and/or substance use disorders, children and youth with behavioral health challenges, and family members.
• Monitor, review, and evaluate, not less than once a year, the allocation and quality of statewide, recovery-oriented behavioral health services.
The Council has a total of 37 members. Council members with lived experience serve as Council officers and Chairs for the following committees: Executive, Membership, Finance and Data, and Bylaws. Those officers are members of the Council's Planning Team; they meet monthly with Council staff to collaboratively plan meetings and steer the Inclusion Plan work.
Since implementing virtual meetings, Council membership and participation have increased. For the first time in the history of the Council, all six Parent seats are full; however, the Council is struggling to recruit young adult applicants.
Council members advocate for individuals with SED, SMI, and SUD by learning about and critically reviewing current initiatives, sharing service gaps, and making funding recommendations to the department (discussed previously). Council members have a broad reach of contacts, and they share the experiences of those individuals during meetings. The Department values their individual and collective voices and takes action on their recommendations as appropriate. During the April 2023 Finance and Data Committee meeting, members were provided with a list of their priorities that were funded. This feedback is a vital part of the advocacy process.

2020 Census data reports the following population breakdowns for Kentucky: 61.6% White; 12.4% Black; 18.7% Hispanic; 6% Asian; 1.1% American Indian/Alaskan Native; .2% Native Hawaiian/Pacific Islander. The Planning Council consists of geographically diverse representation, including urban and rural areas, has three members who identify as older adults, has four members who identify has a Service Member, Veteran and family members (SMVF), and has many parents and family members. However, the ethnic and cultural diversity of the Council does not mirror the state's diversity as a whole. Members do bring their diverse experiences and the input of the respective groups they represent. The following explains the composition of the Council and efforts to enhance diversity:

Kentucky's Planning Council members bring their diverse experiences and the input of the following groups they represent:
• Six (6) adults with lived experience of behavioral health disorders;
• Six (6) parents, guardians, grandparents, guardians, or foster parents who are caring for a child (birth through age 20) with behavioral health challenges;
• Six (6) family members of an adult with lived experience of behavioral health disorders;
• Two (2) young adults with lived experience of behavioral health disorders (age 18-25);
• One (1) organization representing individuals with lived experience of substance use disorders;
• One (1) organization representing individuals with lived experience of mental health disorders and/or substance use disorders;
• One (1) organization representing family members of adults with lived experience of mental health disorders and/or substance use disorders;
• One (1) organization representing youth and family members of youth with significant behavioral health challenges.
• One (1) Regional Prevention Center representative;
• One (1) Community Mental Health Center provider representative.
• Eleven (11) representatives of state agencies that provide services to people with behavioral health disorders.
The Council has developed a Diversity, Equity, Inclusion, and Accessibility Plan (Inclusion Plan) and the Council's Planning Team (Council officers, committee chairs, and Council staff) reviews progress monthly during planning meetings.
The Inclusion Plan is a living document that currently has the following four overarching goals and includes strategies to achieve each goal.
1. Ensure language services are available for members and guests attending Council and committee meetings.
2. Ensure Council documents are accessible.
3. Increase diversity and inclusion on the Council.
4. Enhance the Council's communication strategy.
The following progress has been made:
• The Council's budget was modified to provide for accessibility services.
• The Council incorporated ASL interpreters, a captioner, and tips for making meetings deaf friendly.
• The Planning Team has developed a relationship with the Department's Communication Specialist and has begun creating infographics that members will be able to share on their social media pages.
• The membership application is being updated with new membership categories, more information about how applicants' information will be shared publicly, and a tool to assist applicants with determining if the Council is right for them.
• The Council conducted its first online demographic survey in May 2023. This survey confirmed that new recruitment strategies are needed to reach underrepresented community members. A list of outreach organizations is being developed.
• A member satisfaction survey/needs assessment is being developed.

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

N/A

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

The Council reviews the combined block grant application each year during the August quarterly meeting, and the block grant reports during the November quarterly meeting. However, meeting summaries are not approved by the Council until the following quarterly meeting. So specific meeting minutes for this year's application review are not available. Attachments do include, April 2023 Finance

Committee meeting summary, which is when the Council review annual allocations and makes funding recommendations, the "draft" meeting summary of the May 2023 quarterly Council meeting, where allocations were again distributed for Council review and recommendations, and the letter from our Council showing they have indeed met and reviewed and were given an opportunity to provide feedback on the current application. This letter is signed by the Co-Chair of the Council. Our Chair recently resigned due to taking full time employment and although voting on a new Chair occurred at the August meeting, the process for appointment of said Chair has to be approved and ordered by the DBHDID Commissioner, which takes additional time.

# Kentucky Behavioral Health Planning and Advisory Council
# Finance and Data Committee Minutes

April 20, 2023 10:00am to 12:30pm

**Members:** Tracy Gross, Angeline Davis, Steve Lyons, Sharon Darnell, Robin Osborne, Sherry Sexton, Betty Sue Abshire, Peggy Roark, Rebecca Seavers, Tara Hyde, Marcie Timmerman, Russ Williams, Christy Shuffett, Sherri Estes, Phyllis Millspaugh, Cecilia Webber (for Jessica Wayne, DAIL)

**Department Staff:** Christie Penn, Missy Runyon, Diana Hobbs, Anthony Adkins, Karen Howard, Alan Jaques, David Susman

**Guests:** Andrea Polk (Aetna)

**Accessibility Support:** Hunter Bryant (Interpreter), Macklin Hamilton (Interpreter), Tracy Lundergan (captioner)

| Topic | Discussion | Next Steps |
|---|---|---|
| Call Meeting to Order and Introductions | Peggy Roark, Chair, called to order at 10:02 am and welcomed attendees. Members, guests, and staff introduced themselves. | Approved committee meeting summaries are available online. |
| Overview of Mental Health and Substance Abuse Prevention & Treatment Block Grants (including contracting process) | Missy Runyon presented information about the Mental Health and Substance Abuse Prevention and Treatment Block Grants, including allocation amounts, priority populations, the role of DBHDID, how the state allocates funds, and how funds may be spent.<br><br>Missy also provided information about Coronavirus Response and Relief Supplemental Appropriations Act (CRRA), Bipartisan Safer Communities Act (BSCA), and American Rescue Plan Act of 2021 (ARPA), American Rescue Plan COVID Mitigation (ARPA Mitigation) funds. The state allocation and how the funds may be spent were provided.<br><br>Missy reported that the department sent out allocation notices to contracted providers last week and final negotiations are in process. For that reason, she shared that SFY 2024 allocation lists for each funding stream (MHBG, SABG, CRRA-MH, CRRA-SA, ARPA-SA, ARPA-MH) are not currently available, but will be shared at an upcoming quarterly meeting.<br><br>Missy shared the many items the department considers as it prioritizes Block Grant funds | Staff will share allocation lists at an upcoming quarterly meeting. |

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|---|---|---|
| | and how the structure of the department's contracts ensures clear communication of services purchased, reporting requirements, and monitoring mechanisms.<br><br>Members shared the following comments:<br>• "I love that we're not an HIV/AIDS designated state. That's good news! But I'm also glad that we're monitoring the numbers since we do have high numbers for other issues."<br>• "Excellent presentation! Very helpful!" | |
| Summary of DBHDID Data Collection | Data was provided on the number of individuals served by CMHCs in 2022 who had a mental health or substance use disorder diagnosis (over 166,000) and for those with a marker of serious mental illness (SMI) or severe emotional disturbance (SED).<br><br>Comment: "I would like to see the annual trend data as a graph to better understand possible impacts on clients served."<br><br>Response: Staff will create graphs of the data and share with members. | Share graphs at upcoming quarterly meeting. |
| Block Grant Drafted Budgets for SFY 2024 – Facilitated Review and Discussion of SFY 2024 Planned Expenditures and Finance Committee Member Feedback and Priority Setting | Missy shared a list of the Council's past priorities and a list of projects that have been funded in the past couple of years.<br><br>Members shared the following comments:<br>• "I'm so happy to see consumer-run programs on the list."<br>• "Yay! Warmlines are so helpful!"<br>• "Yay on EDC too! So often that's ignored."<br>• "We need more consumer operated programs, especially in Eastern Kentucky. We need more people with lived experience to help others along the way."<br><br>Missy asked committee members to share 2024 priorities for additional Block Grant funding:<br>1. Longer length residential treatment for SUD/SMI dual diagnoses. (more than 30 days)<br>2. More ongoing support services for youth with dual diagnosis (MH/SUD)<br>3. More peer-run services (such as consumer operated support programs) | |

| | | |
|---|---|---|
| | 4. Collaboration with Probation/Parole services to encourage more options be considered for medications for opioid use disorders (MOUD)<br>5. More work focused on LGBTQIA+, especially more trans-specific and youth-specific services<br>6. More residential programs that allow parents to take their children<br>7. More youth mental health overall<br>8. More harm reduction services (such as Xylazine test strips)<br>9. More youth/young adult drop-in centers<br>10. More crisis stabilization units for children<br>11. Support for fathers/not just mothers<br>a. Fathers with SUD<br>b. Fathers of children with SUD/MHD<br>12. Maternal/Paternal mental health services<br>13. Permanent supportive housing for adults with SMI<br>14. More housing and supported employment services<br>15. Jail diversion for adults with SMI<br>16. Jail transition services for those with SUD/MH getting released<br>17. SUD recovery services for youth and young adults in all regions of the state<br>18. More first responder training, especially in rural areas (regarding emergency and involuntary hospitalization, assisted outpatient treatment, involuntary SUD treatment, compassion for those with BH disorders, linkages to treatment resources, and Crisis Intervention Team training)<br>19. More access to services/better access for services | |
| Adjourn | Robin Osborne made a motion to adjourn at 11:53 am. Sherry Sexton seconded. **Motion passed.** | |

# Kentucky Behavioral Health Planning and Advisory Council
## Minutes
## May 18, 2023 10:00 - 12:30

**Members:** Angeline Davis, Steve Lyons, Sharon Darnell, Robin Osborne, Sherry Sexton, Valerie Mudd, Lynn Haney, Betty Sue Abshire, Peggy Roark, Fallon Kilgore, Carmilla Ratliff, Kelly Gunning, Marcie Timmerman, Jessica Wayne, Deborah Sauber, Bill Heffron, Angela Sparrow, Christy Shuffett, Ron O'Hair, Steve Shannon, Michelle Niehaus, Deanna Bentley, Tara Hyde, Phyllis Millspaugh

**Staff**: Missy Runyon, Christie Penn, Diana Hobbs, Angela Rowe, Tara Brewer, David O'Daniel, Jason Bagley, Allison Paul, Janice Johnston, Karen Howard, Anthony Adkins, John Broadus, Melissa Hopkins, Deb Davidson

**Guests**: Andrea Polk (Aetna), Bridgett Fulkerson

**Interpreters:** Marva Johnson, Hunter Bryant



| Topic | Discussion | Notes/Next Steps |
|---|---|---|
| Call Meeting to Order | Sherry Sexton, Chair, called the meeting to order at 10:03 AM and welcomed members, guests, and staff.<br><br>Anthony Adkins, DBHDID staff member, notified members and guests that ASL interpreting services were being provided and provided tips for ensuring the interpreters can work effectively.<br><br>Quorum was confirmed. | Planning Council's homepage: http://dbhdid.ky.gov/dbh/kbhpac.aspx |
| Introductions and Member Updates | Members introduced themselves and provided updates.<br><br>Sherry Sexton shared that she has graduated from UK's Social Work Program and accepted a position with the Department for Behavioral Health, Developmental and Intellectual Disabilities and will be resigning from the Planning Council. Members expressed their appreciation to Sherry for her 10 years of service on the Council. | Members will recommend a new Chair at the August quarterly meeting. |
| Approval of February 2023 Minutes | Members reviewed the February quarterly minutes. Peggy Roark made a motion to approve the minutes as written and Marcie Timmerman seconded. **Minutes approved.** | Approved meeting summaries are available online. |
| Committee Reports | Membership Committee<br>Membership Committee Chair, Sharon Darnell provided the following membership updates:<br>• Sherry Sexton, Valerie Mudd, and herself had been reappointed to another term. | |

| Topic | Discussion | Notes/Next Steps |
|---|---|---|
| | • A Parent membership application (BF) was received since the last meeting and one seat is currently available for a Parent. Staff provided a summary of the application. Kelly Gunning made a motion to recommend the applicant for appointment. Peggy Roark seconded. Motion approved.<br>• The Council is engaging in its first demographic survey to learn more about the Council's diversity and to assist with Block Grant reporting. A link was shared with members in the meeting notice, during the meeting, and will be shared after the meeting. Members are asked to complete the survey by Friday, June 2nd and results will be shared at the August meeting.<br>• With Sherry's resignation, nominations for Chair were requested. Two nominations were provided. The Council will vote during the August meeting.<br><br><u>Finance and Data Committee</u><br>Peggy Roark, Chair, provided the following Finance and Data Committee updates:<br>• April Committee minutes were reviewed. Valerie Mudd made a motion to approve the minutes. Sherry Sexton seconded. Minutes approved.<br>• Peggy notified members that draft Block Grant allocation lists were included in members' handouts. Missy Runyon stated that she will review the lists in more detail in August and invited attendees to email her with comments and questions.<br>• Peggy shared the funding priorities generated during the April meeting and invited members to complete a survey to prioritize funding needs. A link was shared with members in the meeting notice, during the meeting, and will be shared after the meeting. Members are asked to complete the survey by Friday, June 2nd and results will be shared at the August meeting. | The Council's recommendation will be submitted to Acting Commissioner Stephanie Craycraft. |
| Olmstead Housing Program | Christy Shuffett (New Beginnings-Bluegrass), Angela Rowe (DBHDID), and Jason Bagley (DBHDID) provided an overview of the Olmstead Housing Rental Assistance Program, including who qualifies, how to apply for assistance, approved referral sources (Wellspring in Louisville area, New Beginnings-Bluegrass in Lexington area, all 14 CMHCs), and the approval process.<br><br>The following comments were shared:<br>• "The problem is no places to rent…"<br>• "Housing is so important!" | <u>DBHDID Homeless and Housing Programs</u> |
| Strategic Planning Focus Group | Michelle Niehaus and Deanna Bentley led a facilitated discussion of current trends and opportunities that DBHDID should capitalize on, current needs of populations served by the department, strengths to leverage, and current weaknesses to overcome. Staff and guests were asked to return to the meeting after the discussion. | DBHDID's Strategic Plan will be shared with the Council once it is developed. |

| Topic | Discussion | Notes/Next Steps |
|---|---|---|
| Updates from Department for Behavioral Health, Developmental and Intellectual Disabilities | Phyllis Millspaugh, Assistant Director of the Division of Mental Health provided updates on the following:<br>• Dinner Table Partner and Family Surveys<br>• KY School of Alcohol and Other Drug Studies Conference and Learning Series<br>• System of Care Academy<br>• Behavioral Health Conditional Dismissal Program and Treatment Provider Application opportunity | • Dinner Table Project: Families Survey 2023<br>• Dinner Table Project: Partner Survey 2023 |
| Meeting Adjournment | Sherry reminded members that the next meeting is Thursday, August 17, 2023.<br><br>Peggy Roark made a motion to adjourn the meeting at 12:25 PM. Christy Shuffett seconded. **Motion approved.** | Next Meeting: Thursday, August 17, 2023<br><br>The Council's meeting schedule is posted here. |

# Kentucky Behavioral Health Planning & Advisory Council

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

August 17, 2023

Odessa Crocker
Grants Management Officer
Division of Grants Management
Office of Financial Resources
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane
Rockville, MD 20857

Odessa Crocker,

I am writing on behalf of Kentucky's Behavioral Planning and Advisory Council to confirm that Council members met today and reviewed the combined funding application for Kentucky's mental health and substance use prevention, treatment and recovery services block grants for FFY 2024-2025. Time was allotted at today's meeting to discuss the application and it is also posted for review on the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities website at https://dbhdid.ky.gov/dbh/kbhpac-bg.aspx. Department staff welcomes comments and recommendations prior to and after submission of the 2024-2025 application on September 1, 2023.

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

Sincerely,

Sharon Darnell

Sharon Darnell
Vice Chair, Kentucky Behavioral Health Planning and Advisory Council

Cc: Melissa Runyon, Block Grant State Planner

# 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.
State Medicaid Agency

Start Year: 2024 End Year: 2025

| Name | Type of Membership* | Agency or Organization Represented | Address,Phone, and Fax | Email(if available) |
|---|---|---|---|---|
| Betty Sue Abshire | Family Members of Individuals in Recovery (to include family members of adults with SMI) | | | |
| Sharon Darnell | Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services) | | | |
| Angeline Davis | Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services) | | | |
| Emily Eldridge | Parents of children with SED | | | |
| Sherri Estes | Providers | | Regional Prevention Center<br>Somerset KY, 42501<br>PH: 606-679-9425 | |
| Bridget Fulkerson | Parents of children with SED | | | |
| Tracy Gross | Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services) | | | |
| Kelly Gunning | Others (Advocates who are not State employees or providers) | | NAMI Lexington<br>Lexington KY, 40504<br>PH: 859-809-2856 | |
| David Gutierrez | State Employees | | Department for Community Based Services<br>Frankfort KY, 40601<br>PH: 502-564-9433 | david.gutierrez@ky.gov |
| Lynn Haney | Family Members of Individuals in Recovery (to include family members of adults with SMI) | | | |
| | | | Department for | |

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|---|---|---|---|---|
| Bill heffron | State Employees | | Juvenile Justice<br>Frankfort KY, 40601<br>PH: 502-573-2738 | billm.heffron@ky.gov |
| Tara Hyde | Others (Advocates who are not State employees or providers) | | People Advocating Recovery<br>Louisville KY, 40222<br>PH: 812-399-2659 | |
| Fallon Kilgore | Parents of children with SED | | | |
| Steve Lyons | Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services) | | | |
| Phyllis Millspaugh | State Employees | | Department for Behavioral Health, Developmental and Intellectual Disabilities<br>Frankfort KY, 40601<br>PH: 502-564-4456 | phyllis.millspaugh@ky.gov |
| Jennifer Mingo | Parents of children with SED | | | |
| Valerie Mudd | Family Members of Individuals in Recovery (to include family members of adults with SMI) | | | |
| Ron O'Hair | State Employees | | Office of Vocational Rehabilitation<br>Morehead KY, 40351<br>PH: 606-780-2287 | ronniel.o'hair@ky.gov |
| Robin Osborne | Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services) | | | |
| Rachel Petit | State Employees | | Department for Public Advocacy/Kentucky Protection and Advocacy<br>Frankfort KY, 40601<br>PH: 502-564-7029 | racheln.petit@ky.gov |
| Carmilla Ratliff | Others (Advocates who are not State employees or providers) | | Kentucky Partnership for Families and Children<br>Frankfort KY, 40601<br>PH: 502-875-1320 | |
| Peggy Roark | Family Members of Individuals in Recovery (to include family members of adults with SMI) | | | |
| Deborah Sauber | State Employees | | Department of Education<br>Frankfort KY, 40601<br>PH: 502-564-4772 | deborah.sauber@education.ky.gov |
| Rebecca Seavers | Parents of children with SED | | | |
| | | | KARP | |

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|---|---|---|---|---|
| Steve Shannon | Providers | | Lexington KY, 40515<br>PH: 859-272-6700 | sshannon.karp@gmail.com |
| Christy Shuffett | State Employees | | New Beginnings Bluegrass<br>Lexington KY, 40508<br>PH: 859-245-2400 | christy.shuffett@newbeginningsbg.com |
| Matthew Smith | Family Members of Individuals in Recovery (to include family members of adults with SMI) | | | |
| Angela Sparrow | State Employees | | Department for Medicaid Services<br>Frankfort KY, 40601<br>PH: 502-564-6890 | angela.sparrow@ky.gov |
| Marcie Timmerman | Others (Advocates who are not State employees or providers) | | Mental Health America of Kentucky<br>Lexington KY, 40511<br>PH: 859-684-7778 | |
| Jessica Wayne | State Employees | | Department for Aging and Independent Living<br>Frankfort KY, 40601<br>PH: 502-564-2927 | jessica.wayne@ky.gov |
| Sandy Weaver | Parents of children with SED | | | |
| Connie White | State Employees | | Department for Public Health<br>Frankfort KY, 40601<br>PH: 502-654-3970 | connie.white@ky.gov |
| Russell Williams | State Employees | | Department of Corrections<br>LaGrange KY, 40032<br>PH: 502-222-9441 | russell.williams@ky.gov |

*Council members should be listed only once by type of membership and Agency/organization represented.

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**Footnotes:**

Kentucky's State Social Services Agency is also the State Child Welfare Agency and is the Department for Community Based Services.

# Environmental Factors and Plan

## Advisory Council Composition by Member Type

Start Year: 2024 End Year: 2025

| Type of Membership | Number | Percentage of Total Membership |
|---|---|---|
| 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) | 5 | |
| Parents of children with SED | 6 | |
| Vacancies (individual & family members) | 4 | |
| Others (Advocates who are not State employees or providers) | 4 | |
| **Total Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services), Family Members and Others** | **24** | **64.86%** |
| State Employees | 11 | |
| Providers | 2 | |
| Vacancies | 0 | |
| **Total State Employees & Providers** | **13** | **35.14%** |
| Individuals/Family Members from Diverse Racial and Ethnic Populations | 3 | |
| Individuals/Family Members from LGBTQI+ Populations | 1 | |
| Persons in recovery from or providing treatment for or advocating for SUD services | 0 | |
| Representatives from Federally Recognized Tribes | 0 | |
| Youth/adolescent representative (or member from an organization serving young people) | 0 | |
| **Total Membership (Should count all members of the council)** | **37** | |

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**Footnotes:**

Kentucky's individuals in recovery include those with lived experience of mental illness, substance use, or both. For this form, individuals with lived experience of either mental illness, substance use or co-occurring were ALL marked as individuals in recovery.
Disclosures of racial, ethnic or other diversity categories is voluntary for members. A voluntary demographic survey was recently provided to the Council. This form shows the survey results regarding voluntary disclosures. In addition to categories on this form, the survey showed 3 Council members identified as older adults and 4 Council members identified as Veterans, Serve Members or Families. It is expected there is more diversity than is shown.

## 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

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

https://dbhdid.ky.gov/dbh/kbhpac-bg.aspx

**c)** Other (e.g. public service announcements, print media) ( ) Yes (●) No

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

N/A

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

**Footnotes:**

Department of Behavioral Health, Developmental and Intellectual Disabilities
275 East Main Street, 4W-G
Frankfort, KY 40601

Mental Health and Substance Use Prevention, Treatment and Recovery Services Block Grants
Comments on Application for 2024/2025

A Behavioral Health Planning and Advisory Council meeting was held on August 17, 2023, in a virtual, zoom-based format, from 10:00am – 12:30pm Eastern Time. The Block Grant process and pending combined application were discussed at this meeting, as well as the draft Bipartisan Safer Communities Act (BSCA) two year plan. Council Members had received hard copies of the draft block grant application to review at least 10 days 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/dbh/kbhpac-bg.aspx and review the completed draft application and submit comments to Melissa.Runyon@ky.gov by August 28, 2023. 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. Public Comments will continue to be taken after application submission.

DBHDID received the following comments:

1. Comment: "When is the last day for submitting comments and questions?"

   Response: DBHDID staff explained comments can be taken until August 28, 2023, for inclusion in the block grant application. However, comments will continue to be taken after submission as all comments assist the state with making the process better for all.

2. Comment: "Why does Northern KY NAMI not get funds?"

   Response: DBHDID staff explained that most of the advocacy organizations that are funded through block grant were initially funded through a Request for Proposal (RFP) process in 2011, that was an equitable process and allowed any organization to apply. Currently two NAMI affiliates receive funding to provide specific deliverables statewide, but Northern Kentucky NAMI is not one of those affiliates.

3. Comment: "Such important work! Thanks to everyone for all you do each and every day!"

   Response: DBHDID staff thanked the Council.

4. Comment: "The presentation isn't dry; just a lot of numbers!"

   Response: DBHDID staff thanked the Council.

5. Comment: "Reading the Block Grant is SO HELPFUL."

   Response: DBHDID staff thanked the Council.

6. Comment: “I think about our organization around the 2000s. We were struggling! Now we look at our budget and we’re grateful to be able to do this work.”

   Response: DBHDID staff thanked all community partners and state agencies that help the state with this important work.

DBHDID received the following requested edits:

1. Edit: “Under #4 of the BSCA plan, Fair Teams should be changed to FAIR teams”

   Response: Block Grant Planner made the requested edit.

2. Edit: Under #4 of the BSCA plan, edits to the composition of the state SIAC group was needed.

   Response: Block Grant Planner corrected the BSCA plan regarding the SIAC edits specified.

# Environmental Factors and Plan

### 23. Syringe Services Program (SSP) - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

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.samhsa.gov/sites/default/files/grants/ssp-guidance-for-hiv-grants.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 does not fund Syringe Services Programs with block grant funds.

## Environmental Factors and Plan

### Syringe Services Program (SSP) Information – Table A - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

| Syringe Services Program (SSP) Agency Name | Main Address of SSP | Planned Dollar Amount of SUBG Funds to be Expended for SSP | SUD Treatment Provider (Yes or No) | # of locations (include any mobile location) | Naloxone Provider (Yes or No) |
|---|---|---|---|---|---|
| No Data Available | | | | | |

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