Kentucky Revision Submission for ARPA SAPT Funds Award
July 2, 2021
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The American Rescue Act of 2021 (ARPA), signed by President Biden on March 11, 2021, directed SAMHSA to provide additional funds to support states through their respective Mental Health (MH) and Substance Abuse Prevention and Treatment (SAPT) Block Grants to improve and enhance community-based, mental health and substance use services and supports for designated populations. The designated populations include adults with serious mental illness (SMI), children with serious emotional disturbance (SED), adolescents and adults with substance use disorders (SUD) and those with co-occurring mental health and substance use disorders. There also are designated "set-asides" to address Primary Prevention of SUD, behavioral health crisis services and early interventions for first episode psychosis/early SMI. SAMHSA provided guidance requesting that states apply for the ARPA funds by including specific programming/considerations (i.e., Comprehensive Crisis Continuum, Increase access and low barrier services, technical assistance, including planning for Certified Community Behavioral Health Clinics, use of FDA–approved medications/digital therapeutics for SUD, SUD recovery supports, advanced telehealth access, expanded Assisted Outpatient Treatment services (AOT), school-based services, etc.). It also was requested that states use a specific format to make application (i.e., Identified Needs/Gaps, Plans to Address Needs/Gaps, Spending Plan/Budget, Collaborations with Other Departments/Agencies, etc.). In accordance with federal law that addresses block grant allocations, there are specific terms and conditions that must be adhered to and Kentucky complies with these laws.

ARPA allocated $1.5 billion each for MH and SAPT grants to states/territories and Kentucky's allocations are **$18,541,924.00 for MH** and **$16,496,159.00 for SAPT**, for a total of $35,038,083.00. Funds are to be utilized over a four year period.

Kentucky is pleased to receive these additional funds to further enhance its Recovery Oriented System of Care for its citizens with SUD, including Primary Prevention Services, SUD Treatment Services and Recovery All required *Set-Aside* amounts will be met and no more than 5% will be used for Administration. Please find below Kentucky's *Identified Needs/Gaps* and *Plans to Address* them over the grant period of September 1, 2021 through September 30, 2025. A budget summary can be found at the end of this document.

Crisis Continuum – 988 Implementation

Identified Need/Gaps in Crisis Response
In 2020 alone, 754 people in Kentucky died by suicide, a 4% increase from 2019. Since 2000, more than 18,000 people have died by suicide in the Commonwealth. Suicide is the second leading cause of death among young people, and the tenth leading cause of death in the U.S. In Kentucky, it is the second leading cause of death for residents under the age of 35. Suicide deaths among youth, ages 10-

24, in 2019 (latest data available) total 89, with 57% of those over the age of 19. Youth suicide deaths comprised 12% of all Kentucky suicide deaths. Suicide is a worst-case scenario for untreated mental health needs and substance use disorders. More Americans died from mental health and substance use disorder crises in 2018 alone than have died in combat in every war combined since World War II. For every person who dies by suicide annually, there are 316 people who seriously consider suicide but do not attempt suicide. Additionally, 135 people are impacted for every suicide death. In Kentucky alone, in 2020, more than 340,000 people – nearly 8% of the state's population - were impacted by suicide. A new national suicide prevention and mental health crisis hotline will be accessible to Americans in July 2022 by dialing a universal, easy-to-remember telephone number, 988. This new hotline and assistance system represents an opportunity to develop an infrastructure that focuses on immediately connecting individuals in suicidal, mental health and/or substance use crisis to supportive care. This easy-to-remember number is the first step in a fundamental shift in how people experiencing a behavioral health crisis will be engaged in our communities. 988 creates parity for mental health care access similar to that available for physical health through the 911 system and represents the next giant step in reducing stigma for those at risk of a behavioral health crisis. A landscape analysis conducted in March 2021 revealed that all of Kentucky's crisis centers are understaffed to respond to the anticipated volume of need once 988 is implemented, that they do not have the technological capacity to answer all calls, that mobile crisis services are insufficient to meet expected demand, and that a significant promotion effort will be needed to increase awareness of the services available through 988.

Plans to Address Identified Need/Gaps

KY is pleased that the ARPA application guidance letter specifically encouraged states to utilize funds to support a sustainable behavioral health crisis continuum of care, including the emerging 988 network- as was suggested in the federal legislation. Kentucky has received a 988 Implementation Planning Grant to support the initial planning process, with the state's initial plan due to SAMHSA by Dec. 31, 2021. That grant has funded the creation of a stakeholder coalition designed to provide insight into the implementation process. This proposed project takes that implementation plan to the next steps and ensures that crisis centers have the capacity needed to meet the projected volume requirements. Funds are needed to support increased staffing to meet the anticipated volume as projected by Vibrant.org, owners of the National Suicide Prevention Lifeline, through which the 988 number will be rolled out. Crisis center directors have indicated they do not currently have the capacity to ensure calls from all residents in their region will be responded to in a timely basis by a local provider and the coalition and others are strategizing solutions. Plans are underway for all 14 CMHC crisis centers will be accredited to answer 988 calls. Should a given CMHC not be able to become accredited, they will contract with an accredited call center to provide primary and backup coverage. The overarching goal is for all 988 accredited crisis centers to have the staffing capacity to meet anticipated year one call, text, and chat volume as proposed by the National Suicide Prevention Lifeline. This is anticipated to be around 42,000 for KY in the coming year. For optimal success, these systems must have the capacity to coordinate crisis care in real-time, have full array of available crisis services (mobile, 23 and 24 hour crisis beds, psychiatric beds) and the ability to readily track such availability with interoperable IT systems. It also is imperative that appropriate and sustainable data collection systems be in place to ensure quality monitoring aimed at improving systems over time. These issues are challenging and additional funding and strategic

planning for sustainable funding is underway. ARPA funds are greatly needed to meet immediate needs, particularly as KY is determining the actual costs associated with 988 implementation.

Behavioral Health Workforce Development Initiative

Identified Need/Gaps

Current research about the impact of the COVID-19 pandemic and other natural disasters on individuals, families, and communities points to the inevitable truth that swift and appropriate intervention is needed. Many of Kentucky's citizens will experience short-term distress and a smaller, but measurable, portion of citizens will experience more long-term negative consequences. Specific plans to address the growing demand for behavioral health wellness and behavioral health treatment for individuals and their families can mitigate these consequences. As we move forward, behavioral health wellness interventions can be the best defense against long-term and more devastating outcomes for a larger percentage of the population. Prevention, early intervention, and research-informed treatment strategies should be provided by skilled preventionists, clinicians and paraprofessionals who meet the needs of Kentucky's continuum of care and are adequately compensated for their expertise.

Kentucky lacks an adequate number of behavioral health professionals needed to meet current demands for services along the continuum of care. Without long-term strategies to address these workforce shortages, including the implementation of prevention and promotion strategies, the situation will worsen. According to the U.S. Healthcare Resources and Services Administration (HRSA), Kentucky is designated as an underserved state for behavioral health services, meaning that there is not a sufficient number of various types of behavioral health providers (psychiatrists, prescribers, licensed clinicians, etc.) to meet the estimated need. Kentucky lacks a robust plan for attracting students into behavioral health and related careers and offers very few loan forgiveness or tuition reimbursement opportunities. The salaries for publicly funded providers are very low and the productivity standards are very high. Staff recruitment and retention is a constant struggle and clients often report staff turnover as a primary reason for discontinuing services. In order to adequately meet the behavioral health needs of Kentucky, workforce development issues must be elevated as a point of priority.

Plan to Address Identified Need/Gaps

DBHDID seeks to ensure that there is an adequate behavioral health workforce in Kentucky to meet the current demand for services across the continuum of care and the anticipated increase in the demand for the short- and long-range future. DBHDID also seeks to provide/support the provision of intensive training/coaching for the current workforce and all new hires of the publicly-funded, behavioral health providers in the 14 CMHCs, to meet the immediate- and short-range need to address the behavioral health demands initiated or exacerbated by the past couple of years. A multi-year strategic plan to address Kentucky's perpetual behavioral health workforce shortage is needed and will require a varied approach that is comprehensive and well executed. To ensure optimal outcomes, DBHDID proposes to utilize ARPA funds to employ a dedicated staff person to serve in a leadership role to address the short-term and training related workforce needs and

an additional dedicated staff person to serve in a leadership role to address the long-term workforce shortage of behavioral health professionals in Kentucky. Optimally, to be successful in a rather short timeframe (present to 2025), these proposed staff members must possess significant knowledge of the current publicly-funded healthcare network and the national entities with which Kentucky needs to partner, awareness of research-related strategies specific to workforce development, blueprints for initiation of career pipelines, skillsets to work with post-secondary institutions to address college curricula, and have the personal characteristics to engage a wide variety of persons and organizations to assist with meeting the objectives set out in this proposal and the organizational skills to oversee such an endeavor. To best achieve these goals, DBHDID plans to engage the assistance of multiple state agencies to rapidly advance the plans, including:

1) Department for Public Health in the Cabinet for Health and Family Services that is responsible for reporting to the National Surveillance entities the number of behavioral health professionals statewide;
2) Kentucky Council on Post-Secondary Education that collectively represents all public colleges and Universities who mission it is to provide needed workforce with appropriate knowledge and skills in a given profession;
3) Cabinet for Education and Workforce Development;
4) Department of Professional Licensing in the Public Protection Cabinet that oversee the certification and licensure of behavioral health professionals (Social Work, Marriage and Family Therapists, Art Therapists, Professional Counselors, Alcohol and Drug Counselors, etc.);
5) State Boards of Psychology, Nursing and Physicians (psychiatrists and pediatricians);
6) Kentucky Higher Education Assistance Authority (KHEAA) that improves access to college and technical training; and
7) Kentucky Certification Board of Prevention Professionals (KCBPP) that provides standards, examinations and certification for alcohol, tobacco and other drug (ATOD) prevention specialists (Certified Prevention Specialists, CPS).

Proposed activities would include: 1) Establishing data sharing agreements in order to have access to the certified and licensed behavioral health providers statewide that address Kentucky's continuum of care needs. It might be necessary to hire or contract for a portion of an FTE to collect, organize and analyze data. The data will assist with understanding capacity in particular degree fields, including the number of graduates entering the workforce and those who attain and maintain licensure. This type of data collection will allow for data-driven decision-making; 2) Engaging behavioral health providers along the continuum of care in the strategic planning process inclusive of creating a multi-year plan to address the statewide behavioral health workforce shortages including region-specific goals and objectives; 3) Providing finances to incentivize/off-set costs associated with recruitment and retention of staff within the CMHCs including designating funding sources for this specific purposes; 4) Exploring, creating, and providing funding for tuition reimbursement and/or loan forgiveness programs across the network of CMHCs; 4) Expanding the role of students and their families in recovery;
5) Enhancing the means for promotional opportunities and the exploration of career ladders for behavioral health professionals of all types along the continuum of care, including fostering leadership skills; 6) Ensuring access to and provision of quality supervision strategies focused on attaining and maintaining competence; 7) Establishing pilots in different regions to test projects for successful

implementation of different approaches to addressing the issue of behavioral health professional shortages, including strategic experiential learning opportunities throughout coursework, developing scholarships for community partners to pursue further education and financially supporting the establishment of faculty position(s); and 8) Promoting oversight of infrastructure sustainability to support workforce development. All national resources would be used to accelerate and enhance these activities (e.g., Annapolis Coalition, MTTC Workforce Development materials, HRSA, BH Workforce Resource Center, etc.).

CCBHC Readiness Initiative

Identified Need/Gaps

In an effort to improve and sustain a strong behavioral health "safety net" provider system statewide that ensures optimal access to and improvement of quality, community behavioral health services, KY is anxious to adopt the Certified Community Behavioral Health Clinic (CCBHC) model. Kentucky is one of two states recently added to the CCBHC Demonstration Project. Currently, 4 of Kentucky's 14 CMHCs are CCBHC Demonstration candidate agencies. They, in partnership with KY Medicaid, DBHDID and other partners are working towards meeting the CCBHC certification criteria to demonstrate the effectiveness of this business model in KY. It is proposed that each of the four will receive $500,000 in ARPA funds from January 2022 through September 2025 to assist with readiness activities and expansion of needed infrastructure and service capacity. Specifically, this would include efforts to recruit, onboard and train required staffing, improve their IT capacity and improve their mobile services capability (including lab services) to ensure overall readiness for implementation of the CCBHC model.

Disaster Preparedness, Response and Resilience

Identified Need/Gaps

During February 6 - March 10, 2019, 60 of Kentucky's 120 counties experienced severe storms producing prolonged episodes of heavy rain, strong winds, and isolated tornadoes resulting in flooding, flash flooding, landslides, and mudslides. Declared a disaster on April 17, 2019, the event impacted federal, state, and local roads and bridges; state and local parks; and critical facilities such as utilities, schools, and drainage, water and sewer systems with estimated physical damages totaling $150 million (FEMA-4428-DR). There were subsequent events in 2020, including ice storms, flooding and landslides and FEMA was once again in the state to access and estimate damages.

While the majority of individuals who survive a disaster may not seek or require formal behavioral health services, most can benefit from short -term interventions that validate and normalize their reactive feelings or behaviors. Rates of psychological distress among survivors double after a disaster with nearly one-third of survivors reporting a post-disaster mental health disorder, one-fifth of which are Post Traumatic Stress Disorder (Gordon, et. al, 2011; North, et al, 2002). Post-disaster psychological responses fluctuate from emotional highs with community cohesion in the honeymoon stage immediately after the event to psychological lows and grief during

the disillusionment and reconstruction periods 6-24 months later (Zunin & Myers as cited in Wolfe, 2000). Kõlves et al. (2013) purport that behavioral health impact should be monitored and appropriate interventions offered for several years after a disaster. The behavioral health impacts of the 2019 natural disasters in KY are further compounded by other public health crises, such as the opioid epidemic and the COVID-19 global pandemic, have been especially felt in some areas of the state. Given the high mortality rate for "diseases of despair" (e.g., overdoses, suicide), these individuals and communities were already suffering tremendous stress and strain. The confluence of the opioid crisis, suicide crisis, natural disasters, and the current COVID-19 pandemic place individuals in these communities at particularly high risk for serious psychological distress, especially those with pre-existing behavioral health conditions (SAMHSA, 2019). Thus, the need to support these communities with behavioral health resources to prepare, respond, and recover from disasters is paramount.

Plan to Address Identified Need/Gaps

Recent and on-going weather related disasters in KY, as well as the pandemic and have reminded us of the vulnerabilities of the SMI and SED populations when disasters occur. To this end, a small portion of ARPA funds will be used to secure a state level position to lead planning and implementation efforts around disaster preparedness, response and resilience for the individuals served in the publicly funded behavioral health network. Workgroups and strategic planning forums will be conducted to ensure that there are guidance documents created and implemented by the 14 CMHCs to assist the individuals, including those with SUD and co-occurring mental health and SUD, and their families.

Substance Use Treatment

Identified Need/Gaps

Work to address the needs of individuals who are experiencing substance use disorder (SUD) in Kentucky continues. This includes concerted efforts to mitigate complications stemming from the COVID-19 pandemic and other recent events, 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.

An estimated 10% of the population age 12 and older meet diagnostic criteria for SUD. Based on the 2010 census data, this equates to 363,204 of Kentucky's population over the age of 12 (3,632,035; U.S. Census Bureau, 2010). In state fiscal year 2020 (July 1, 2019 - June 30, 2021), Kentucky's Community Mental Health Centers (CMHCs) provided substance use specific treatment for 21,858 unique individuals; 366 of whom were under age 18. These numbers are slightly lower than the year prior but are anticipated to increase in the current and subsequent years. The total number of unique individuals served across the CMHCs in state fiscal year 2020 was 153,355 and 30,248 were identified as having co-occurring mental health and substance use disorders.

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

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

According to the Kentucky Housing Corporation (KHC) (2021), of the 4,011 homeless individuals in the commonwealth, 568 individuals self-reported having a substance use disorder (SUD) during its annual point-in-time count in 2020. While this number only indicates those who self-identified having SUD, the Substance Abuse and Mental Health Services Administration (SAMHSA) (2011), indicates generally higher rates of substance use among individuals who are homeless, with 34.7% of individuals who were homeless experiencing chronic substance use; lifetime substance use rates around 80% for those who are chronically homeless.

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

during pregnancy. Increased access to MOUD may explain why they are two of the most common substances reported to the NAS registry.

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

In addressing NAS and the issues of families affected by substance use, the Kentucky Department for Public Health and the Department of Behavioral Health, Developmental and Intellectual Disabilities 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 very important steps are to identify demographic patterns and addressing social determinants of health to reach these high-risk populations.

COVID-19 exposed individuals to increased psychological distress which is associated with increased substance use and its consequences. As individuals became more isolated, lost employment and other supports systems reports indicate increases in individuals feeling stressed, anxious and depressed. These feelings are associated in increased in substance use including binge drinking, taking prescriptions drugs for non-medical reasons and using illicit drugs. A National Institutes of Health-funded study found that people with substance use disorders (SUDs) are more susceptible to COVID-19 and its complications. People with a lifetime SUD diagnosis experienced more severe outcomes with increased hospitalizations and increased death rates.

COVID-19 also exposed racial disparities in susceptibility and outcomes between African Americans and White Americans with lifetime substance use disorder. A 2020 study found that "among those with recent SUD diagnosis, African Americans had significantly higher risk (2.17 times more) of COVID-19 than Whites particularly when they had an OUD; 50.7 % of African Americans hospitalized vs. 35.2 % of whites hospitalized. 13% of African Americans died vs. 8.6% of Whites with both diagnosis.

In order to adequately address the needs discussed above, barriers to accessing care that exist for these most vulnerable groups must be overcome. For a multitude of reasons (lack of internet access, distrust of healthcare/institutions, lack of transportation, insurance,

language barriers, etc.) these individuals and families who we so desperately need to reach may not be coming to providers through traditional entry points. Thus, providers must begin a concerted effort to visit each area and provide assertive engagement, access to services offered within the community and ongoing support to ensure individuals stay engaged in care and continue to move forward toward remission, recovery, and health. Though a significant gap in this kind of crisis and mobile outreach exists throughout Kentucky, we have made important progress since the launch of the QRT initiative in 2019 and the launch of Kentucky's first mobile delivery models earlier this year, both of which have clearly demonstrated the effectiveness of community-based models. The cohort has grown to a current total of 12 Quick Response Teams (QRTs) and 3 Mobile Treatment & Recovery Teams; however, together, these 15 teams cover just over 40 of Kentucky's 120 counties, which leaves 65% without this crucial service. Geographically, large areas of Northern, Central and Western Kentucky lack these needed crisis resources. Grant and Anderson counties, who were in the top 5 counties for most resident overdose deaths in 2019, continue to lack access to both QRT and mobile service units.

While there has been an expansive response to the opioid epidemic, which remains the leading driver for overdose deaths in Kentucky, adjacently there has been a major increase in overdose deaths related to stimulants and other drugs. According to the Office of Drug Control Policy, Methamphetamine was involved in 517 overdose deaths in 2019, an increase from 428 in 2018. Additionally, Amphetamines were detected in 415 overdose deaths, Gabapentin was detected in 292 overdose deaths, and Cocaine was detected in 181 overdose deaths in 2019. Resources have been primarily allocated to those with OUD, leaving Kentuckians with Stimulant or other use disorders with minimal options and resources for treatment and recovery. With the influx of Fentanyl and the uptick in Methamphetamine and other stimulant use, Kentucky is facing one of the direst situations yet, with the most overdose deaths on record. Community-based models like QRTs can not only follow up with individuals after an overdose, but they can ensure entire families and neighborhoods are provided access to crucial harm-reduction resources and ongoing support.

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. Nationwide, 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 individual and their support person(s) to reduce the risk of harm associated with parental substance use/misuse.

Currently, KY has funded eight Plan of Safe Care (POSC) sites to develop a coordinated system of care for Pregnant and Parenting Women and their families affected by substance use. There are 6 regions that do not currently have this initiative and expansion of this

initiative would support community collaboration around the needs of families experiencing SUD and enhance the ability of communities to provide comprehensive coordinated care.

Housing Supports

With expansion of KY's Oxford House network and establishment of a National Alliance of Recovery Residence (NARR) affiliate, Kentucky has made significant effort to increasing capacity to accessible and appropriate recovery housing. While capacity has grown, need still exists. Kentucky Injury Prevention and Research Center (KIPRC) (2020) identified several gaps related to housing supports for individuals in recovery in Kentucky.

1. MOUD Acceptance – while housing providers indicated acceptance of MOUD, they were often limiting on which specific medications were allowable, and some indicating restrictions on accessibility to medications.
2. A majority of recovery houses in the Commonwealth indicated a lack of handicap accessibility; houses are often single-family dwelling with accommodations being made on an individual basis, houses specifically designed for persons with physical disabilities are lacking.
3. Service gaps in the rural communities of eastern and western parts of the state. Similar to other services, accessibility and availability of recovery housing is limited in rural areas of the state. Having less density of services in these areas contributes to difficulty in sustaining recovery homes.
4. Limited funding and difficulty with establishing sustainable housing.
5. Inadequate recovery housing options for single parents and families. Some recovery housing is equipped to meet the needs of persons in recovery with dependent children.

Plan to Identified Need/Gaps

Kentucky's strategy to address gaps in service will focus on utilizing a harm reduction framework. Working with community partners from regions across the state, the focus will be to increase utilization of evidence-based harm reduction and treatment services by building towards a recovery-oriented system-of-care that links crisis to engagement and retention in treatment and recovery services for the most vulnerable populations. Services and programs will be tailored to meet the needs and gaps in services identified by each community.

Utilizing this funding, in coordination with other funding sources, Kentucky will establish a formal request for proposals (RFP) process. The gaps identified in the preceding section will be used to establish funding priority areas that will be outlined in the RFP announcement and community partners will be asked to identify their particular needs/gaps in services and submit proposals that align with the established funding priority areas to enhance their substance use treatment and recovery services continuum. This approach permits continued development of a recovery-oriented system of care and enables locally-directed change efforts to address the relevant gaps

and particular needs of each community. A menu of evidence-based interventions and models will be provided from which communities can choose to ensure that chosen interventions will appropriately address current gaps in the ROSC and crisis systems in their area.

A recovery-oriented system of care is a coordinated network of community-based services and supports and builds on the strengths and resiliencies of individuals, families, and communities. For those entering this system in crisis, including an overdose or substance-related event, crisis call, release or diversion from incarceration, a pathway towards stabilization is facilitated by models including crisis response and quick response teams as well as non-emergent mobile outreach and engagement. Persons can then be linked to additional services through provider-based settings (e.g., treatment centers, crisis centers, primary care, hospital-based bridge clinics, and syringe service programs) and community-based settings (e.g., mobile treatment and harm reduction, telehealth, ATLAS).

Concurrent with all services should include harm reduction services (i.e., overdose education and naloxone distribution, infectious disease prevention and treatment), recovery capital education and support (e.g., medical care, housing, basic needs, mutual aid, employment) and collaborative community partnerships to provide a "whole-patient" approach to the treatment. Evidence-based models utilize evidence-based screenings and assessments, behavioral interventions, FDA-approved pharmacological interventions including all forms of medications for opioid use disorder, coordinate care, integrate family supports, treatment retention, and are trauma-informed and recovery-oriented.

Ongoing evidence suggests the strong need for Peer Support Specialists (PSS) embedded within healthcare settings. In Kentucky, there is a large opportunity to intervene with people experiencing substance abuse issues within the primary care, FQHC, RHC, and hospital setting. PSS aid in engaging clients, facilitating access to treatment, and providing ongoing support to keep people engaged in services. PSS provide a unique opportunity to connect with clients with SUD, through having navigated their own lived experience and recovery. One clinic in Kentucky demonstrated that Peer Support Specialists maintained a rate of 85% of patients referred to the appropriate level of care. Recovery Coaching sessions within one hospital have continued daily for each patient for the duration of their hospital stay and a follow up instrument is being utilized by the peer support specialists to regularly engage every person to come through any door of the bridge clinic program whether they initiated services or declined, to establish ongoing communication with individuals at risk of experiencing an overdose and ensure they have access to treatment and other services. 12 FQHCs currently provide MOUD across the state, with 18 PSS providing services. Weekly group supervision is provided to all of the clinics' hired peer support specialists and monthly learning collaboratives are convened for all clinic leadership teams. This strong evidence demonstrates the need for more PSS embedded as a standard of care within healthcare settings, to capture and engage Kentuckians struggling with substance abuse. Peers are an integral part of the mobile and QRT teams, but all providers across the continuum of care could make some level of this kind of assertive engagement and ongoing follow up available to the communities they serve by adding PSS positions and providing appropriate training and supervision.

During this unprecedented period of the COVID-19 pandemic, individuals with behavioral health disorders have been severely impacted, not only through a greater vulnerability to the virus, but in experiencing more difficulty accessing services. This is particularly true for individuals in our communities who may be houseless, lack transportation and internet access to participate in services, and for Black, Indigenous and People of Color (BIPOC) who are experiencing increased risks due to systemic health and social inequities. Priority will be given to programs to serve populations most at risk.

APRA grant funds will function to develop or enhance components of the above described system.

Programs may include:

- Quick Response Teams or similar services to provide assertive engagement in the community in places where people are intersecting with other systems than are underequipped to identify and offer behavioral health services. Composition may vary, but often includes a peer and first responder. Does not require clinicians on the outreach and engagement team ($150,000 – 200,000 per QRT depending on reach

- Mobile outreach teams to provide harm reduction, referral and treatment, recovery support services in the community. Inclusion of telehealth capacity with mobile outreach teams maximizes workforce and the diversity of services available. Will require van rental. ($200,000 – 300,000 per mobile team)

- Crisis center enhancement
- Harm reduction training and integration into practice
- Peer support co-location in ED & other settings
- Naloxone & FTS
- Transportation
- Bridge Clinics
- Expansion of Housing and Other Recovery Supports including Oxford House and National Alliance of Recovery Residence (NARR) certified houses.
- Reintegration Services for justice involved individuals
- Workforce development—Co-occurring training/support, recovery capital training etc.

To manage and support this process will require additional staff positions for the Division. These include a Program Manager to oversee and implement the process and staff with particular expertise in; dual diagnosis treatment and co-occurring mental health and SUD program implementation, Medication for Opioid Use Disorder', and integrated BH/SUD and physical health services.

References

1. Kirby, A, Kizewski, A, Bunn, T. (2020). *Recovery Housing in Kentucky: Assessing the Landscape of*
    a. *Recovery Housing in Kentucky: Findings from the Exploratory Project*. KY Injury Prevention Research Center.
    b. https://kiprc.uky.edu/programs/kentucky-recovery-housing-landscape-assessment

2. Kentucky Housing Corporation. (2020). *2020 K-Count Results*. Retrieved from: https://www.kyhousing.org/Data-Library/Pages/K-Count-Results.aspx.

3. Slavova, Rock, Bush, Quesinberry, & Walsh, 2020

4. Kentucky Substance Use Research & Enforcement, 2021)

5. HCUP Fast Stats, 2020

6. CDC/NCHS, National Vital Statistics System, Mortality. CDC WONDER, 2020

7. Kentucky Death Certificate Database, Kentucky Office of Vital Statistics, CHFS, 2009-2019

8. Source: Wang Q.Q., et al., (2020). COVID-19 risk and outcomes in patients with substance use disorders: analyses from electronic health records in the United States. Molecular Psychiatry

9. The COVID Tracking Project

10. CDC National Vital Statistics System

11. Kaiser Family Foundation, 2020; Health Affairs, 2020

12. Children's Bureau, 2020

13. Office of Drug Control Policy, 2019

14. Substance Abuse and Mental Health Services Administration (SAMHSA) (2011). *Current*

Statistics on the Prevalence and Characteristics of People Experiencing Homelessness in the United States. Retrieved from: https://www.samhsa.gov/sites/default/files/programs_campaigns/homelessness_programs_resources/hrc-factsheet-current-statistics-prevalence-characteristics-homelessness.pdf

Substance Use Primary Prevention (Required Set Aside: 20% of SABG Total – For KY this is $3,299,232.00)

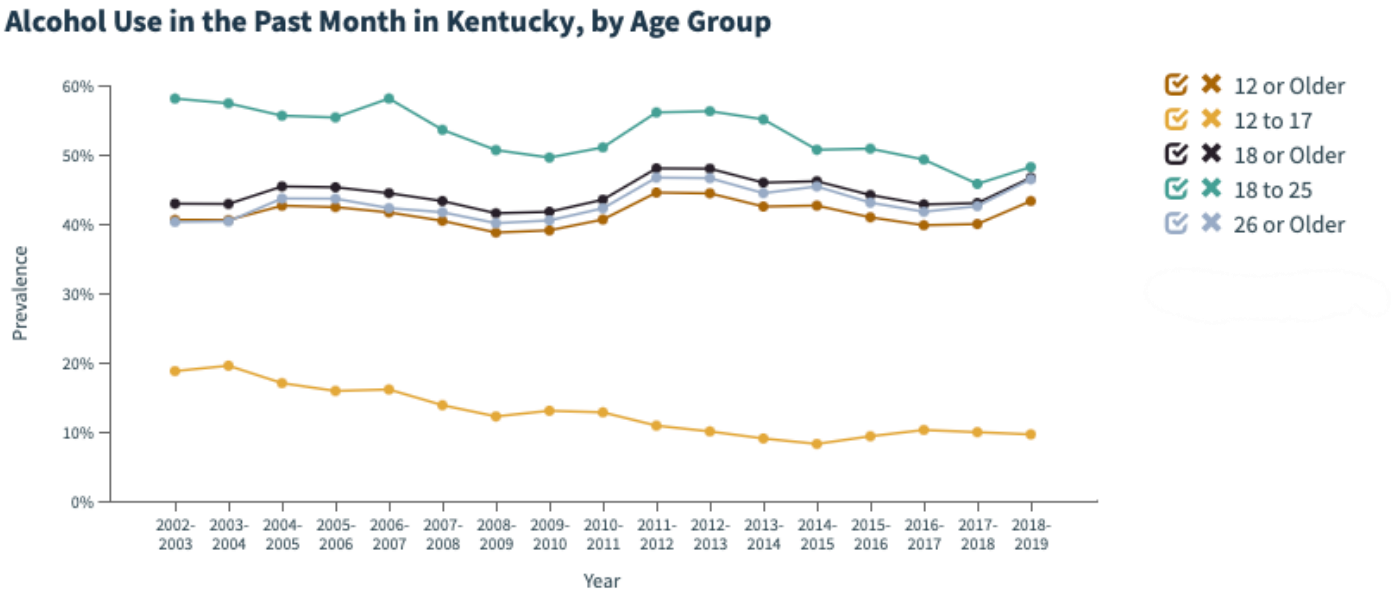
Identified Need/Gaps

Over the past 10 years, Kentucky, like many other states across the nation, has been in throes of an opioid crisis. This public health crisis has impacted individuals, families, and communities, leaving disability, death, loss of income, and the spread of infectious diseases, across the state. But opioids, including fentanyl, heroin, and prescription drugs, are not the only substances of misuse in Kentucky. Alcohol, tobacco, and marijuana, along with stimulants, including cocaine and methamphetamines, impact the health and wellbeing of Kentucky's communities, as well.

While primary prevention efforts over the past decade have addressed alcohol, tobacco, and marijuana use, the need to address the growing opioid and stimulant crisis has reduced Kentucky's prevention capacity to focus on early initiation of use of these easily accessible substances. To ensure that alcohol and cigarette use trends continue downward, and that e-cigarette and marijuana use do not continue to climb, increased emphasis is needed regarding both youth use and adult use and misuse of these substances. Closing this capacity gap will involve supporting additional staff serving each of Kentucky's 14 regions and 120 counties. Additionally, needs for increased programming to address these substances is required to increase awareness of the consequences of alcohol, tobacco, and marijuana use and misuse. Additional support is needed to ensure youth across the state receive evidence-based curricula increasing their awareness of the consequences of substance use, that parents and guardians know and understand how to raise resilience among youth to offset both individual and community-level adverse childhood experiences, that transition-aged youth and adults are provided resources and awareness on the consequences of excessive substance use, especially binge drinking and marijuana use.

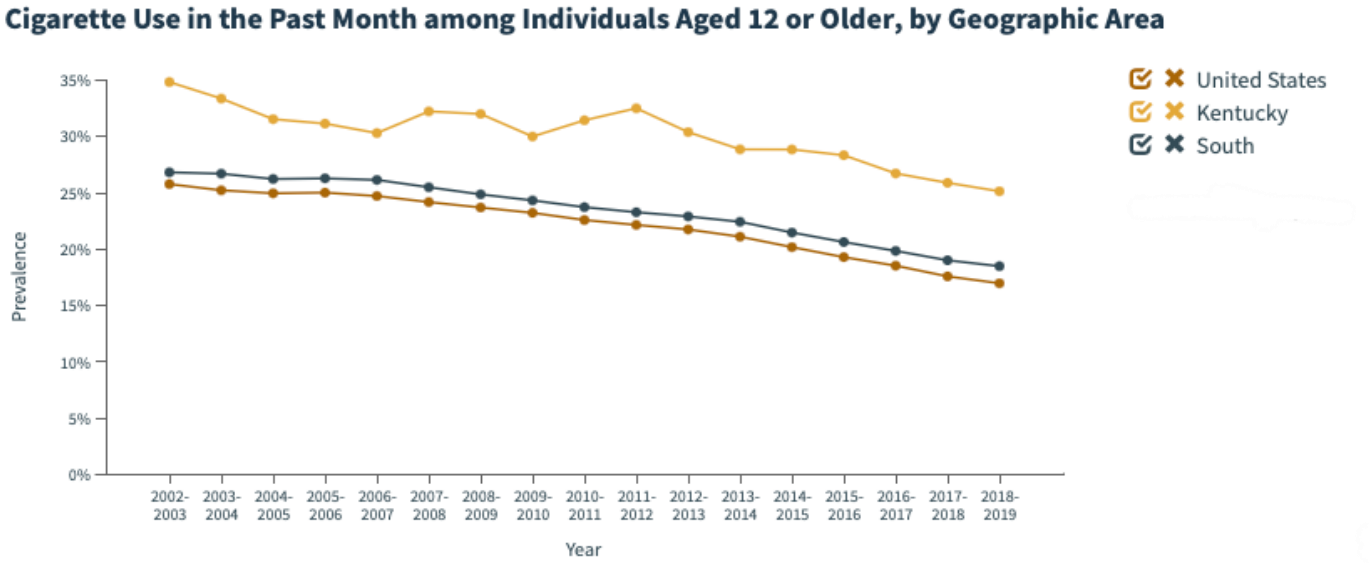
ALCOHOL

More than 43% of Kentucky's population over the age of 12 (NSDUH) report they've used alcohol in the past 30 days and that rate is rising especially among those over the age of 18. Those between the age of 18 to 25 use at higher rates than other age groups in Kentucky and are experiencing increases at greater rates. Nearly 23% of Kentucky residents report they binge drink and the state's binge drinking rate has increased at faster rates than other age groups. According to revenue data from April 2020, wine consumption taxes increased 32 percent and taxes from distilled spirits rose by almost 20%. For 2020, that retailer's sales were up 15% over 2019 and remained elevated through the early part of 2021. About 5% of the state's population reports an alcohol use disorder in the past year and nearly 5% report they needed treatment but did not receive it in the past year. Fewer than 45% of Kentucky's residents perceive that having five or more drinks once or twice a week (binge drinking) is harmful.



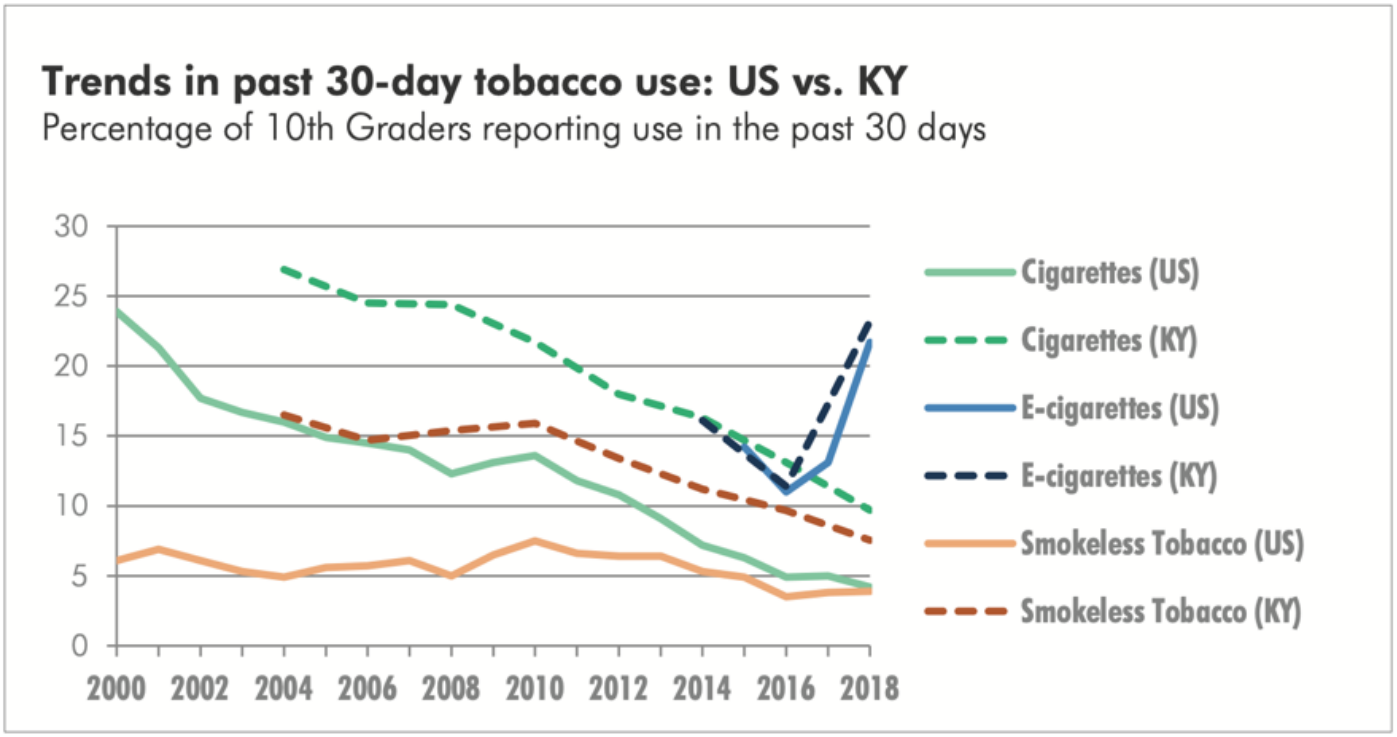
NICOTINE

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



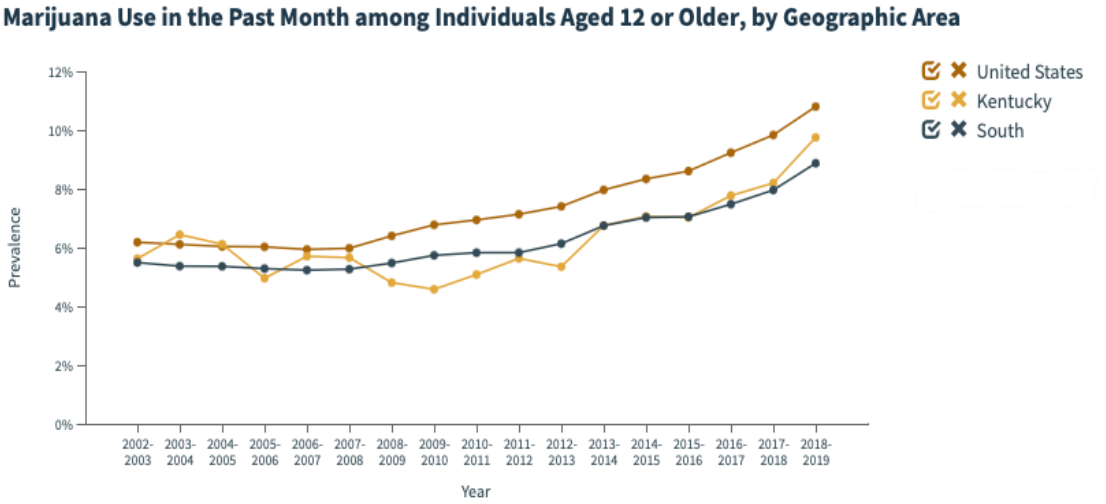
Additionally, in 2018, according to the Kentucky Incentives for Prevention (KIP) Youth Risk Survey, e-cigarette use skyrocketed among 10th graders, outpacing, for the first time ever, alcohol as the number one substance of choice by youth. While the increase mirrored national trends, Kentucky's youth e-cigarette use still outpaces national numbers.

In 2017, nearly 9,000 people died from smoking related illnesses. More at that time than alcohol, AIDS, car crashes, illegal drugs, murders, and suicides combined (Foundation for a Healthy Kentucky). Smoking is attributed to the cause of 34% of all cancer cases in Kentucky, which has both the highest incidence of cancer and the highest number o cancer deaths in the country. Each year in the Commonwealth, 4,830 new cases of lung cancer are tied to smoking. Accessibility and retail price of tobacco has been attributed as contributing factors to high use of nicotine-containing products in the state. Kentucky's cigarette tax of 60 cents per pack ranks 43rd in the country, significantly below the national average of $1.71. The Campaign for Tobacco-Free Kids estimates that increasing that tax by $1 would result in 29,400 adults quitting smoking, 23,200 youth never starting, and 5,900 babies born healthier over the five-year period after the enactment. Additionally, $31.6 million in medical costs would be saved and $266.2 million in increased revenue would be generated.

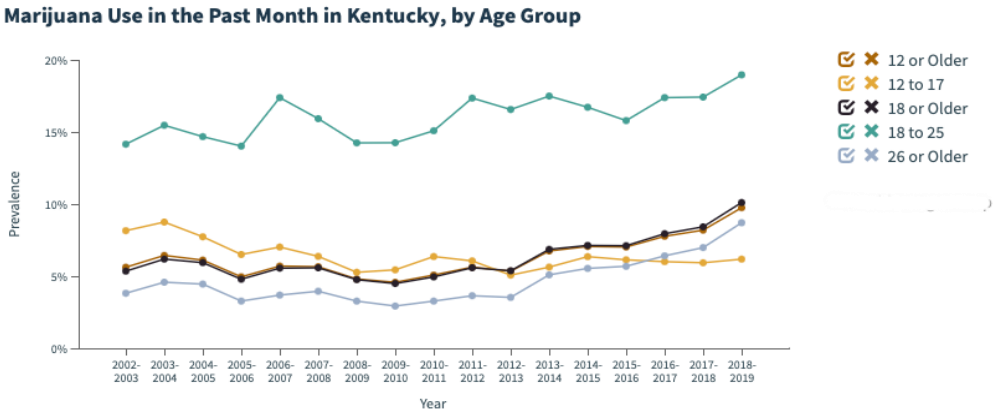


MARIJUANA

While Kentucky currently does not have legal medical or recreational marijuana sales, the use of marijuana among residents is climbing exponentially. Since the 2015-2016 NSDUH report, Kentucky's past use marijuana use among those over the age of 12 has climbed 38%, from 7.02% to 9.75%. The majority of those increases are among Kentucky residents over the age of 26. Past 30-day use rate among that age group has climbed 38% since 2015, from 6.8% to 9.39%. Among the 18-25 age group, the rate has climbed 11% and among the 12-17 age group, 4%.



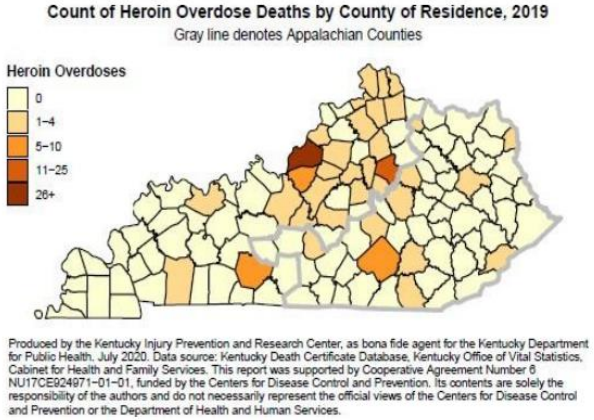
Residents aged 18-25 use marijuana at significantly greater rates than other age groups, with nearly 23% reporting past 30-day use in 2018-2019. Over the past two iterations of the survey, Kentucky's rate has climbed twice as fast as the rest of the nation (19% KY vs. 9% U.S.). Overall, nearly 10% of Kentuckians report 30-day use of marijuana. A little over 2% of Kentucky's residents reported first use of marijuana in the last year, with increases noted in all age groups, but significantly within those who are 12 to 17 and 18-25. Marijuana use also has been attributed to a 40% to 60% increase in suicidal ideation, planning and attempts among those aged 18-34 over the past decade with the greatest increases noted among women and those with major depressive episodes (NSDUH).



OPIOIDS

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

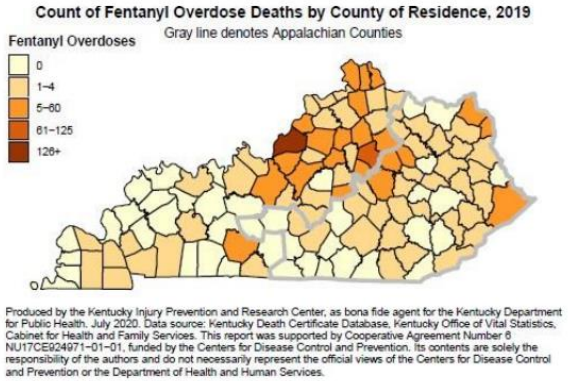
Heroin was present in approximately 13% of OD deaths in which autopsy and toxicology reports are available. This is down from 2015 and 2018 data. The top five counties for heroin-related overdose deaths were Jefferson (61), Fayette (17), Bullitt (8), Pulaski (5), and Warren (5). Additionally, the report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



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

to KASPER data, which is approximately 1.01 prescriptions per person. The number of total opioid prescriptions have been slowly declining for years.

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



The 2018 KIP result also show that 1.9% of 10th graders report that they first used a prescription drug (such as OxyContin, Percocet, Vicodin, etc.) without a doctor's prescription before the age of 12. This rate has been steady for 10th graders since 2012 when the question was added to the KIP survey. The results for 12th graders have also been steady since 2012, but in 2018, it dropped from 1.7% to 1.3%. However, this same question has shown significant increases for 6th and 8th graders in that time frame, rising from 2% to 2.6% for 8th graders (30% increase) and from 1.3% to 1.7% for 6th graders (31% increase).

Past year prescription drug use, as reported on the KIP, has shown a decrease from 2010 to 2018 for all age groups. There was a decrease of 1.8% to 1.2% for 6th graders, 5.3% to 3.1% for 8th graders, 11.3% to 4.9% for 10th graders, and 13.1% to 4.9% for 12th graders. Thirty-day use of prescription drugs has similarly declined in that time frame as well, falling from 1% to 0.5% for 6th graders, 2.9% to 1.6% for 8th graders, 6.2% to 2.5% for 10th graders, and 7.2% to 2.3% for 12th graders. These declines speak to the significant prevention efforts that have been in place across the state over this time frame and serve as effectiveness indicators of strategies implemented to address the non-medical use of prescription drugs in that time frame. However, past-year and 30-day painkiller usage, specifically, OxyContin, Percocet, Vicodin and Codeine) has increased in the same time frame (see graphs below for specifics). This suggests that more attention should be given for prevention efforts that address the misuse of these painkillers specifically.

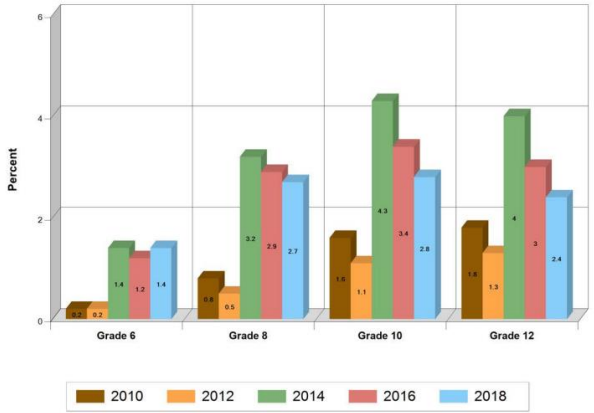
30 Day Painkiller Usage

Kentucky

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

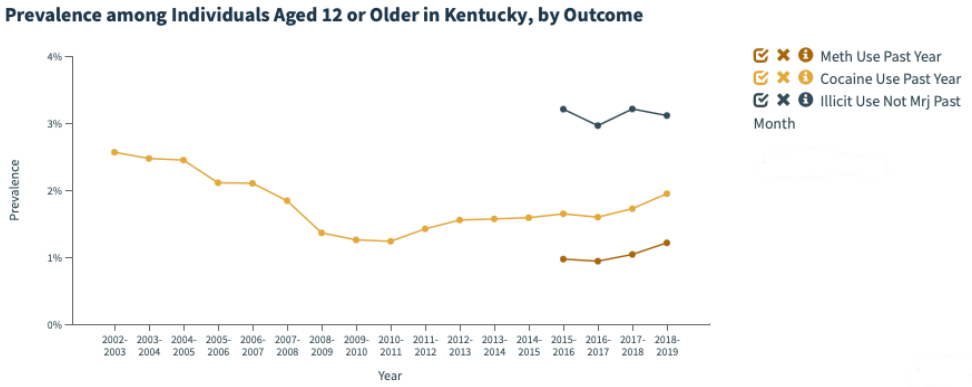
Percent that answered at least 1 occasion

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



STIMULANTS (Methamphetamines, Cocaine, Prescription Drugs)

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



Lethality, availability, and polysubstance use have all increased the consequences of using and misusing these substances (KYODCP). The switch to methamphetamine has been attributed by state substance use subject matter experts as a response to a reduction in access to pain medication. Often, meth is mixed with cocaine and/or fentanyl because it is inexpensive to produce, enhances the effects of meth, and results in a faster addiction to the substance. Both synthetic and natural cocaine have been found in Kentucky, and as is the case with methamphetamines, it is often mixed with an opioid to increase its effects. This deadly mixture has increased overdose death numbers in the state.

EARLY INITIATION OF ALCOHOL, TOBACCO AND MARIJUANA

Research indicates, and Kentucky data confirms, that youth who begin to use alcohol, tobacco, and marijuana before the age 12 are more likely to use opioids and other substances earlier and have greater consequences, including developing a substance use disorder (KIP). Among 10th graders who began using alcohol, tobacco, and marijuana before the age of 12, after controlling for gender, race/ethnicity, free/reduced lunch, and military connection, those who began using alcohol, tobacco or cigarettes before the age of 12 were 15.9 times as likely to misuse prescription opioids and 16.4 times as likely to use heroin compared to their peers who had never used these substances. Even when use doesn't start as early, youth use still increases the likelihood that problematic use will occur, and those consequences will be greater. Among those 10th graders who reporting using after the age of 12, compared to their peers, they were 9.6 times as likely to misuse prescription drugs and 9.3 times as likely to use heroin.

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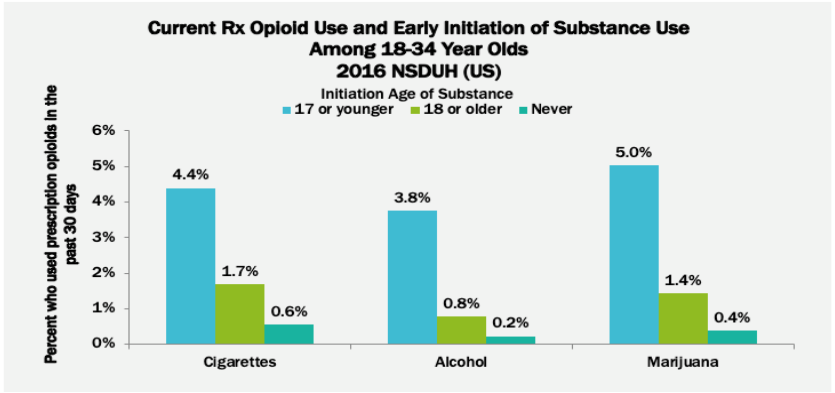
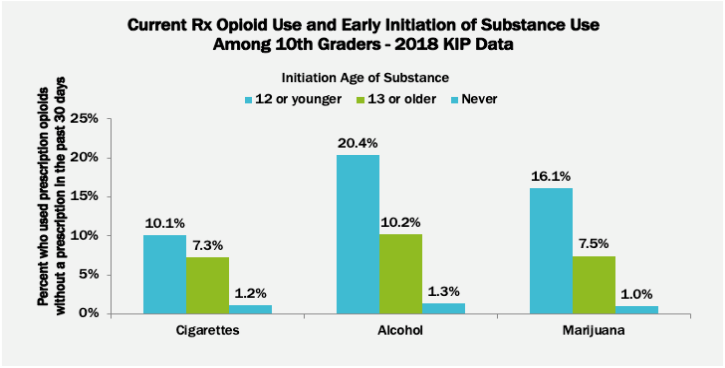
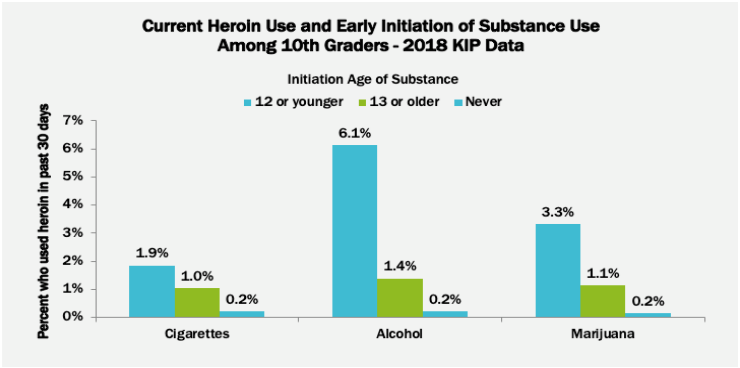
EARLY INITIATION OF SUBSTANCE USE & OPIOIDS



EARLY INITIATION OF SUBSTANCE USE & OPIOIDS



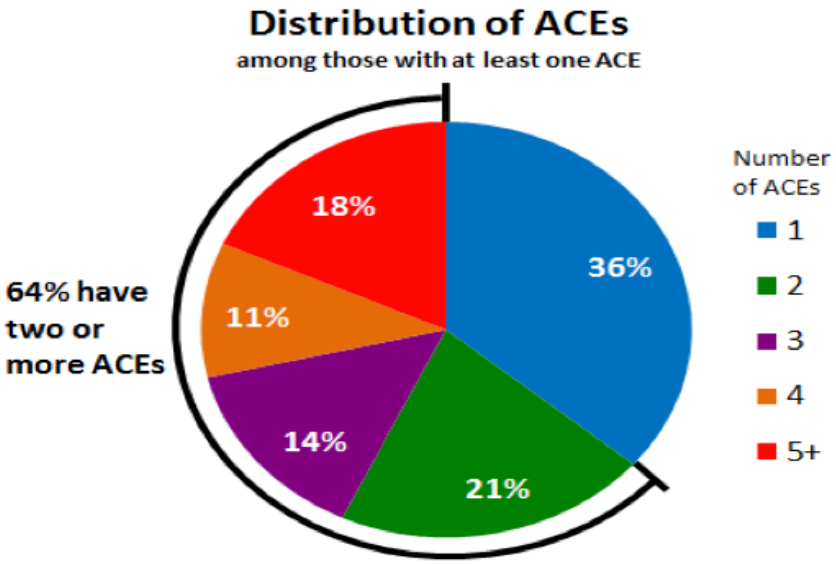
EARLY INITIATION OF SUBSTANCE USE & OPIOIDS



Those increased risks carry into adulthood. Among 18-34 years, those who began using substances before the age of 17 were 8 times as likely to misuse prescription opioids (NSDUH). Those who began use after the age of 17 were 2 times as likely to misuse prescription opioids, compared to their peers who had never used cigarettes, alcohol, or marijuana.

COMMUNITY ACES AND HEALTH DISPARITIES

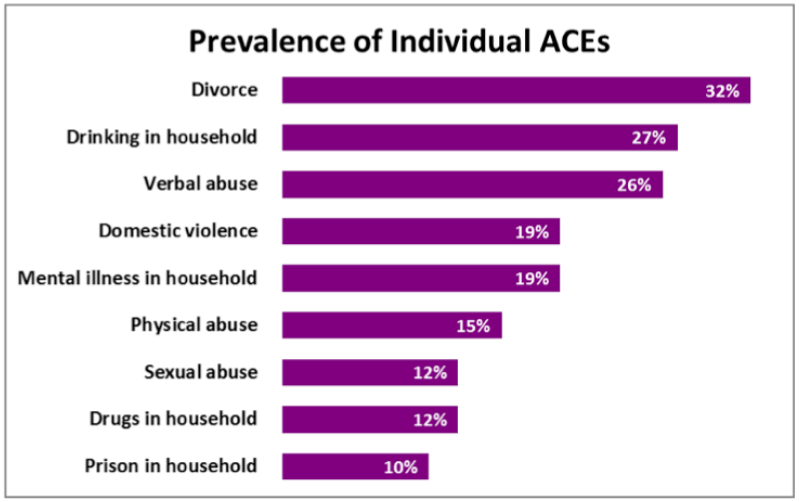
Adverse Childhood Experiences (ACEs) are certain events that when experienced during childhood can dramatically increase one's risk for everything from heart disease and diabetes to depression, drug drug use, and suicide. In Kentucky, 27% of children and youth (0-17) have experienced two or more ACEs (Kentucky Youth Advocates). Overall, the state ranks 39th for ACES (County Health Rankings, 2020).



Data Source: Kentucky Behavioral Risk Factor Surveillance (KyBRFS); Year 2015

The national average is less than 15%. In Kentucky, the most common adverse childhood experiences among Kentucky children are divorce or separation of parents (33%), economic hardship (27%), and the incarceration of a parent or guardian (15%). In the adult population, nearly 60% of Kentuckians report at least one ACE and 64% have experienced two or more (KyBRFS). Of those experiencing at least one ACE, 32% experienced divorce, 27% experienced drinking (problem drinker or alcoholism) in the household, and 26% experienced verbal abuse. As the number of ACEs increase, the likelihood of risky behavior and other consequences also increase. Those who experience five or more ACEs are significantly more likely to experience binge drinking compared to peers who

have no ACEs or even just one or two ACEs. Increased smoking (4X greater risk), depression (5X greater risk), and poor mental health (4X greater risk) are also correlated with an increased number of ACEs.



Data Source: Kentucky Behavioral Risk Factor Surveillance (KyBRFS); Year 2015

Additionally, Kentucky's children and youth experience adverse community environments, such as poverty, discrimination, and housing instability, which contribute to systemic inequities that exacerbate poor long-term health outcomes. Overall, Kentucky is ranked 37th in overall child well-being (Kids Count). The poverty rate for 2019 in Kentucky was 16.3% and the state was ranked 48th in the nation for the number of residents living in poverty (talkpoverty.org). Among children under the age of 18, the poverty rate climbs to 22%. Higher poverty rates are also noted for those who are Black (32%), Hispanic (30%), and Two or more races (33%) (Kids Count). Fifteen percent of Kentucky kids live in high poverty neighborhoods, where poverty rates for the total population are 30% or more. While the percent of total children who live in families receiving public assistance was 26%, among Black families it climbed to 42%. Nearly 14% of Kentucky's households reported hunger and food insecurity from 2017 to 2019 (talkpoverty.org). The state averages 72 affordable housing units for every 100 renter households with very low incomes in 2018. Very low-income households are those with incomes at or below half of median income in the metropolitan or other area where they live. In 2019, 23% of Kentucky's kids lived in a household where more than 30% of the monthly income was spent on housing expenses (Kids Count). The state's unemployment rate was 4.5% in May 2021 and the state was ranked 19th compared to other states (U.S. Bureau of Labor Statistics). Four percent of children live in a home with at least one unemployed parent (Kids Count). More than 50% of Kentucky households with children between the ages of zero and 17 had at least one household member experience unemployment between March 13, 2020 and March 13, 2021. Less than 39% of young adults ages 24-35 have an associate's degree or higher (talkpoverty.org). These data indicate that prevention efforts should focus on changing the environment where children live and go to school in order to create healthier residents and communities, especially focusing on Black and Brown communities.

Plan to Address Need/Gaps

ARPA funds will be utilized to support increased program implementation at the community level. Each of Kentucky's 120 counties will receive an additional $10,000 over the life of this project to implement community-level prevention efforts. These efforts will build capacity of community coalitions and other key stakeholder to deliver prevention services, as well as focus on data-driven environmental strategies to change community conditions that contribute to increased substance use. Each individual community will determine/select

the initiatives it will address based on a local needs assessment. The funds will also be targeted at reducing early initiation of alcohol, tobacco, or marijuana use as indicated by the needs assessment.

Collaboration Specialists were put in place in Kentucky's 14 Regional Prevention Centers in 2019 as part of the State Opioid Response efforts. These specialists have focused on engaging and empowering key stakeholders to support and implement prevention efforts across the state. The positions are currently funded through September 2023 with funding from the SOR grant. ARPA funds may be utilized to continue these positions, supporting the retention of capacity to implement primary prevention efforts, at the community level.

Similarly, Youth Empowerment specialists were put in place in the state's RPCs in 2019 as part of the State Opioid Response efforts. These specialists have focused on engaging and empowering youth and their adult advisors to implement primary prevention strategies and engage in prevention initiatives at the community level. The positions are currently funded through September 2023 with funding from the SOR grant. ARPA funds may be utilized to continue these positions, supporting the retention of capacity to implement primary prevention efforts, at the community level.

Kentucky is home to two large military installments, Fort Campbell and Fort Knox, and has a significant National Guard population. As a result, 40% of Kentucky's youth report being military connected. Youth who report they are military connected have higher rates of substance use and psychological distress. Efforts began in Kentucky's Partnership for Success 2015 grant to address the military connected population in the state. It is proposed that a military focused prevention specialist be placed in one RPC and will provide training and technical assistance to the other 13 RPCs across the state. This position will be responsible for coordinating Kentucky's Purple Start program and working collaboratively with the Kentucky National Guard to provide prevention information and curriculum to youth and family members during Yellow Ribbon events. The events are conducted for family members of soldiers who will, or are deployed, or who have recently returned from deployment.

Sources of Strength is a peer-led, evidence-based prevention project designed to harness the power of peer social networks to change unhealthy norms and culture to prevent substance use. Kentucky has been implementing the middle and high school version of Sources of Strength since 2015 through its Garrett Lee Smith Youth Suicide Prevention Grant and its State Opioid Response efforts. Support for the elementary program began in 2021 with SOR funding, which expire in September 2023. ARPA funds will be utilized to continue and enhance implementation beyond the current funding cycle to increase participation in the program.

Too Good for Drugs is a K-12 evidence-based curriculum delivered to students in the classroom setting. ARPA funding will be used to replenish workbooks and kits for schools that have onboarded during the initial years of the project and expand the reach of the program moving forward.

The Dinner Table Project is a resilience building project focused on increasing conversation and connection between children and their families and other trusted adults. It is deployed through a variety of community stakeholder and includes materials to reach elementary, middle, and high school students and military-connected families. It is built on the research behind the 40 Developmental Assets needed to support youth thriving in a community. Funding from ARPA will support enhanced implementation of the project beyond its current status.

ARPA SAPT Block Grant Proposed Budget

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