# I: State Information

## State Information

### Plan Year

Start Year:
2012

End Year:
2013

### State SAPT DUNS Number

Number
927049767

Expiration Date

### I. State Agency to be the SAPT Grantee for the Block Grant

Agency Name
Cabinet for Health and Family Services

Organizational Unit
Department for Behavioral Health, Developmental and Intellectual Disabilities

Mailing Address
100 Fair Oaks Lane 4 E-B

City
Frankfort

Zip Code
40621

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

First Name
Louis

Last Name
Kurtz

Agency Name
Division of Behavioral Health

Mailing Address
100 Fair Oaks Lane 4 E-D

City
Frankfort

Zip Code
40621

Telephone
502-564-4456

Fax
502-564-9010

Email Address
louis.kurtz@ky.gov

### State CMHS DUNS Number

Number
927049767

Expiration Date

### I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name

Cabinet for Health and Family Services

Organizational Unit

Department for Behavioral Health, Developmental and Intellectual Disabilities

Mailing Address

100 Fair Oaks Lane 4 E-B

City

Frankfort

Zip Code

40621

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

First Name

Louis

Last Name

Kurtz

Agency Name

Division of Behavioral Health

Mailing Address

100 Fair Oaks Lane 4 E-D

City

Frankfort

Zip Code

40621

Telephone

502-564-4456

Fax

502-564-9010

Email Address

louis.kurtz@ky.gov

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

From

7/1/2009

To

6/30/2010

## IV. Date Submitted

NOTE: this field will be automatically populated when the application is submitted.

Submission Date

Revision Date

4/26/2012 2:16:43 PM

## V. Contact Person Responsible for Application Submission

First Name

Michele

Last Name

Blevins

Telephone

502-564-4456

Fax

502-564-9010

Email Address

michele.blevins@ky.gov

## Footnotes:

# I: State Information

## Assurances - Non-Construction Programs

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Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

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Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

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| | |
|---|---|
| Name | Janie Miller |
| Title | Cabinet Secretary |
| Organization | Kentucky Cabinet for Health and Family Services |

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Signature: _____ Date: _____

Footnotes:

The Attachments section of the 2012 Combined Behavioral Health Assessment and Plan contains the signed .pdf version of the Assurances.

# I: State Information

## 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 45 CFR Part 76, and its principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

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 45 CFR Part 76 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), ?, (d), ?, and (f).

For purposes of paragraph ? regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

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)

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.

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| | |
|---|---|
| Name | Janie Miller |
| Title | Cabinet Secretary |
| Organization | Kentucky Cabinet for Health and Family Services |

---

Signature: _____ Date: _____

Footnotes:

5

The Attachments section of the 2012 Combined Behavioral Health

Assessment and Plan contains the signed .pdf version of the Certifications.

6

# I: State Information

## Chief Executive Officer's Funding Agreements/Certifications (Form 3) [SAPT]

FY 2012 Substance Abuse Prevention and Treatment Block Grant Funding Agreements/Certifications as required by Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act

Title XIX, Part B, Subpart II and Subpart III of the PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute.

SAMHSA will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached.

I. FORMULA GRANTS TO STATES, SECTION 1921

II. Certain Allocations (Prevention Programs utilizing IOM populations ; Pregnant women and women with dependent children) Section 1922

III. INTRAVENOUS DRUG ABUSE, SECTION 1923

IV. REQUIREMENTS REGARDING TUBERCULOSIS AND HUMAN IMMUNODEFICIENCY VIRUS, SECTION 1924

V. Group Homes for Recovering Substance Abusers, Section 1925

VI. State Law Regarding Sale of Tobacco Products to Individuals Under Age of 18, Section 1926

VII. TREATMENT SERVICES FOR PREGNANT WOMEN, SECTION 1927

VIII. ADDITIONAL AGREEMENTS(IMPROVED REFERRAL PROCESS, CONTINUING EDUCATION, COORDINATION OF ACTIVITIES AND SERVICES), SECTION 1928

IX. IX SUBMISSION TO SECRETARY OF STATEWIDE ASSESSMENT OF NEEDS, SECTION 1929

X. MAINTENANCE OF EFFORT REGARDING STATE EXPENDITURES, SECTION 1930

XI. Restrictions on Expenditure of Grant, Section 1931

XII. APPLICATION FOR GRANT; APPROVAL OF STATE PLAN, SECTION 1932

XIII. Opportunity for Public Comment on State Plans, Section 1941

XIV. Requirement of Reports and Audits by States, Section 1942

XV. ADDITIONAL REQUIREMENTS, SECTION 1943

XVI. Prohibitions Regarding Receipt of Funds, Section 1946

XVII. Nondiscrimination, Section 1947

XVIII. Continuation of Certain Programs, Section 1953

XIX. Services Provided By Nongovernmental Organizations, Section 1955

XX. Services for Individuals with Co-Occurring Disorders, Section 1956

I hereby certify that Kentucky will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, as 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.

| | |
|---|---|
| Name | Janie Miller |
| Title | Cabinet Secretary |
| Organization | Kentucky Cabinet for Health and Family Services |

Signature: _____ Date: _____

## Footnotes:

The Attachments section of the 2012 Combined Behavioral Health Assessment and Plan contains the signed .pdf version of the Chief Executive Officer's Funding Agreements/Certifications (Form 3) [SAPT].

# I: State Information

## Chief Executive Officer's Funding Agreements/Certifications (Form 3) [CMHS]

Community Mental Health Services Block Grant Funding Agreements
FISCAL YEAR 2012

I hereby certify that Kentucky agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

I. Section 1911:

Subject to Section 1916, the State will expend the grant only for the purpose of:
i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:
ii. Evaluating programs and services carried out under the plan; and
iii. Planning, administration, and educational activities related to providing services under the plan.

II. Section 1912:

(c)(1)&(2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms “adults with a serious mental illness” and “children with a severe emotional disturbance” and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

III. Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2011, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a “service area”)
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

IV. Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:
(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:
(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and
(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

V. Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.
(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

VI. Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;
(2) to make cash payments to intended recipients of health services;
(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or
(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

VII. Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

VIII. Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]
(c) The State will:
(1) make copies of the reports and audits described in this section available for public inspection within the State; and
(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

IX. Section 1943:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

Notice: Should the President's FY 2008 Budget be enacted, the following statement applies only to States that received the Mental Health Transformation State Infrastructure Grants:

This Agreement certifies that States that received the Mental Health Transformation State Infrastructure Grants shall not use FY 2008 Mental Health Block Grant transformation funding to supplant activities funded by the Mental Health Transformation Infrastructure Grants.

| | |
|---|---|
| Name | Janie Miller |
| Title | Cabinet Secretary |
| Organization | Kentucky Cabinet for Health and Family Services |

Signature: _____ Date: _____

## Footnotes:

The Attachments section of the 2012 Combined Behavioral Health Assessment and Plan contains the signed .pdf version of the Chief Executive Officer's Funding Agreements/Certifications (Form 3) [CMHS].

# I: State Information

## Disclosure of Lobbying Activities (SF-LLL)

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Footnotes:

# II: Planning Steps

## Step 1: Assess the strengths and needs of the service system to address the specific populations

Page 22 of the Application Guidance

Narrative Question:

Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the State, intermediate and local levels differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other State agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities as well as youth who are often underserved.

### Footnotes:

Substance Abuse Treatment
Women who are pregnant and have a mental health and/or substance use disorder:

In Kentucky, pregnant women are the only adult population with a benefit covering substance abuse treatment and prevention. Most of the CMHCs screen at initial contact and provide care within twenty-four (24) hours; the remainder within forty-eight (48) hours.

Four (4) additional long term residential treatment programs and eleven (11) short term (approximately 30 days) residential programs accept pregnant women. Only one (1) residential program accepts pregnant adolescents.

Intensive outpatient treatment is available in eleven (11) of the fourteen (14) regions for pregnant women and in four (4) regions for pregnant adolescents. Four (4) of the residential programs that accept pregnant women (including Independence House) also accept the woman's dependent children.

The University of Kentucky Medical Center in Lexington has a high risk pregnancy clinic that provides medical detoxification and/or stabilization on methadone for those who will be able to continue in medication assisted treatment upon returning home. All of the eleven (11) Opiate Treatment Centers accept pregnant women and all (including nine (9) private programs) consider pregnant women a priority population.

Persons who are Intravenous Drug Users (IDU):

Overall, there were a total of 5,265 individuals over the course of approximately four years who sought addiction treatment in Kentucky and had a history of injection drug use. Only one-fourth of those individuals were in OTPs during that time period and the numbers across years did not change significantly among the OTP client sample. The increase in individuals reporting a history of injection drug use among the CMHC substance abuse treatment sample is statistically significant.

Kentucky has 11 licensed OTPs; 2 publically funded and 9 independently owned. Kentucky regulates and monitors its OTPs more stringently than many states, and as a result, the programs provide quality care, both medical and psychosocial.

Individuals with Tuberculosis:

The Division of Behavioral Health continues to assess for compliance with both contractual and regulatory mandates through comprehensive onsite reviews conducted biennially at the CMHCs and annually at the licensed Opioid Treatment Programs. Review teams including a peer reviewer from the field, examine client service records for documentation of a referral for TB screening and evidence that the client was provided with information and the option to be tested for HIV. Review team members also interview clients and program staff and review personnel records and agency policies to ensure requirements are met and the appropriate services are provided. The DBHDID continues to ensure appropriate training is available to substance abuse staff and that continuing education is provided that offers the most current information on infectious diseases.

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

The Kentucky HIV/AIDS Program is operated by the Cabinet for Health and Family Services (CHFS), Department for Public Health (DPH), and is mandated by state law to document and maintain the HIV/AIDS case reports data.

Kentucky is exempt from the HIV early intervention set aside requirement due to the number of AIDS cases being less than 10 per 100,000 for the last several years.

## Section II. Planning Steps

### Step 1: Assess the strengths and needs of the service system to address the specific populations

*(page 21 of the Application Guidance)*

*Narrative Question: Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state, intermediate and local levels differentiating between child and adult systems. This description should include a description of regional, county and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities.*

The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) is Kentucky's designated State Mental Health Authority (SMHA) and Single State Agency for Substance Abuse Services (SSA), as well as the State Opioid Treatment Authority (SOTA). Per Kentucky Revised Statute (KRS) 194.030, DBHDID is identified as the primary state agency for developing and administering programs for the prevention, detection and treatment of:

- Mental Health (Adults and Children)
- Substance Abuse Prevention and Treatment Services
- Developmental and Intellectual Disabilities

DBHDID is part of the Cabinet for Health and Family Services (CHFS), which was most recently reorganized in February 2011. CHFS is one of the largest agencies in state government, with nearly 8,000 full and part-time employees. Among other offices and councils, the following are also within the Cabinet:

- Office of the Secretary
- Office of Health Policy (including Certificate of Need)
- Office of Legal Services
- Office of the Inspector General (Licensing and Regulation Authority)
- Office of Communications and Administrative Review
- Office of the Ombudsman
- Office of Policy and Budget
- Office of Human Resource Management
- Office of Administration and Technology Services
- Department for Public Health (Local and State Public Health Programs)
- Department for Medicaid Services (Medicaid Authority)
- Department for Aging and Independent Living (Aging, Guardianship, Brain Injury Services)
- Department for Community-Based Services (Adult and Child Protection, Child Welfare)
- Department for Income Support (Disability Determinations, Child Support Enforcement)
- Department for Family Resource Centers and Volunteer Services
- Kentucky Commission on Community Volunteerism and Service
- Kentucky Commission for Children with Special Health Care Needs
- Governor's Office of Electronic Health Information

Within DBHDID, there are three Divisions, including: Administration and Financial Management; Developmental and Intellectual Disabilities; and Behavioral Health. The Division of Behavioral

Health is a product of the merger of the Division of Substance Abuse and the Division of Mental Health in July 2004. With an increased focus on the treatment needs of individuals with co-occurring disorders (behavioral health and substance abuse) at the national, state and local level, the goal of the merger continues to be transformation to a more integrated, seamless service system.

Within the Division of Behavioral Health, there are four Branches, including:

- *Data Research Branch* – Consists of the Substance Abuse Prevention Branch, which targets the prevention of the abuse of alcohol, tobacco and other drugs in Kentucky, as well as the Driving Under the Influence (DUI) Program;
- *Program Development Branch* – Responsible for creating and planning program infrastructure based on assessment of need, promising practices, and stakeholder participation (also functions as the Children, Youth and Family Services Branch);
- *Program Support Branch* – Provides expert support through training, consultation and customer relations (Substance Abuse Treatment Branch); and
- *Provider Services Branch* – Provides administrative oversight and promotion of quality assurance with networks of service providers and contractors (also functions as the Adult Behavioral Health Services Branch).

An Executive Administrative Order was executed by the Cabinet for Health and Family Services, effective December 16, 2010, establishing a new Branch within the DBHDID's Division of Administration and Financial Management. The new Outcome, Transformation and Education Branch was created to allow the Department to continue to meet quality standards while moving the Department forward with transformation of services to more appropriately meet the needs of individuals with mental/emotional disorders, substance use disorders and those with intellectual and developmental disabilities. This new Branch is slated to work closely with all Divisions.

In February 2011, a Recovery Services Coordinator was hired as part of the management team for the Division of Behavioral Health. The Recovery Services Coordinator is responsible for coordinating consumer and family member support services across the state, and guiding Kentucky towards full implementation of a recovery-oriented behavioral health system. The Coordinator is also committed to identifying disparities, in service provision, with regard to race, ethnicity, age and sexual orientation.

The Department has oversight of inpatient and community programs to address the behavioral health needs of all citizens. The following is a description of the current system and plans for improving it.

Adult Mental Health Inpatient Facilities

For over 180 years, Kentucky has operated psychiatric facilities that provide evaluation and treatment. Kentucky's state hospitals for adults are:

| State Hospital | Location | Operation | Census* |
|---|---|---|---|
| Western State Hospital | Hopkinsville | State operated | 104 |
| Central State Hospital | Louisville | State operated | 74 |
| Eastern State Hospital | Lexington | Contracted | 161 |
| ARH Hazard Psychiatric Center | Hazard | Contracted | 82 |
| | | TOTAL | 421 |

* SFY 2011 Average Daily Census

Census at state hospitals has declined over the past decade as efforts were made to place persons in appropriate community programs. However, various factors, such as the closing of many psychiatric units within local community hospitals, has affected state hospital census.

A replacement hospital for Eastern State Hospital facility is currently under construction and is slated to open in December 2012. Currently, Eastern State Hospital serves an average of 2,000 patients a year from 80 (of the 120) Kentucky counties. The new 300,000-square-foot facility and campus will cost $129 million and will replace the 185-year-old facility, the second oldest psychiatric hospital in the country. Once completed, the new 239-bed facility will provide a modern setting for inpatient psychiatric treatment, along with specialized services for individuals with acquired brain injuries, individuals with psychiatric disabilities requiring nursing facility level of care and forensic mental health services. The facility will be Leadership in Energy and Environmental Design (LEED) certified, meaning it will meet the highest green building and performance measures.

Nursing Homes

The Department operates two facilities that provide care for persons with psychiatric disabilities who also need a nursing level of care for a co-morbid condition, or because they are medically fragile. The facilities primarily serve persons who are discharged from state hospitals, or who are at risk of hospitalization in a state facility. They are:

- WSH Nursing Facility, located on the campus of Western State Hospital in Hopkinsville, which cares for approximately 128 persons; and
- Glasgow Nursing Facility in Glasgow, which cares for approximately 79 persons.

Specialized Personal Care Homes

To provide a less restrictive alternative for people in state hospitals who qualify for a transitional placement from a hospital level of care, specialized personal care homes for adults with serious mental illness (SMI) are available in three of the four hospital districts (admissions are not restricted to residents of regions or districts). These homes, which are licensed in Kentucky as "Personal Care" (combination of room, board, and some supervision and oversight), are operated by Regional Boards.

The focus of the rehabilitative programming within these facilities is the teaching of skills that will enable residents to be integrated into community living situations. The facilities are:

- Center for Rehabilitation and Recovery, a thirty-eight (38) bed unit located on the campus of Central State Hospital, outside Louisville, and operated by Seven Counties Services;
- Bluegrass Personal Care Home, a forty (40) bed facility located on the campus of Eastern State Hospital, in Lexington, and operated by the Bluegrass Regional MHMR Board; and
- Caney Creek Personal Rehabilitation Complex, an eighty (80) bed facility located in Pippa Passes, in southeastern Kentucky, and operated by Kentucky River Community Care.

During SFYs 2008 and 2009, the Center for Rehabilitation and Recovery (CRR) began gradually moving some individuals from the CRR facility to smaller living situations within the community. During SFY 2011, fifteen (15) residents moved to apartments in the community and continued to be provided with necessary supports by CRR staff to maintain their independent living status. In June 2011, a new and separate contract was established between DBHDID and Seven Counties Services, Inc. to operate the Center for Rehabilitation and Recovery, with the goal of moving all residents into permanent, community-based housing by the end of SFY 2013. CRR will continue to operate, but as a Supported Housing program in lieu of a personal care home. This, in essence, creates a less restrictive living environment for adults with SMI. This contract mandates that community housing for this population must follow supportive housing principles, utilizing SAMSHA's Permanent Supportive Housing Toolkit. This contract is a

performance based contract, based on an evidence based practice and requiring positive outcomes utilizing several performance indicators (e.g., Occupancy Standards; Data Reporting; Outcome/Functioning; Person Centered Planning; Staff Training; Psychiatric Inpatient Admissions; Successful Transition; and Fidelity to the Supported Housing Model). The goal for SFYs 2012 and 2013 is to continue to monitor and support this program. The DBHDID will also work with the other specialized personal care homes, during SFYs 2012 and 2013, to develop supported housing plans, assuring that plans are person centered and individualized to regional strengths and needs.

Forensic Psychiatric Services

The Kentucky Correctional Psychiatric Center (KCPC) is an inpatient psychiatric hospital, located within a correctional system complex, but operated by DBHDID. It primarily provides court-ordered inpatient evaluation and treatment to restore competency to persons charged with a felony offense. When inpatient evaluation is unnecessary, the Center facilitates outpatient competency evaluations through contracts for professional services with Regional Boards. In SFY 2011, the facility's average daily census was 56 people.

Children's Mental Health Inpatient Facilities

Although Kentucky has operated a variety of psychiatric facilities for adults, for over 180 years, the state does not operate any inpatient facilities for children and adolescents under age eighteen.

There are currently 735 (up from 712 last year and from 672 in the previous year) available child and adolescent psychiatric beds in Kentucky. The average daily census for the 735 beds is 590 and the average length of stay for patients is 25 days. The 735 beds are located in 14 hospitals that are geographically located in nine of the 14 regions. Other residential care for children includes Psychiatric Residential Treatment Facilities (PRTFs), Private Child Care (PCCs) facilities, Therapeutic Foster Care (TFC). These services are provided by an array of privately operated organizations and most are collectively represented by the Children's Alliance. The Children's Alliance works with state agencies to promote collaboration and create effective public policy for at-risk children and families. The Office of Inspector General, within the Cabinet, 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. Therefore, neither licensing, nor "care, custody and control" of children are a function of the Department for Behavioral Health, Developmental and Intellectual Disabilities.

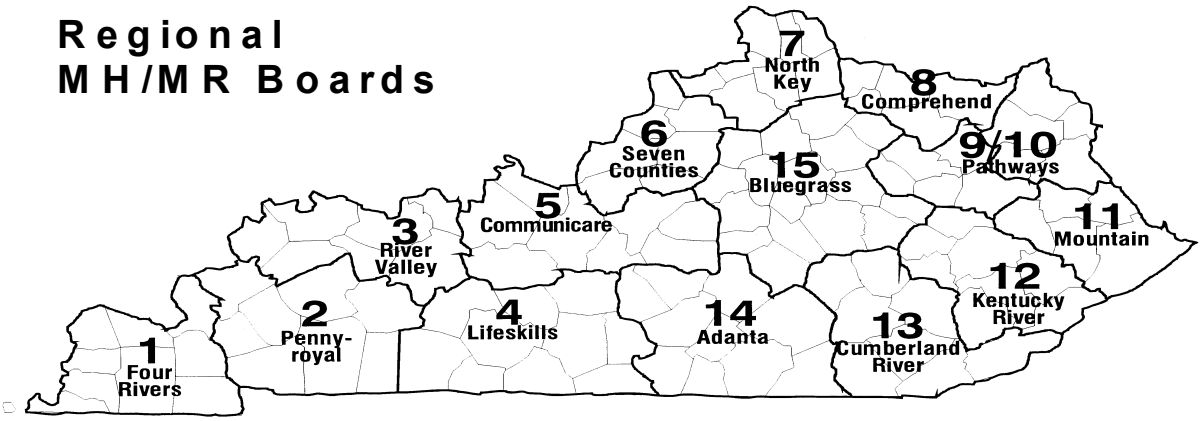
As of May 2011, the Cabinet for Health and Family Services revised the statutes and regulations relating to psychiatric residential treatment facilities (PRTFs). Through legislation, the cabinet added 135 PRTF beds that will be utilized for youth with multiple and complex treatment needs. This includes children with a severe emotional disturbance and other complex treatment needs (e.g., severe and persistent aggressive behaviors, intellectual or developmental disabilities, or sexually reactive behaviors). Facilities have not yet been approved to provide these higher level services but approvals are anticipated within the next year. This adds to the exiting 315 PRTF beds allocated for youth with lower level behavioral health needs.

Community Programs

Kentucky is divided into fourteen geographic regions for the purposes of planning and providing publicly funded community mental health, substance abuse and prevention services. Together, they serve all 120 Kentucky counties. For each region, a Regional Mental Health and Mental Retardation Board has been established pursuant to KRS 210.370-210.480

(http://www.lrc.ky.gov/KRS/210-00/370.PDF) as the planning authority for behavioral health programs in the region. County and municipal governments do not provide community behavioral health services. A Regional Board is:

- An independent non-profit organization;
- Overseen by a volunteer board of directors that broadly represents stakeholders (including consumers and family members) and counties in the region; and
- Licensed by the Cabinet for Health and Family Services as a "Community Mental Health Center."




*Outpatient services are provided primarily through a network of Regional Boards also called "Community Mental Health Centers or Comprehensive Care Centers."*

*Note of Clarification: Regions 9 & 10 were originally two different Boards but merged some years ago and are now counted as one region, thus there are a total of 14 Boards but they are represented with numbers one through fifteen.*

Kentucky Revised Statute 210.410 authorizes the Secretary of the CHFS to make state grants and other funding allocations to Regional Boards to provide, at a minimum, the following behavioral health services:

- Inpatient Services (generally through referral);
- Outpatient Services;
- Partial Hospitalization or Psychosocial Rehabilitation Services;
- Emergency Services;
- Consultation and Education Services; and
- Services for Individuals with an Intellectual Disability.

Behavioral health services, including mental health services for adults and children, substance abuse services for adults and adolescents, and services for individuals with co-occurring are provided in county level clinics. Services may not be denied to any individual based on age, race, ethnicity or ability to pay. In addition to the clinics, there are fourteen (14) Regional Prevention Centers (RPCs) established to provide technical assistance and training on evidence-based prevention strategies. RPCs will be broadening their focus to include mental health prevention and promotion during SFYs 2012 and 2013.

The five (5) Criterion required for the mental health portion of the block grant application are included in this Section and primarily separated into the Adult System of Care and the Child System of Care.

**Assessment of the Strengths and Needs of the Service System to Address Adults, including those with Severe Mental Illness (SMI)**

**Criterion 1: Comprehensive Community Based Mental Health Services**

*Narrative Question: Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:*

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

**HEALTH, MENTAL HEALTH, AND REHABILITATION SERVICES**

**HEALTH**

The interface between the physical healthcare system and the mental health system is of growing importance to providers of behavioral health services. It is well known that a significant amount of behavioral health services are provided in the physical healthcare arena. Continuity of care across these systems is critical if individuals are going to recover and succeed in establishing chosen roles in the community.

Kentucky is a relatively unhealthy state and struggles with poor health outcomes overall. To maintain focus on improving access to dental and physical health services, a representative of the Department for Public Health was appointed to the Kentucky Mental Health Services Planning Council. That representative has been attending planning council meetings since SFY 2003 and contributing valuable suggestions for collaboration between the physical health and mental health system. Additionally, meetings between the Commissioners of DBHDID and the Department for Public Health produced an agreement to establish a formal liaison between the Departments for the purpose of improving collaboration and developing strategies for better integration of physical healthcare service with mental healthcare services.

In April of 2010, the Governor announced the creation of a Health Information Exchange where hospitals and clinics will be able to exchange health information electronically regarding Medicaid clients. Six hospitals and one clinic are participating in this project which is funded by a $4.9 million federal grant. The facilities were selected based on technological readiness, volume of Medicaid clients and referral patterns. The hope is to deliver care more efficiently and improve care and health as well as reducing the number of duplicative tests and treatments, ultimately reducing costs.

The Division of Behavioral Health was awarded a two-year SAMSHA grant in June 2003 to develop regional behavioral health emergency disaster preparedness plans for each of the Regional Boards. As a continuation of that initiative, the Division continued to receive additional

funding (2005-2011) from the Kentucky Department for Public Health to help fund regional and statewide Behavioral Health Disaster Preparedness Coordinators. These Coordinators have provided a behavioral health focus for Kentucky's 14 regional ASPR (Assistant Secretary of Preparedness and Response) healthcare planning coalitions and ongoing interagency collaboration has resulted in integrated and coordinated responses to emergencies and disasters. Despite a 65% cut in the 2009 FFY funding, regional plans continue to be updated annually and the Department continues to designate a Program Administrator to coordinate regional and statewide efforts. The regional emergency disaster planners meet at least quarterly with the statewide coordinator and annually as a group to share information and resources. Goals for SFYs 2012 and 2013 are to continue to work with Public Health in these efforts. Due to a reduction in funding for SFY 2012 from $170,000 to $90,000, each region will experience a reduction of 50% in disaster preparedness funding.

**MEDICAL/DENTAL**

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

During SFY 2010, two Regional Boards received funding to assist with integrating physical and behavioral health services. One region located in rural Western Kentucky received a SAMHSA grant for $500,000 per year for four (4) years. This area serves individuals with primary needs related to poverty, unemployment, obesity, tobacco use, etc. This grant is targeting adults with SMI with numerous primary care needs in eight (8) counties in Western Kentucky. Another region located in Northern Kentucky received several smaller grants from the Health Foundation of Greater Cincinnati focusing on integrated care. A $206,366 grant received in 2007 allowed for the beginning of integration. Five (5) behavioral health clinicians were placed into five (5) separate primary care clinics. A $155,000 grant received during SFY 2010 allowed for the provision of primary care services in more primary care clinics and seeks to address health disparities experienced by individual with SMI.

Physical health services are available through Medicaid or local "free" clinics that provide indigent health care. A number of Regional Boards have chosen to "partner" with local health providers in developing/constructing clinics with shared space for both mental and physical health. These partnerships have been very successful in better identifying both mental health and physical health problems experienced by members of their community.

For dental care, access to low or no cost services are provided by the dental schools at the University of Louisville and the University of Kentucky (in Lexington). They serve individuals in the clinics located in Lexington and Louisville. The University of Kentucky also provides mobile dental services which reach out to uninsured families in Eastern Kentucky (those who do not make enough money to pay for dental care but who make too much money to qualify for Medicaid assistance). There are four dental vans from the University of Kentucky. Several faith based organizations have provided the financial support needed to start these services and to keep them operating. In addition, some faith based groups have opened free clinics in church buildings, which are staffed by volunteer dentists who come to the region from all over the state for weeklong mission trips. And yet others hold dental events in Wal-Mart parking lots, handing out free samples of toothpaste, dental floss and toothbrushes. Still, case managers and clinicians that have knowledge of local resources and well-developed relationships with local

providers tend to lead to better access to dental services. There are, in many communities, those dentists who will serve individuals in need who have no ability to pay. However, overall access to dental care is generally considered poor.

## MENTAL HEALTH

Suicide prevention is a critical consideration for Kentucky's system of care. While suicidality is often recognized among vulnerable youth, research consistently indicates youth are not the most vulnerable group. In Kentucky suicide is the 4th leading cause of death for the 35 to 54 age group. While the attempt rate may level off in middle age, the completion rate increases. Recent data from the CDC indicates that in the last couple of years, for the first time, the suicide death rate among the middle aged population rose higher than what has always been the highest risk group---the elderly age 65+. In 2006, Kentucky's rate of death by suicide went from 16th to the 12th highest in the nation. In October 2004, out of concern for deaths by suicide and the impact for a growing number of survivors, a suicide prevention coordinator was hired within the DBHDID. After gathering together key stakeholders, the KY Suicide Prevention Group (KSPG) emerged as the collaborative group to develop a state suicide prevention plan that guides the state's response to suicide within the Commonwealth. The plan was finalized in 2008, with stakeholder involvement, with key elements of this plan being awareness, intervention and evaluation. The goal for SFY 2012/2013 is to update the current state suicide prevention plan, making sure to include all at-risk populations.

DBHDID has trained over 240 gatekeepers to conduct QPR (Question, Persuade and Refer) awareness trainings throughout the state, nine local suicide prevention coalitions have been established, school-based prevention programs have been introduced to multiple school districts, over 800 clinical trainings have been conducted and statewide media campaigns involving the production of a Kentucky specific video chronicling the impact of suicide on Kentucky citizens have raised the level of awareness throughout the Commonwealth.

During the 2010 Legislative Session, HB 51 was passed, requiring CHFS to post suicide prevention awareness information on its website, and requiring public school administrators to disseminate suicide prevention awareness information to middle and high school students on an annual basis. DBHDID's suicide prevention coordinator has provided training and technical assistance to many school districts regarding suicide prevention, including students as well as education staff.

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

**Regional Availability of Community Support Services SFY 2012**

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 10 | 11 | 12 | 13 | 14 | 15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Services** | **Consumer and Family Support** | | | | | | | | | | | | | |
| Training and Advocacy | X | X | | X | X | X | X | X | X | X | X | | | X |
| Consumer Support Group | | | | X | X | X | X | X | X | X | X | | X | X |
| Social Club Drop In | X | | X | | | | X | | X | | | X | | X |
| Local NAMI of Kentucky | X | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Consumer Conferences | | | X | X | X | | | X | X | X | X | | X | X |
| Peer Support | X | | X | X | | X | | | X | X | X | X | X | X |

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Emergency Services** | | | | | | | | | | | | | | |
| Emergency-Help Line | X | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Walk-In Crisis Services (8-5 M-F) | X | X | | X | X | X | X | X | X | X | X | X | X | X |
| Mobile Crisis Services | X | X | | | | | X | X | X | X | X | | | X |
| Residential Crisis Stabilization | X | | X | X | X | X | | X | X | X | X | X | X | X |
| **Mental Health Treatment** | | | | | | | | | | | | | | |
| Medication Management | X | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Community Medication Support | X | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Outpatient Therapy | X | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Intensive Outpatient | | X | | | | X | | | X | | | | X | |
| Specialized Co-occurring Disorder Services | | X | | | | X | | | X | | X | X | | X |
| **Case Management Services** | | | | | | | | | | | | | | |
| Case Management | X | X | X | X | | X | X | X | X | X | X | X | X | X |
| Wraparound Funds | X | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Specialized Intensive Case | | X | | | X | X | | | X | | X | | | X |
| Assertive Community Treatment | | X | | X | | | | X | X | | X | | | |
| Continuity of Care and Specialized Initiatives | | | | | | X | | X | X | | X | | X | X |
| Homeless Outreach | X | X | X | X | | X | X | X | X | | X | | X | X |
| Payee Services | | X | X | X | | X | X | X | X | | X | | X | X |
| **Rehabilitation Services** | | | | | | | | | | | | | | |
| Therapeutic Rehabilitation | X | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Supported Employment | X | X | X | | X | X | X | X | X | X | X | X | | X |
| Educational Services | | | X | | | | | X | X | | X | | | X |
| Other Community Support | | | | X | | X | | | | | X | | X | X |
| **Housing Options** | | | | | | | | | | | | | | |
| Supported Housing Program | | X | | X | X | X | X | X | X | | X | X | | X |
| Residential Support | | | | X | | X | X | X | X | | | | | X |
| Housing Development | X | X | | | | | X | X | | | X | X | X | X |

**MENTAL HEALTH TREATMENT**

Each Regional Board provides a full array of outpatient services including, but not limited to, individual psychotherapy, group psychotherapy, psychiatric evaluations, walk-in emergency appointments, psychopharmacology, and medication education. Effort is made to place these outpatient clinics within close geographic proximity for consumers in order assure easy access to needed services. Budget constraints have forced some providers to scale back availability of mental health treatment in less populous, rural counties. Additional areas of focus include:

- Recognizing the need to provide assertive outreach so fewer appointments are missed although most Regional Boards do report having a system for following up with missed appointments;
- Assuring medication continuity within the agency when level of care changes;
- Addressing shortages of professional staff, especially prescribers, increasing waiting periods for appointments;
- Assuring continuity of care between Regional Boards and inpatient settings or other community providers, thereby ensuring quality, holistic care;
- Screening adequately for substance use disorders/co-occurring disorders; and

- Providing opportunities for staff training in co-occurring mental health and substance use disorders (screening, assessment and treatment).

***Substance Abuse Treatment Overview***

Services provided primarily through contracts with community-based service providers (14 Regional Mental Health and Mental Retardation Boards and their subcontractors, local government agencies and other community-based organizations) include:

- Prevention programming in communities offered through 14 Regional Prevention Centers;
- Juvenile diversion programs; DUI assessment and education programs;
- Consultation with businesses on the development of a drug-free work place and employee assistance programs;
- Social setting detoxification centers, residential treatment centers, outpatient treatment services;
- Specialized treatment services for pregnant women, adolescents and intravenous drug users; and
- Opiate replacement therapy to opiate dependent persons who are high-risk for HIV disease due to their intravenous drug use.

Training, consultation and client evaluations are made available, within budget limitations, to criminal justice agencies and other agencies within the Cabinet for Health and Family Services for clients with alcohol and other drug problems.

The Division of Behavioral Health provides alcohol and other drug abuse prevention and treatment services pursuant to KRS Chapter 222 (Alcohol and Drug Education, Treatment and Rehabilitation). The provision of alcohol intoxication fees is pursuant to KRS 431.100. Other statutes affecting the Division of Behavioral Health services include: KRS 189A (DUI assessment, education and treatment) and KRS 218A.410 (drug forfeiture).

Effective prevention and treatment of alcohol and other drug abuse will have a major impact on the health and well being of every Kentuckian. From peer pressure of youth to use alcohol and drugs to the risks of being involved in a drunk driving accident, all Kentuckians are at risk for alcohol and other drug related problems. The Division of Behavioral Health has the statewide responsibility for providing leadership and program direction for the implementation of primary prevention, early identification (intervention) and treatment for persons who are alcohol or drug dependent.

***Co-Occurring Disorders***

In 2004, the Division of Mental Health and the Division of Substance Abuse were merged into the Division of Mental Health and Substance Abuse. In 2005, a Co-Occurring Advisory Council was formed by the Commissioner of the Department. This Council developed recommendations that would help create the infrastructure within the state to assist with providing a comprehensive, continuous and integrated system of care for persons with co-occurring disorders. In 2009, the Division was renamed the Division of Behavioral Health. Formal steps have been taken by the DBHDID towards the integration of mental health and substance abuse services across the Commonwealth. Currently, one staff position within the Division of Behavioral Health is dedicated solely to the development, implementation and monitoring of integrated mental health and substance abuse services across the Commonwealth.

Additional steps have been taken by the Division including:

- Evidence-Based Practice "Seed" Grant to Kentucky River Community Care with Mental Health Block Grant Funding ($25,000) – involvement of Dr. Mee-Lee in region specific consultation and statewide training event
- Establishment of specific Performance Indicator in SFY 2006 related to Co-Occurring Disorders
- NIMH / SAMHSA Evidence-Based Practice Planning Grant – Case Study of Integrated Treatment Implementation in Bluegrass Region
- "One Time" training events – Mental Health Institute, Kentucky School, etc. focused on providing mental health training to substance abuse staff and vice versa (substance abuse training to mental health staff)
- Motivational Interviewing training
- Ongoing research on co-occurring financing policy (existing barriers with Kentucky Department of Medicaid Services, study of Michigan system, technical assistance from national consultant)
- Use of "implementation drivers" format to examine implementation of integrated treatment for adolescents (under Robert Woods Johnson Foundation (RWJF) Reclaiming Future grant)

Technical assistance was received from the Co-Occurring Center for Excellence (COCE) and from a Dual Diagnosis Capability in Addiction Treatment (DDCAT)/ Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) national trainer during SFY 09. A core team of integration specialists were trained to use the DDCAT/DDCMHT tools. Pilot sites were identified at four (4) Regional Boards. These sites agreed to have their adult outpatient programs reviewed for co-occurring capabilities. During SFY 2010, four (4) baseline DDCMHT/DDCAT reviews were completed and three (3) follow-up assessments were done. Kentucky has been active in the DDCAT Collaborative monthly calls since March 2009 and the Division's co-occurring program administrator attended the annual COSIG meeting in Washington DC, where an all day round table meeting of the DDCAT Collaborative was held. A second training on the use of data and outcome of a program's DDCAT/DDCMHT evaluation, with an emphasis on strategic planning was held June 2010. All fourteen (14) Regional Boards have been supplied with the Hazelden Integrated Services for Substance Use and Mental Health Problems, Clinical Administrator's Guidebook. Three (3) staff members from the DBHDID Division of Behavioral Health attended a train the trainer workshop on the Hazelden dual diagnosis curriculum and will be providing technical assistance to the Regional Boards in areas indicated by the DDCAT/DDCMHT reviews. At present, eight (8) integration specialists from the CMHCs have been trained and will assist the three (3) state evaluators with plans to train at least two (2) more specialists from the CMHCs and two (2) more from the Division of Behavioral Health. The Mid-western Atlantic Addictions Transfer and Technology Centers (ATTC) provided a workshop on the Treatment Improvement Protocol (TIP) 42 and Motivational Interviewing with Co-Occurring clients, at the annual Kentucky Drug and Alcohol School in 2011, which is planned and implemented by the DBHDID. The Division of Behavioral Health continues to promote the use of the Seeking Safety model by offering training at the Kentucky Drug and Alcohol School and continuation of year long monthly consultation calls with an expert consultant. With a full time co-occurring program administrator working within the Division of Behavioral Health progress is being made and movement toward more co-occurring capable programs is being seen in Kentucky. It is now the expectation of the Division that all staff working in community programs will meet minimum dual diagnosis capable standards by the end of SFY 2013 (June 30, 2014).

## CONSUMER AND FAMILY SUPPORT

Since the mid-1980s, the DBHDID has been committed to consumer and family involvement in program development and service delivery as a strategy for strengthening informal community supports. This focus has empowered consumers and family members to become more active in assisting Department staff in developing policies, monitoring and providing technical assistance to local programs, and evaluating requests for funding. The Division of Behavioral Health was directed by leadership to convene a workgroup in SFY 2009 with the goal of redesigning the consumer affairs function within the Division. A framework for a redesign of the consumer affairs office was developed.

During SFY 2010, the Division of Behavioral Health began working to implement these recommendations. Department leadership agreed to hire a full time "Recovery Services Coordinator", who is a self-identified consumer of behavioral health services and who is a part of the management team. Department staff as well as consumers gave input on the job description for this individual. In February 2011, a Recovery Services Coordinator was hired.

The Department currently provides funds for a variety of statewide and local consumer and family support initiatives. These initiatives are focused on goals related to advocacy, discrimination reduction, wellness and recovery programs, peer support, education and training, and operating support. During SFY 2010, Division staff used consumer recommendations to rewrite contracts to be awarded to statewide consumer and family groups. These two contracts were renamed, appropriately, as the Recovery Oriented Training and Technical Assistance contract and the Recovery Oriented Family Support Services contract. These two (2) contracts were awarded during SFY 2011, as prescribed by the Request for Proposal (RFP) process monitored by the Finance Cabinet. A Department liaison was designated to monitor these contracts.

The Recovery Oriented Family Support Services contract was awarded to NAMI Kentucky and included requirements for providing quality family support groups across the state. In addition, NAMI Kentucky must provide at least one instructor training per year for the "family to family" support training. This contract also required the provision of leadership in advocacy activities including collaboration with other organizations in supporting improved and evidence based practices such as supported employment, stigma reduction and mental health recovery. New to this contract was the provision of educational symposiums to regional areas across the state, based on needs and requests of local populations. During SFY 2011, a statewide instructor training for "Family to Family" was held, NAMI Kentucky partnered with DBHDID to host "Community Conversations" across the state, NAMI Kentucky partnered with DBHDID to assist with a Supported Employment pilot project in four (4) regions in the state, and provided seven (7) educational symposiums to seven (7) different regions in the state. In addition, a listserv was created by NAMI Kentucky to promote mental health and community integration with statewide providers, consumers and family members.

The Recovery Oriented Training and Technical Assistance contract required the development of a Technical Assistance Center and the provision of recovery oriented trainings across the state. Contractors gathered stakeholders from across the state, including consumers, family members and providers, and developed consensus for the formation of Kentucky System Transformation, Advocacy, Recovery and Support (KY STARS), a training and technical assistance center focusing on recovery oriented mental health services. During SFY 2011, KY STARS provided education to consumers in state psychiatric hospitals, consumers in treatment at local CMHCs, staff of two state psychiatric hospitals and regional CMHCs, and to Kentucky Peer Specialists and Leadership Academy graduates. KY STARS also provided technical assistance to

consumers of peer run programs, staff of local CMHCs, and staff of state psychiatric hospitals. In addition, KY STARS worked to expand the number of peer to peer support groups available across the state and worked to train peers as facilitators of activities that are considered best practices.

The Recovery Oriented Training and Technical Assistance contract requires the provision of Leadership Academy across the state. The **Leadership Academy** is a three (3) day educational program for persons with a mental illness who have a desire and interest in developing and improving their leadership and advocacy skills. Lessons are geared to address local and state concerns and provide students with practical and useful communication skills. The Leadership Academy consists of two training levels. Level One Training is the general skills training. Level II training is a Train-the-Trainers format, where graduates are able to return to their regions and teach groups. Graduates of the leadership academy are able:

- To identify and assess community issues and needs,
- To create, develop and participate in group action plans,
- To organize local advocacy groups into a respected and effective voice on mental health issues, and
- To participate on boards, councils and commissions.

Since April of 2007, Leadership Academy graduates have attended and participated on Eastern State Hospital's Recovery Mall Leadership Council, by attending monthly meetings. These graduates assist the attendees at the Council meetings in learning recovery skills and in learning how to conduct effective meetings. These meetings benefit both the residents at Eastern State Hospital who are working on their own recovery, as well as the Leadership graduates who are utilizing their newly learned skills.

During SFY 2011, two (2) Leadership Academy trainings were held, one in Louisville and one in Bowling Green, Kentucky. Instructors for these trainings are Kentucky Peer Specialists. The goal for SYF 2012/2013 is to continue to provide at least two (2) Leadership Academy trainings per year. Many behavioral health consumers have reported that this specific training has been the start of their journey to recovery.

During SFY 2011, KY STARS met with staff at Western State Hospital to assist with implementation of a Recovery Mall as part of the services offered to inpatient mental health consumers. This program was modeled after the Recovery Mall at Eastern State Hospital and Appalachian Regional Hospital psychiatric facilities.

**Kentucky Peer Specialist Training** is a five day intensive training program for persons with a mental illness who have a desire to learn more about the recovery process and learn how to help others move forward in their own recovery process. The training program was modeled after the Georgia and South Carolina models of Peer Support.

While Kentucky Peer Specialist Training is still not currently a billable service under Medicaid, DBHDID continues to train consumers for this service. In November of 2010, a one-day training event was held in Louisville, focusing on the "whole health" aspect of peer support. Larry Fricks and Ike Powell facilitated this training event, with one of the Regional Boards (Seven Counties Services, Inc.) co-sponsoring the event. Approximately twenty (20) Kentucky Peer Specialists were trained in whole health. In April of 2011, eighteen (18) peers attended a Peer Support Training event at Blue Licks State Park. There were eight (8) graduates of that program. The goal for SFYs 2012 and 2013 is to reorganize the Peer Specialist Training curriculum and to provide credentialing for peers in Kentucky.

Part of the reorganization has begun, with training expanding to a minimum of a two week program, with one core module and two other module offerings. After completing an extensive application process, candidates will be required to successfully complete a one week (40 hours) core module. This core module will include an introduction to Recovery concepts, ethics, listening skills, Wellness Recovery Action Plan (WRAP) services, a brief introduction to Motivational Interviewing, how to navigate the social services network, the five stages of recovery and an introduction to whole health. Candidates who successfully complete this core module will be offered the opportunity to take either or both of the modules around Mental Health and/or Substance Abuse. The Mental Health module will continue to follow the Georgia/South Carolina model and will be one week (40 hours) in length. The Substance Abuse module will be one week (40 hours) as well. At the completion of these modules (the core module plus either Mental Health, Substance Abuse, or both) individuals will be awarded a provisional certificate. When individuals complete an internship consisting of one hundred, twenty (120) hours of supervised peer support services, a full certification will be provided. To maintain this certification, Kentucky Peer Specialists will be required to complete a minimum of two (2) continuing education units per year.

The DBHDID and the Regional Boards encourage consumer and family member participation in planning, monitoring, and service delivery. To build on existing strengths, the plan is to:

- Continue to involve consumers and family members in the Behavioral Health Block Grant planning process;
- Design programs, trainings, and outcome measures that incorporate recovery principles;
- Implement Supported Employment training to encourage hiring of consumers;
- Encourage the growth of consumer run services;
- Continue to encourage statewide consumer participation at all planning events; and
- Make Recovery Model training available in all regions.

While the DBHDID and the Regional Boards have come a long way in fostering consumer and family member participation in planning, monitoring, and service delivery, many challenges remain, including:

- Lack of dedicated funding for consumer run services;
- Few programs that fully incorporate recovery principles;
- Limited number of consumer run services that can serve as “mentor” programs; and
- Persistent transportation barriers for individuals to attend meetings and other events.

**EMERGENCY SERVICES**

Since 1995, the DBHDID has made a concerted effort to develop a statewide network of Crisis Stabilization Programs (CSU). These programs, which primarily serve individuals with SMI, can be home-based interventions or residential units and are a major factor in Kentucky’s stabilization of inpatient utilization. Department staff supports the ongoing development and enhancement of the network by facilitating quarterly meetings of Emergency Service and crisis stabilization program directors and training events. The Department supports a full range of crisis services, including:

- 24 hour emergency hotlines;
- Warm lines;
- Walk-in Crisis Services;
- Mobile Crisis Services;
- Suicide Hotlines;
- Residential Crisis Stabilization Units;

- Overnight Crisis Beds;
- 23 Hour Observation Beds in Hospitals; and
- After Hours Face to Face Crisis Evaluations.

Regional Boards have flexibility in how they choose to provide emergency services based upon the unique needs and population within the region. As such, this ideal array is not available in every region. For example, one region has set aside one bed in their facility to serve the crisis needs of adults with Developmental and Intellectual Disabilities and has set forth specific protocols when an individual is admitted to their Crisis Stabilization Units. (CSU).

A Performance Indicator regarding emergency services has been developed and included in the data collection set from the Regional Boards. These steps are in line with the Departments focus on transforming the system of care and strengthening the safety net for persons with mental illnesses.

The fourteen Regional Boards report, through their annual Plan and Budget submissions, that:

- All fourteen regions have a 24 hour Crisis and Information line;
- All fourteen regions have qualified mental health professionals on call for emergency evaluations for involuntary psychiatric hospitalization 24 hours a day, seven (7) days a week;
- All regions respond within three (3) hours to a request for involuntary hospitalization evaluation;
- Crisis Stabilization Units are available in 12 regions while Crisis Stabilization Case Management Services are available in the other two (2) regions;
- Training is provided to law enforcement related to accessing emergency psychiatric care in every region; and
- Mobile Crisis Services are available in eight (8) regions.

A growing trend is the centralization of staff that performs various types of emergency evaluations, such as involuntary hospitalization certifications, competency to stand trial evaluations, jail triage emergency evaluations and walk in emergency evaluations. In the past all clinical staff were expected to do these as part of their work. By centralizing this as the sole duty of a few staff, it allows for specialization of screening, risk assessment, forensics, etc. for some staff, while at the same time allowing those who are providing psychotherapy to devote their schedules to the consumers they serve, without disruption. One region has developed a central triage center where all crisis calls, emergency evaluations and involuntary hospitalizations are staffed by qualified mental health professionals who are empowered to arrange for an array of emergency services from expedited appointments to hospitalization at the point of contact.

Three major projects will continue to be an area of focus during SFYs 2012 and 2013.

1. Specialized Training for Law Enforcement by means of a 40 hour Crisis Intervention Team (CIT) Training currently being implemented by contract with a retired police lieutenant. State police officers, local police officers, sheriff department officers, university and college campus police officers, and court officers are trained using the Memphis Crisis Intervention Team model. Officers volunteer and are assigned by their supervisors for the training. CIT held their 3$^{nd}$ Annual CIT Conference for Law Enforcement in June of 2011, which provided additional opportunities to gain an understanding of mental health issues and their effects on individuals. Several CIT officers across the state have now been trained and qualify to be CIT instructors. Several regions in Kentucky are utilizing local trainers to increase the

number of local police officers trained. Several local trainings occurred during SFY 2011. This process is being supervised closely by contract staff and DBHDID.

The objective is to continue training more CIT instructors and continuing to increase the number of CIT trained officers across the state. To date approximately 800 law enforcement officers from agencies across Kentucky have been trained in the 40 hour Kentucky Law Enforcement Council (KLEC) certified CIT training class. This includes city police, county police, university campus police, sheriff departments and state police. These totals exclude the Louisville Metro Police Department (LMPD). The LMPD currently has over 600 trained CIT officers and also trains all new recruits in the full 40 hour CIT class. In the statewide training, twenty-seven (27) CIT classes have been taught to date. Twenty-nine (29) will have been completed by December of 2011. To date officers have been trained from 167 law enforcement agencies in Kentucky. Eight (8) regions currently have active CIT Advisory Committees. The CIT Advisory Committees build upon the relationships between law enforcement, mental health professionals and mental health advocates, established in the 40 hour CIT class. However, these committees allow for long term and systemic improvements in services to persons with mental illness, developmental disabilities and substance use issues. Where there is a strong CIT Advisory Committee we have seen improvements in the "system" and in the response to those we serve.

2. DBHDID will continue to provide a 40-hour course for law enforcement, often referred to as "Mental Health 101," by the Kentucky Department for Criminal Justice Training (DOCJT) twice annually. This course serves as an elective for any law enforcement officer in the state who wants to better understand not only persons with mental illness but also those with developmental disabilities, substance use issues, brain injuries, co-occurring disorders and persons from the Deaf or Hard of Hearing community.

3. The Department will continue to build a working relationship with the Kentucky Department of Veterans Affairs, as well as the Veterans Administration, to explore further opportunities to enhance the current systems' response to Veterans, Service members, and their family members with behavioral health issues.

**REHABILITATION SERVICES** ***(Includes Educational and Employment Services)***

The DBHDID incorporates the philosophy of "psychiatric rehabilitation" (outcomes improve when skills are taught in a social setting) and **"**recovery**"** (outcomes and satisfaction improve when consumers develop new meaning and purpose in life and grow beyond the catastrophic effects of mental illness) to assist the development of Community Support Services. As psychiatric rehabilitation technology has evolved, DBHDID has promoted rehabilitation and recovery models through training, education, technical assistance, and targeted funding opportunities.

The DBHDID promotes the use of psychiatric rehabilitation technology by regional programs. The Psychiatric Rehabilitation model developed by the Center for Psychiatric Rehabilitation at Boston University was selected as the exemplary model as it has been extensively documented, validated, and replicated in hundreds of different settings for over two decades. This model also addresses the four major components of Community Support Services identified by DBHDID with a focus on improving the lives of persons with psychiatric disabilities by enhancing their use of skills and/or environmental supports to live, learn, work, and socialize in the community and role of their choice.

Currently the DBHDID, Kentucky Medicaid, the Regional Boards, and other providers have not adopted a specific model of practice. Some programs have independently adopted a specific

model but, without system support, 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 three key rehabilitative services at the regional level: **therapeutic rehabilitation**, **supported employment**, and **supported education**. While they each rely on psychiatric rehabilitation technology, they are supported in very different ways.

DBHDID supports rehabilitation services through the Regional Boards in a variety of ways:

- The Division of Behavioral Health designates a statewide community support program coordinator;
- DBHDID offers technical assistance and training for Community Support Program Directors who coordinate services for the state's eighty-five (85) **therapeutic rehabilitation programs** (TRP). **Therapeutic rehabilitation programs** are goal directed services aimed at improving skills in living, working and socializing in communities of one's choice. Technical assistance is provided to regional programs in how to incorporate psychiatric rehabilitation technology into daily programming;
- DBHDID has an interagency agreement with the Office of Vocational Rehabilitation that uses CMHS Block Grant funds to leverage **supported employment** services for adults with severe mental illness. In SFY 2010, the Department secured funds from the Johnson & Johnson Dartmouth Community Mental Health Program. This program provides funding and technical assistance for **supported employment** to State Mental Health Authorities; and
- Improving access to **educational services** through sites that provide Community Support Services remains a priority. According to the Kentucky Adult Literacy Survey, over 340,000 people lack the literacy skills necessary to compete in the workforce. Lack of literacy skills act as a hindrance to the personal advancement of another 656,000 Kentuckians. The lack of available educational services can seriously hinder persons with a severe mental illness in accessing and maintaining employment, and can negatively impact their quality of life. Providing access to educational support services has been a priority for Community Support Program Directors in community mental health settings.

Plan and Budget submissions reveal that access to rehabilitation services is available in all 120 of Kentucky's counties in the following manner:

- All fourteen regions provide access to therapeutic rehabilitation program services with approximately 85 programs available throughout the state;
- Twelve (12) regions provide access to long term supports through supported employment services for adults with severe mental illness; and
- Five (5) regions have specific educational support available in their programs.

Although adult rehabilitation services are available to individuals in all 120 counties in the state, access to services is inconsistent and often inadequate to meet the need. Only a fraction of adults with SMI in the state participate in rehabilitation programs offered through the Regional Boards.

Most regions have adopted Illness Management and Recovery, as adapted from the evidence-based practice model articulated by SAMHSA, and have restructured their Therapeutic

Rehabilitation services model to deliver this service, utilizing both professional staff and Peer Specialists.

The delivery of quality, timely rehabilitation services is challenged by a number of factors including:

- The current billing system that limits therapeutic rehabilitation as a site based service limiting community skills taught in the natural community;
- Kentucky Medicaid rates for therapeutic rehabilitation are quite low and significantly below the reimbursement rate for outpatient treatment services;
- Funding sources other than Medicaid do not reimburse for therapeutic rehabilitation services or have challenging processes of reimbursement. Consumers without Medicaid have difficulty accessing this service;
- Therapeutic Rehabilitation Program services are inconsistent and have not adopted a specific model of practice with stated values, principles, practice guidelines, and expected outcomes of service;
- Peer Specialist services are not yet reimbursable in Kentucky;
- Supported employment is not reimbursed by Medicaid and there is limited funding for the long term employment supports needed by adults with a severe mental illness;
- Supported education is not reimbursed by Medicaid and is interpreted by some centers as being discouraged due to the possible interpretation of duplicity of services; and
- There are difficulties with transportation, especially for consumers who do not receive Medicaid.

## SUPPORT SERVICES

### *Criminal Justice System/Behavioral Health Interface*

Since the implementation of a multi-faceted legislative initiative in 1994, Kentucky has eliminated the use of jails during acute psychiatric crises and the involuntary hospitalization process. Instead, consumers are evaluated in emergency rooms or by staff of Regional Boards. These efforts have:

- Increased understanding of mental illness by emergency responders such as ambulance drivers, paramedics, and peace officers;
- Improved access to evaluation and treatment;
- Improved communication among local peace officers, judges, mental health professionals, other community resources and the general public; and
- Reduced the stigma and trauma of involuntary hospitalization.

DBHDID has intensified efforts to build an integrated service system for individuals with severe mental illness who are involved in the criminal justice system, by collaboration among DBHDID, the Kentucky Department of Corrections, and other stakeholders in our communities' "safety net".

Regional Boards provide training to a number of entities in the criminal justice system in order to assure that persons with severe mental illness are diverted into treatment whenever possible rather than being arrested and booked into jail. In Jefferson County the Crisis Intervention Team within the County Police Department has been in place for over seven years and has successfully diverted thousands of individuals into care.

In SFY 2002, as the result of a series of investigative reports published in the Louisville Courier Journal related to suicides in local jails, the legislature appropriated $550,000 to DBHDID to

develop a training curriculum for jail staff to address this issue. During SFY 2003, DBHDID developed, implemented and monitored this training curriculum on suicide prevention and recognizing the signs and symptoms of mental illness. Regional board staff were trained in a "model curriculum" and then expected to train the staff in their local jails. In addition to this training, Regional Boards were encouraged to improve their working relationships with the local jails to assure mental health needs were being met for inmates housed in these facilities.

The relationship between Regional Boards and local jails has been enhanced through the delivery of the mental health and suicide prevention training that the Boards have been providing. Funding was also included to provide consultation to the jails, on an as needed basis, to improve jail personnel's response to inmates with behavioral health needs. Regional Boards reported entering into more formal agreements with their local jails in thirty-one counties across the Commonwealth in SFY 2004.

During the 2007 Kentucky Legislative Session Senate Bill 104 was passed. This bill called for the establishment of a statewide curriculum for training of peace officers in the Crisis Intervention Team (CIT) Memphis model. The goal for SFY 2012/2013 is to continue working to expand CIT trainings throughout the state.

DBHDID has also partnered with the Kentucky Department of Corrections (DOC) on a re-entry project, partially funded by block grant funds. This program allows for strategic planning for inmates with mental illness who are exiting Kentucky prisons and returning to eight different communities in Northern Kentucky. Other projects that the Department is involved in include a Diversion Program being led by the Kentucky Department of Public Advocacy, which places a social worker in public defenders' offices to develop diversion alternatives for persons with behavioral health issues.

DBHDID's Community Mental Health Centers (CMHC's) Contract Language changed for SFY 2012 to allow for individuals within the Department of Corrections Correctional Psychiatric Treatment Unit (CPTU), an all male unit within one prison and the Psychiatric Care Unit (PCU), an all female unit within another prison, who are serving out or being paroled from one of the two units, to be served as a priority population by the Regional Boards. This will allow high risk individuals who are serving out of or being released from the CPTU and PCU to be seen within fourteen (14) days of release at a CMHC for mental health and medication management services. By having this population be seen as a priority population, the hope is that recidivism will reduce for this group of individuals. DBHDID's Adult Services Branch and the Department of Corrections Mental Health Division are working collaboratively to develop a Memorandum of Understanding to include data sharing and collection mechanisms, and to gather information to help facilitate a smooth transition for all parties.

DBHDID has been actively participating on the Governor's Reentry Taskforce, helping to develop recommendations for legislation in order to reduce many of the negative outcomes that are associated with incarceration and help to improve the reentry process for individuals with behavioral health issues. Goals for SFY 2012/2013 are to continue to collaborate with state and local entities in order to improve overall outcomes for individuals with behavioral health issues who are involved in the criminal justice system.

***Services to Persons who are Deaf or Hard of Hearing***

Effective behavioral health and substance abuse treatment begins with communication. If an individual is not provided language access, s/he is essentially blocked from the recovery services available to those proficient in spoken English. This fact is a common barrier for individuals who are Deaf, Hard of Hearing, or Deaf-Blind and need to access the CMHC system

and state facilities. The Kentucky Deaf and Hard of Hearing Services (DHHS) staff strives to create an environment where individuals have linguistically accessible and culturally affirmative services. Through training, technical assistance, collaboration with community partners, funding assistance, program development, and policy review, DHHS aims to address unmet needs for the population. The program functions with one full-time staff member. Lack of sufficient numbers of human resources necessitates creativity and collaboration in developing and implementing effective mental health services. Developing a network of skilled direct service professionals is key. At the beginning of SFY 2011, only two regions had full-time staff dedicated to Deaf or Hard of Hearing Services: Bluegrass Mental Health / Mental Retardation Board and Seven Counties Services. One 0.2 FTE was lost in Western KY due to attrition. A PRN position was added at Lifeskills by the end of SFY 2011. Most consumers in the CMHC system must still access services through an interpreter and with clinicians who have limited experience with the biopsychosocial effects of hearing loss. Training of clinical staff, interpreters, and peer specialists emphasize the importance of direct communication and lived experience.

Priorities for DHHS for SFYs 2012 and 2013 include the following:

- Improving the quality of services provided to consumers being served by the Regional Boards and State Facilities;
- Developing partnerships with community agencies in order to create effective wraparound services so that providers are equipped to and accountable for providing linguistically accessible and culturally affirmative services equal to those individuals who are hearing receive; and
- Providing education, prevention, outreach, and early intervention in regards to behavioral health, substance abuse, and developmental or intellectual disabilities to individuals who are Deaf and their family members will be accelerated. A “cradle to grave” public health approach could further the development and implementation of effective community-based services.

In addition, the following objectives for DHHS are noted for SFYs 2012 and 2013:

- Contracting for specific services to assist with individuals who have SMI in the Seven Counties region;
- Supporting four interpreters to attend the Alabama Mental Health Interpreter Training then return to their state hospital regions to provide specific training and outreach to providers, consumers, and fellow interpreters on Best Practices in mental health interpreting;
- Offering telehealth services on a trial basis in the Bluegrass region once language for reimbursement is clarified;
- Addressing the high incidence of abuse histories among Deaf or Hard of Hearing consumers in CMHCs;
- Developing and implementing Consumer Satisfaction Surveys for consumers of one Regional Board (Seven Counties Services, Inc.) as a pilot for other regions;
- Identify, train, and utilize peer supports who are Deaf or Hard of Hearing;
- Developing visual toolkits for use with individuals who have language dysfluency;
- Emphasize early identification and treatment for children’s services; and
- Collaborating with the KY Commission for the Deaf and Hard of Hearing study group on the need for case management services to identify and equip community providers to serve as advocates, case finders, and educators within the Deaf community.

***Case Management Services***

Case management is an essential Community Support Service because it coordinates an individual’s service array, making maximum use of available formal and informal supports.

Case management has been available through Regional Boards since 1985 and was first covered by Kentucky Medicaid in 1991. Priority is given to adults with severe mental illness who have the greatest difficulties accessing resources and those with more intense service needs. Kentucky embraces a strengths based model advocated by the University of Kansas (Dr. Charles Rapp) blended with the psychiatric rehabilitation model endorsed by Boston University (Dr. William A. Anthony). Kentucky's Case Managers have caseloads of 25-30 individuals, with a maximum caseload of 35.

During SFY 2008, an Advisory Committee was formed, consisting of key CMHC and DBHDID staff. The Case management certification training curriculum was updated through the input from this Committee and was placed in an online format. Face-to-face Level I Case Management certification training requirements were decreased from 2 ½ days to 1 day. Newly hired case managers are now able to begin certification training immediately upon hire, by utilizing the information module online. The certification exam was also placed in an online format. Designated Department staff monitors exam status and issues certificates upon completion of all the required elements.

During SFY 2011, approximately 80 case managers received Level I Case Management training, utilizing Block Grant funding. The DBHDID held a two-day statewide training event in December 2010 for all case managers that work with adults with SMI and children with SED. The keynote address and some workshops focused on the culture of poverty. Other workshops included: Motivational Interviewing skills; Dialectical Behavior Therapy overview for case managers; Strengths-based goal setting; and Documentation guidelines. This conference was well attended and very well received.

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

- The Division of Behavioral Health designates a statewide coordinator of case management services;
- DBHDID requires and provides certification training for all case managers within six months of employment.
- The DBHDID provides additional training opportunities for case managers and case management supervisors;
- DBHDID encourages the provision of case management services of a more intensive design to persons with severe mental illness who have a history of violent or volatile behavior; and
- Adaptations of evidence-based practices such as Assertive Community Treatment are occurring in a few regions in the state.

Case management services are available in all 120 of Kentucky's counties. Currently, case managers provide support to approximately 8,238 individuals with severe mental illness in a variety of ways. Plan and Budget submissions from the regions show that:

- Five (5) regions report having an Assertive Community Treatment Team, although fidelity to the evidence-based practice is low;
- Eight (8) regions report having mobile outreach teams;
- Six (6) regions provide specialized intensive case management for forensic clients and;
- Six (6) regions provide continuity of care case management for special populations.

During SFYs 2012 and 2013, the focus will be on maintaining stakeholder relationships, through the Advisory Committee, and continuing to respond to the needs of providers as well as monitoring the needs of consumers. There will be continued training opportunities for case managers, offered by the DBHDID, designed to enhance the effectiveness of working with

adults with SMI.

***Community Medication Support Program (CMSP)***

DBHDID supports the Community Medication Support Program (CMSP), a drug replacement program that provides low cost medications to the population who are living below poverty level and who do not otherwise qualify for federal or state assistance. This program is the result of a unique collaborative effort by the state operated/contracted psychiatric hospitals, the Regional Boards, DBHDID, and local pharmacies. The goal of the program is to assist adults with SMI who have no other means of purchasing prescribed psychotropic medication. Prescriptions are filled at local pharmacies, and then the medications are replaced to the pharmacies by our state operated/contracted hospitals. The program is available in all regions. Eligibility for the CMSP is based on age (18+), income (federal HHS poverty guidelines and no third party payer sources), and DBHDID criteria of SMI (diagnosis, disability and duration). During SFY 2011, DBHDID partnered with the Kentucky Prescription Assistance Program (KPAP) administered by the Department of Public Health (DPH) in an effort to support a program for those indigent persons receiving services through regional mental health/mental retardation boards to obtain free or reduced pharmaceuticals, including any pharmaceuticals needed for physical health. The goals of this partnership are to significantly increase access to the Pharmaceutical Companies Prescription Assistance Programs (PAPs); mobilize communities to assist their neighbors in obtaining free and reduced cost prescription drugs; expand collaboration with existing organizations who provide services to the underserved and uninsured, reducing duplication of effort; and promote integration between the primary healthcare system and mental healthcare system to provide a continuum of care for those individuals being served. Since its inception in 2008, KPAP has obtained $90M in free medications overall.

***Housing Services***

The DBHDID Housing Coordinator works with consumers, Regional Boards, the Kentucky Housing Corporation (KHC), the Kentucky Interagency Council on Homelessness, other state agencies and non-profit organizations to develop housing options, foster collaboration among housing and homeless programs, and support local efforts through:

- Technical assistance with other agencies and housing services providers;
- Planning and coordination with other agencies;
- Presentations related to housing; and
- Special training events.

Additionally, DBHDID collaborates with KHC in these key initiatives:

- The Supportive Housing Specialist position, which is jointly funded by the KHC and DBHDID, works to further integrate the housing needs of persons with mental illness into the state housing finance agency's programs.
- Technical assistance and consultation in developing housing projects is provided to local nonprofits by the Specialist.
- For SFY 2012, DBHDID will continue to provide $386,000 in funding to KHC to develop affordable housing options for persons with psychiatric disabilities, developmental and intellectual disabilities, and persons with co-occurring substance use diagnoses (the "priority" populations), through the application of funds by Kentucky Housing Corporation in their administration of the Olmstead Housing Initiative.
- Providing SSI/SSDI Outreach, Access, and Recovery (SOAR) technical assistance and support to case managers, re-entry coordinators and other social services workers throughout the state to give them the knowledge and information needed to successfully assist disabled persons in accessing SSI/SSDI, as a first step toward gaining housing and independence.

- Promoting expansion of local SOAR initiatives by Regional Boards and non-profits across the state.

Regional Boards use a variety of strategies to develop housing options for individuals with severe mental illnesses. Some focus on actual housing development by employing regional housing developers; others focus on housing access by administering their own Section 8 set-aside programs or through collaborative arrangements with local public housing agencies. Information from Plan and Budget submissions from the Regional Boards for SFY 2012 reveals that:

- There are currently 676 units in 57 projects operated by the Regional Boards;
- Many regions also operate a Tenant Based Rental Assistance program or access other assistance, providing over 100 vouchers across the state;
- Nine (9) regions operate housing projects that provide residential support;
- Eight (8) regions have organized formal supported housing programs;
- Seven (7) regions are involved in housing development;
- Eight (8) regions report having developed a regional housing plan; and
- Eleven (11) regions provide specialized housing training to agency staff.

Goals for SFY 2012:

- Provide training and support to the Regional Boards in implementation of SAMHSA's Supportive Housing Toolkit;
- Increase access and availability of housing options for priority populations by promoting the "Housing First" model;
- Collaborate with Regional Boards and other non-profits in establishing local SOAR initiatives.

Goals for SFY 2013:

- Provide technical assistance and support in promoting fidelity to the Supportive Housing EBP;
- Continue to work with housing partners in increasing access for the priority populations through "Housing First";
- Continue to promote establishing local SOAR initiatives, and monitor and support existing initiatives.

## REDUCTION IN INPATIENT PSYCHIATRIC CARE

### CONTINUITY OF CARE

The Department believes that addressing the issue of continuity of care through a well-planned aftercare process is the key to ensuring a successful transition from the hospital to the community. Providing appropriate aftercare following a state hospital stay is critical to reducing readmission rates. The Department requires a Regional Board to provide an outpatient appointment within two weeks of a discharge. DBHDID also requires the provision of case management services to adults with severe mental illness who are discharged from a state psychiatric facility, are determined by hospital staff to be in need of case management service, and agree to receive this service.

The fourteen Regional Boards and the state operated/contracted psychiatric hospitals must work closely together to assure continuity of care. Contracts with all parties address continuity issues such as medications, discharge plans, case management and outpatient referrals. Some Regional Boards function as a single portal of entry for some of the hospitals. Due to the uniqueness of the providers and each individual they serve, a need to re-institute regular continuity of care meetings between the respective hospital and local Regional Boards was identified and DBHDID staff initiated the reconvening of these meetings. The agenda for each meeting includes the following topics:

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

During SFY 2005, DBHDID worked with each of the state operated/contracted psychiatric hospitals and their assigned Regional Boards to develop a Memorandum of Agreement (MOA) between the two entities. In order to assure a seamless system of care, the need to develop these MOAs was identified to strengthen the relationships between the hospitals and the Boards. The MOAs include the contractual responsibilities each entity has to the DBHDID, but also defines and clarifies roles and responsibilities the hospital and Regional Boards have to assure quality continuity of care to patients that they both serve.

DBHDID strategies to reduce unnecessary psychiatric inpatient utilization include the development of residential crisis stabilization programs, responsive emergency services, assurance of continuity of care and the continued development of other community support services as effective alternatives for adults with severe mental illness who are in crisis.

DBHDID has responsibility for the monitoring of the Kentucky **Olmstead Initiative** in each of the four state operated/contracted psychiatric hospital regions. Transition teams comprised of the representatives from the hospital, the Regional Board, DBHDID staff, and other appropriate stakeholders meet on a monthly basis to review transition plans that assure a smooth and timely discharge to the community for identified patients. Funds were appropriated during the 2002 legislative session and in subsequent biennial budgets to pay for individualized and specialized wraparound services to assure the community tenure for each of these individuals.

Continuity of care is a major priority for the Department. A number of challenges are presented to DBHDID and the Regional Boards. These include:

- Private psychiatric beds have been closing or are being converted to acute care beds which generate more revenue;
- The loss of private psychiatric beds in local private hospitals has placed a strain on state operated psychiatric hospital by increasing admissions;
- While crisis stabilization programs have existed in all fourteen regions since SFY 2004, confidence in their appropriateness as alternatives to hospitalization remains low among many psychiatrists and utilization remains relatively low in some programs;
- Supervised residential options are sparse throughout Kentucky, thwarting efforts to discharge individuals with complex service needs; and

- The unavailability of adequate funding for community-based services as alternatives to hospitalization remains a barrier to good continuity of care.

Budget cuts in SFY 2009 resulted in one region reducing staff in their crisis stabilization unit and subsequently reducing the level of care for that program. One other region closed its community-based crisis stabilization unit and moved it to the grounds of the state psychiatric facility in order to be more cost efficient. Plans for SFYs 2012 and 2013 are to continue to support appropriate utilization of regional crisis stabilization units as a diversion to inpatient care.

A project entitled **DIVERTS** (Direct Intervention: Very Early Treatment System) was implemented in the Western State Hospital Catchment area during SFY 2007, as a partnership between DBHDID, the four respective Community Mental Health Centers (CMHC) and the National Alliance on Mental Illness (NAMI). The goal was to reduce psychiatric hospitalizations. Approximately two million dollars that had originally been budgeted to the psychiatric hospital in Western Kentucky was instead allocated across the four Boards serving that hospital "catchment" area. The aim of this project was to reduce admissions to the hospital. Regions have been creative in addressing the issue of lowering hospitalization rates by providing specialized case management and other support services. Results have been good. One of the four regions reduced hospitalizations by 49% in SFY 2007 and by 5% in SFY 2008. Further reductions in hospitalizations have occurred in each fiscal year. The goal for SFYs 2012 and 2013 is to continue the trend of reducing psychiatric hospitalization admissions and readmissions.

**Assessment of the Strengths and Needs of the Service System to Address Children, Youth and Families, including Children with Severe Emotional Disturbance (SED)**

**Criterion 1: Comprehensive Community Based Mental Health Services**

**HEALTH, MENTAL HEALTH AND REHABILITATION SERVICES**

The interface between the physical healthcare system and the behavioral healthcare system is of growing importance to providers of behavioral health services. It is well known that a significant amount of behavioral health services are provided in the primary care arena. Continuity of care across these systems is critical if children and families are to get the most beneficial and holistic services possible.

Regional Boards are required to conduct physical health screening with all clients served. Department staff has assisted several regions in improving tools used to assess physical health concerns and continues to encourage further assessment and integration of physical and behavioral healthcare.

All Regional Boards have a designated Children's Services Director. These Directors, along with others, seek to ensure that the mental health service needs of children and families in their service region are assessed, addressed and evaluated in a structured, yet flexible manner. Such services are designed to meet the holistic needs of children with SED, as well as those of the general population of children served in their region.

A review of the information from the SFY 2012 Annual Plan and Budget applications, submitted to the Department, reveals that Regional Boards continually strive to address barriers and meet the clinical service needs of children and families. Some examples of this include:

- Several regions offer therapy appointments during evening hours in at least one of their office sites, and some offer services during weekend hours;

- All regions offer walk-in appointments for children/families in crisis;
- Most regions formally include crisis planning in the treatment planning process;
- All regions offer services off-site, offering school-based services in the majority of counties in their region;
- Eight of the fourteen regions offer specialized summer programs and six offer after school programs;
- All regions employ at least one designated Early Childhood Mental Health Specialist who provides therapeutic services for children birth to five years of age and education and consultation to others working with this population; and
- Three cohorts of KY SEED programs have become part of a system of care cooperative agreement.

Kentucky's Medicaid State Plan includes the Rehabilitation Option for behavioral health, including statewide coverage for therapeutic rehabilitation and targeted case management for children with SED. Eight of the Regional Boards operate day treatment programs and five Regional Boards operate partial hospitalization programs. There are additional Day Treatment programs, across the state, that are operated by the school districts and several private hospitals operate partial programs. Two Regional Boards also operate residential substance abuse programs for adolescents that offer integrated mental health services.

The Regional Boards rely heavily on their IMPACT programs that offer targeted case management services, utilizing wraparound, to ensure that children with SED, and their families, receive needed services and supports. Over $5 million in state general funds is allocated to the Regional Interagency Councils that govern these IMPACT programs. These funds are used to support program operation, including employment of Family Liaisons and flexible funds to meet the needs (goods and services not otherwise covered) of youth and families. IMPACT is available to children with SED regardless of whether they are Medicaid recipients. Most of the IMPACT programs offer therapeutic aide services whereby a child is assigned an aide that will act as a mentor and skills-building coach. Many of the children, receiving IMPACT services, work to improve organizational skills, impulse control skills, social skills and coping skills. Services may occur on or off site to allow for "real life" learning experiences. The majority of IMPACT services occur in the home, school or community. Some IMPACT programs also offer after-school and/or extended summer programs where children may receive individual and group therapeutic services, as well as mentoring services. The table below represents an overview of the Available Services Array for Children provided by each of the fourteen Regional Boards across the Commonwealth.

## Children's Array of Services: Availability by Region from Plan and Budget Application for SFY2012

| Services | | Clinical Services * | Psychiatry ** | Early Childhood Specialist | Other Early Childhood Clinician *** | Service Coordination for Children Ages 0-5 | Therapeutic Child Support Services | School Based Services | Intensive In-Home | After-School Program | Specialized Summer Program | Crisis Stabilization Program | Day Treatment Program | Therapeutic Foster Home(s) | Partial Hospitalization Program | Other (please specify) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Regions | 1 | X | X | X | X | X | | X | | | | X M | | | X | |
| | 2 | X | X | X | | X | X | X | | | X | X M | | X | | |
| | 3 | X | X | X | | X | X | X | X | | | X U | | X | X | |
| | 4 | X | X | X | | X | X | X | | X | X | X U | | X | | |
| | 5 | X | X | X | X | X | | X | X | | | X U | X | | | |
| | 6 | X | X | X | X | X | X | X | X | X | X | X U/M | X | | X | |
| | 7 | X | X | X | X | X | X | X | | | X | X M | X | | X | X + |
| | 8 | X | X | X | | | X | X | | | | X U/M | | | | |
| | 9/ 10 | X | X | X | X | X | X | X | X | X | X | X U/M | X | | | |
| | 11 | X | X | X | X | X | X | X | | | X | X U/M | X | X | | |
| | 12 | X | X | X | X | X | X | X | X | X | X | X U/M | X | | | X + |
| | 13 | X | X | X | X | X | X | X | X | X | X | X U/M | X | | X | |
| | 14 | X | X | X | | X | X | X | X | | X | X U | X | X | | |
| | 15 | X | X | X | X | X | X | X | X | X | X | X M | | X | | |

* At least 50% of time dedicated to services for children and families
** At least one year of specialized child training
*** Has received specialized child training and is supervised by the ECMH Specialist
\+ Co-occurring MH/SA Treatment

U= Unit
M=Mobile
U/M=Unit

**EMPLOYMENT**

Youth served in the KY IMPACT program across the state are given an opportunity to practice skill sets to prepare them for employment. Such vocational skills training may include writing resumes, job interviewing, and assistance with retaining employment. This option is available if deemed appropriate through the wraparound service team process.

Although not yet widely available, Supported Employment services are a needed service for transition age youth and are being partially addressed through several targeted initiatives, including the Johnson & Johnson/Dartmouth Supported Employment grant and the Kentucky Partners for Youth Transition trainings.

**HOUSING**

Regional Boards strive to offer community based programs for children with SED that will allow them to remain in their own homes and communities, rather than in residential settings. They collaborate with the Departments for Community Based Services (DCBS-child welfare agency) and Juvenile Justice to maintain children in their own homes and communities whenever possible and when in the best interest of the child. Currently, the Department is exploring ways to partner with the private psychiatric hospitals that serve children to determine what measures can be taken to lower hospital admissions, readmissions, and lengths of stay for children.

DBHDID does not assume custody of children within the state, nor do they operate a children's psychiatric hospital or other residential programs for children. The Regional Boards, under contract with the Department, do offer a limited amount of residential care. Therapeutic foster care is offered in six of the fourteen regions. There are also a few Boards that offer overnight respite services on a limited basis. There are ten residential crisis stabilization units for children across the state, with a total of 92 beds. Ten Boards offer mobile crisis stabilization services and may contract for overnight beds with a variety of providers (e.g., 23 hour acute hospital beds, private crisis stabilization residential program beds and private child care beds). Collectively, the five regions without a unit report availability of an additional 10 beds.

The Department for Community Based Services (DCBS-child welfare agency), within the Cabinet for Health and Family Services, is responsible for investigating child dependency, abuse and neglect and makes recommendations for the courts for removal of children from their custodial parents/caregivers. When deemed necessary, the Department for Juvenile Justice (DJJ), within the Justice Cabinet, also may assume custody of children. The Department strives to collaborate with these two state agencies to ensure that the mental health needs of children are appropriately identified and addressed.

Both DCBS and DJJ contract with Regional Boards and private providers to meet the residential needs of children in their custody. The Department solicits data from the Department for Public Health to track hospital utilization of children. In calendar year 2009, there were 712 psychiatric beds within 14 hospitals available for youth aged birth to 17 years, with an average length of stay of 25.23 days, for the year. *(Comparatively, in 2006, there were 633 beds; 7,705 admissions; 195,533 inpatient days; and the average length of stay was 25 days. In 2004, there were 619 beds, 8,646 admissions, 179,561 inpatient days and the average length of stay was 20.8 days.).* On an average day, 549 children are utilizing these psychiatric beds (occupancy – 77%); 412 of these youth are between the ages of 13-17 years old. There are no child/adolescent psychiatric beds in far western Kentucky as well as the five far eastern community mental health center regions of the state.

The Department is also working with partner agency representatives to develop an infrastructure for youth with disabilities who are transitioning to adulthood. There is a state-level

"Transition Core Team" that has worked to organize existing resource information and facilitate the development of regional transition teams. The regional teams report to the Core Team quarterly about their progress and also may solicit technical assistance as needed

**EDUCATIONAL SERVICES (INCLUDING SERVICES PROVIDED BY LOCAL SCHOOL SYSTEMS UNDER IDEA)**

DBHDID staff collaborates extensively with state and local educational agencies in support of IDEA and other initiatives focused on simplifying access to and coordinating services for children and youth with emotional and behavioral needs.

Currently, there are numerous school-based mental health initiatives across the Commonwealth. Various models for school-based and off-site service provision continue to be studied and assessed for feasibility and effectiveness. DBHDID has sponsored several training seminars featuring national presenters to educate personnel of the Regional Boards and the school districts. These have been well attended and partnerships between school districts and Regional Boards continue to grow statewide.

The Department is most involved with promoting an integrated, multi-tiered approach that includes mental health promotion, early intervention, and intensive interventions utilizing a model of Positive Behavior Interventions and Supports (PBIS). The PBIS model encourages the involvement of mental health staff and parents at every level of intervention and support (universal/primary, targeted/secondary, and intensive/tertiary.)

KDE created the Kentucky Center for Instructional Discipline (KyCID) in late 2004. Goals of the program include:

- Enhance schools' ability to achieve proficiency by 2014;
- Involve families, schools, community, and related agencies to understand and support the model;
- Promote healthy school climate and effective school leadership;
- Support creation of local and regional capacity to implement and sustain the model; and
- Utilize ongoing data collection for decision-making on multiple levels.

Staff from DBHDID and the Kentucky Partnership for Families and Children (KPFC) serves on the KyCID steering committee to ensure that mental health and family involvement is supported at all levels of training and implementation. For additional information, please see www.kycid.org.

Chaired by the Division of Exceptional Children within KDE, the Kentucky Interagency Transition Council for Persons with Disabilities is made up of over 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 Department'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 Kentucky Educational Collaborative for State Agency Children (KECSAC) was established through legislation in 1992. KECSAC Interagency Advisory Group (IAG) members include representatives from six agencies, including DBHDID. KECSAC is the responsible entity for assuring that the benefits of the Kentucky Education Reform Act (KERA) are extended to children in the custody of state agencies, in day treatment programs, and schools on the

campuses of residential programs. The Department's participation on the IAG has enhanced communication between treatment and education providers and prompted more opportunities for cross-disciplinary training.

## SUBSTANCE ABUSE SERVICES

Substance use/abuse among children and adolescents, and their caregivers, is often identified by Regional Board clinicians as a contributing factor to the mental health and overall well being of clients they serve. While funding sources for substance abuse services are quite limited for youth, the use and abuse of nicotine, alcohol, inhalants, prescription and illegal drugs is addressed in the treatment provided. Clinicians and case managers utilize education (prevention and intervention), treatment and referral mechanisms available through school districts, law enforcement agencies, private providers and Regional Prevention Centers.

Regional Boards serve youth with substance abuse disorders in their outpatient programs, as well as in the IMPACT (targeted case management) program. Several Regional Boards have specialized residential and intensive outpatient substance abuse programs for youth.

Two Regional Boards in southeastern Kentucky are Robert Wood Johnson Reclaiming Futures sites and expansion of the model statewide is underway. Department staff are available to provide technical assistance and coaching to the regions that plan to submit a proposal to the RF national program office to become an official Reclaiming Futures site. The goals of Reclaiming Futures include:

- Assess teens in the juvenile justice system that are using drugs and alcohol or are at risk for use;
- Provide increased evidence based practice drug and alcohol treatment interventions for youth and streamline community resources and services; and
- Help at-risk youth become more responsible for their actions by linking them with community services and leadership activities.

In April 2010, the state's chief justice announced Kentucky's juvenile and family drug court programs were being eliminated as part of a plan to cope with the court system's budget deficit. Adolescents currently enrolled in the juvenile program are able to continue the program until they graduate. Several juvenile courts have continued to operate with funds secured from local governments and school districts.

## MEDICAL, DENTAL AND VISION CARE

### *Medical Care*

As previously stated, Regional Boards are required to complete physical health screening for all new clients and to update this information at least annually. Data is now being collected through the IMPACT Outcomes Management System on health concerns among children, with SED, served by IMPACT (a targeted case management for children with SED), and the most commonly reported concerns include allergies and asthma. The prevalence of and risk for obesity and diabetes are also high among Kentucky's youth.

According to the Centers for Disease Control, thirty-five percent of low-income children between two and five years of age in Kentucky are overweight or at risk for becoming overweight. According to the Youth Risk Behavior Survey (2009), 61% of public high school students did not participate in sufficient moderate physical activity. Over 33% are overweight or obese (at or above the 85$^{th}$ percentile for body mass index). Almost 15% of high school students are seriously overweight, and an additional 15% are heavy enough to be considered "at risk" of becoming overweight adults. Obesity among Kentuckians is epidemic and Kentucky's children

are among the most obese in the nation. A statewide plan to address this epidemic is a public/private partnership, The Partnership for a Fit Kentucky, which supports the Kentucky Department for Public Health's CDC Obesity Prevention Grant. The focus is on promoting nutrition and physically active communities. This website is a clearinghouse of the Partnership for a Fit Kentucky's initiatives. The intent is to link resources, network programs, provide tools that work, and strengthen partnerships in order to develop cutting edge initiatives. More information about this initiative can be found on the web site at www.fitky.org.
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There are School-Based Health Centers in a handful of schools (9 of 174 school districts) across the state; the Kentucky School-Based Health Center Collaborative is advocating for legislation and funding to sustain such Centers. Schools and community health organizations across the country have concluded that providing medical services in the school building is one of the most effective approaches to reducing health problems and healthcare costs.

***Oral Health***

Kentucky has one of the worst oral health profiles for children of any U.S. states; the state lacks dental providers in poor and rural areas, and many of its providers historically have not accepted Medicaid. A 2005 report produced by the nonprofit group Kentucky Youth Advocates revealed that half of the state's children between ages two and four had cavities and that only a third of those children covered by Medicaid had used dental services in the past year.

The Kentucky Department for Public Health's 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, and oral health education.

For dental care, access to low or no cost services are provided by the dental schools at the University of Louisville and University of Kentucky (in Lexington). They serve individuals in the clinics located in Lexington and Louisville. The University of Kentucky also provides school-based dental services in one community in Eastern Kentucky and mobile dental services through an outreach program for uninsured families in Eastern and Western Kentucky.

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 186 which requires a dental screening the first year that a 3, 4, 5 or 6 year-old child is enrolled in a public school, public preschool or Head Start program. This law went in effect last school year, 2010-2011. Supporters hope this law will decrease the number of school days that Kentucky's students miss due to pain associated with dental problems and will establish a dental home for children from early in life, so that more children receive routine dental care and become less reliant on costly and sometimes invasive emergency care in childhood and later in life.

***Vision Care***

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 hearing screenings. For children with vision problems, the Kentucky Lions Eye Foundation (KLEF) is a great resource for assistance with screenings, exams, and eye glasses. Located in Louisville, KLEF serves citizens across the state by operating a Vision Van and providing vision exams to children at schools and daycares (KidSight program). See http://www.kylionseye.org for additional information.

Visually Impaired Preschool Services (VIPS) is a Kentucky non-profit agency that provides assessments, early intervention services, child care consultation and play groups/classes for infants, toddlers, and preschoolers 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 serves rural areas of the state. See http://www.vips.org/ for additional information.

**SUPPORT SERVICES**

All fourteen Regional Boards offer, to their communities, consultation and education services regarding behavioral health care and services. There are a number of ancillary support services that are offered in the children's array of services including, but not limited to:

- *Respite for parents/families, foster parents;*
- *Therapeutic child support services which generally assist children and youth with enhancing social skills, organizational skills, and hygiene issues;*
- *Assistance and referrals for educational and vocational needs; and*
- *Basic daily living skills.*

*Consumer/Family Involvement and Support*

Across all regions of Kentucky, parents' voices are most consistently heard through their membership on Local and Regional Interagency Councils. These Councils are responsible for the identification of children with SED and for coordination of the services that they receive. These representatives also make up the State Family Advisory Council (SFAC), which serves in an advisory capacity to the State Interagency Council to Children with an Emotional Disability (SIAC).

The majority of regional IMPACT programs, which serve children with SED and their families, also have staff positions of "Family Liaison." These individuals provide peer-to-peer mentoring, facilitate the creation and maintenance of local parent support groups/family network activities, provide education and offer technical assistance on a variety of topics to families and service providers.

A review of the information from the SFY 2012 Annual Plan and Budget applications submitted by Regional Boards reveals that there are ongoing efforts to maintain and increase consumer/family involvement at all levels of the service system, including:

- Parents participating on Regional Planning Councils in all fourteen regions and serving on various regional and state level policy and program development committees;
- A growing number of "grandparents raising grandchildren" support efforts;
- Regions creatively building their consumer networks and providing for parent input into programming and future planning for children's programming;
- At least one parent support group is active in thirteen regions and there are eight support groups across the state for transition age youth;
- A parent newsletter is regularly published in eight regions;

- A resource library either dedicated for use by parents or available to parents and staff in ten regions;
- Parents acting as evaluators for several initiatives and participating in focus groups to analyze gathered data; and
- Provision of parenting skills training for parents/family members, and sponsored "family fun events" for children and families, in most regions.

It is the belief of DBHDID that parents' voices should help shape not only individual treatment decisions, but also program development and policy determinations at the local, regional, and state levels. This principle is strengthened by the advocacy efforts of parents at various points in the system of care. In support of this vision, significant portions of state general funds and approximately 16 percent of the children's portion of CMHS Block Grant funds are allocated to youth consumer and parent initiatives at each level.

Opportunities for Family Leadership (OFL) is a unit within DBHDID which offers a resource line for parents and caregivers. The resource line connects families with the OFL program, which is a first step for accessing education, resources and support. The toll free number for the resource line is (800) 374-9146. OFL provides numerous services for families and the systems that serve them, including:

- Training in advocacy, communication, cultural competency, collaboration and legal rights in schools;
- Awarding mini-grants for parent support groups to develop local training events and provide community resource libraries. Over 250 training events were funded in SFY 2011 and the same is expected for SFY 2012;
- Providing technical assistance to ensure Standards of Practice for Family Liaisons and Kentucky Family Peer Support Specialists across the state are met and approving required trainings per the Standards of Practice;
- Awarding mini-grants for parent support groups to develop local training and awareness events;
- Providing technical assistance to ensure Standards of Practice for Family Liaisons across the state are met and approving required trainings per the Standards of Practice;
- Distributing reader friendly versions of Client Rights and Grievance Procedures, and supporting documents to parents and others to ensure that these policies and procedures are understood by everyone; and
- Providing technical assistance to organizations and individuals with regard to children's mental health, mental retardation and substance abuse services and supports. Resource information and training opportunities are among the many items provided on OFL's web site at http://mhmr.ky.gov/mhsas/OFL.asp.

The Kentucky Partnership for Families and Children (KPFC) is a statewide organization dedicated to improving services for children with emotional, behavioral and/or mental health disabilities by providing support, education and advocacy to youth and families. There are over 1,500 members statewide. Their Board of Directors is comprised of 30 members, with 60% being parent representatives. Activities of the KPFC include:

- Dissemination of printed information and a quarterly newsletter;
- Participation on numerous interdisciplinary committees;
- Operation of a web site (www:kypartnership.net) and a toll-free phone number (800-369-0533) for parents to access information about KPFC and resource information statewide;
- Distribution of scholarships for parents and youth to attend conferences and other advocacy events;

- Formation of a statewide Youth Council comprised of 14-25 year olds who have an emotional disability/mental illness;
- Creation and Facilitation of Family Leadership Academy and Family Peer Support Specialist Training; and
- Formation of Regional Youth Councils in partnership with Regional Boards to replicate the statewide council.

***Early Childhood Mental Health***

DBHDID and the Department for Public Health (DPH) co-administer Kentucky's Early Childhood Mental Health (ECMH) Program, with DPH staff having lead responsibility for program oversight and financing, and DBHDID staff serving as clinical liaison to the program. Funds are contracted to the fourteen CMHCs for regional program administration.

The ECMH Program was created in state fiscal year 2003 as a component of the early childhood development initiative supported by state tobacco settlement funds, KIDS Now. The primary goals of ECMH are:

- To provide program and child level consultation to early care and education (child care) 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.

ECMH funds the equivalent of fourteen ECMH Specialists, resulting in one or two Specialists per Community Mental Health Center region. The Specialists' time is devoted solely to their regional ECMH programs, and to building the capacity of regional providers to better meet the social, emotional and behavioral needs of children 0-5 and their families.

The ECMH Specialists provide approximately the below listed numbers of services annually:

- 500 children receive clinical (outpatient) services;
- 100 training opportunities to approximately 1,300 child care providers;
- 70 training opportunities to approximately 700 mental health professionals; and
- 3,000 consultations to child care centers.

In 2008, Kentucky was awarded its third SAMHSA CMHS system of care cooperative agreement. Named Kentucky’s System to Enhance Early Development (KY SEED), funds from this source will be used to further develop and integrate services and supports to children age birth to five who have social, emotional, and behavioral concerns and their families. This will be done through merging the existing infrastructure and service delivery systems of the KY IMPACT and ECMH Programs. By the end of the six years of funding, KY SEED will have rolled out statewide in cohorts of three or four Regional Interagency Councils per year. The SIAC is serving as the governing body, and has identified an advisory council made up of early childhood program and content experts that will inform it regarding suggested policy and procedure issues pertaining to young children.

During this second year of the six year funding for Kentucky’s System to Enhance Early Development (KY SEED), funds continue to develop the integrated system of care designed to significantly improve coordination of, access to, and effectiveness of services for young children (birth to 5) who have social, emotional, and/or behavioral challenges and their families. The services and supports being implemented are evidence based, promising and practice-based

strategies and developing needed services and building capacity for our young children. KY SEED ensures the family and youth voice is incorporated across the system of care as they are involved at the state, regional, and local level. Improving linkages among entities serving families of young children is being established by the development of KY SEED State Implementation Team (SIT) that serves as an advisory council to the State Interagency Council (SIAC) that is the governing body for KY SEED. KY SEED is currently reaching out to the funded communities to determine special populations to ensure cultural competency is being addressed. KY SEED is rolling out statewide in cohorts of three of four Regional Interagency Councils (RIACs) per year. Currently, children and their families are receiving services in seven of the 17 eligible RIACs.

**Criterion 2: Estimates of Prevalence of SMI among Adult Population**

*Narrative Question: An estimate of the incidence and prevalence in the state of serious mental illness among adults.*

Kentucky's earliest estimates of the prevalence of severe mental illness were based on national work. In 1980, the U.S. Department of Health and Human Services (USDHHS) estimated that 3.14 percent of the population had some level of mental disorder, and that 0.75 percent of the population had a mental disorder that causes prolonged disability.

With the passage in 1992 of P.L. 102-321, the Community Mental Health Services Block Grant, Congress required the Center for Mental Health Services (CMHS) to develop a national definition for "adults with severe mental illness." CMHS was further required to develop an "estimation methodology" based on the definition that state mental health agencies must use to estimate needs in their state plans. While P.L. 102-321 limits CMHS Block Grant spending to persons who meet the federal definition, it does not require states to serve everyone covered by the definition. The federal definition of "adults with a severe mental illness" was published on May 20, 1993.

Early planning in Kentucky for adults with severe mental illness, using the 0.75 prevalence rate for adults with persistent disability, estimated that approximately 28,000 adults in Kentucky should be the priority population for services. Kentucky's mental health planning has historically focused on this subset of the population in development of its Community Support Program system.

A work group comprised of consumers, family members, and providers reviewed the federal definition and Kentucky's statutory definition of "chronic mental illness"; its recommendations were reflected in Administrative Regulations published in 1994. The regulation provided for operational definitions of the target population of adults with severe mental illness consistent with national policy. Kentucky's definition of "adult with severe mental illness," as currently operationalized, uses the following criteria for age, diagnosis, disability, and duration: Kentucky's definition is narrower than the definition promulgated in the federal register for "Adult with Severe and Persistent Mental Illness." Historically, stakeholders have supported the Department's desire to focus limited funding on adults who meet the state's narrower definition.

| Variable | Criteria |
|---|---|
| **Age** | Age 18 or older |
| **Diagnosis** | Major Mental Illness<br>• Schizophrenia and Other Psychotic Disorders<br>• Mood Disorders<br>• Personality Disorders (when information and history depict persistent disability and significant impairment in areas of community living) |

| | |
|---|---|
| **Disability** | Clear evidence of functional impairment in two or more of the following domains:<br>• 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.<br>• 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.<br>• 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.<br>• Physical Functioning: Person's general physical health, nutrition, strength, abilities/disabilities and illnesses/injuries.<br>• 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:<br>• Clinically significant symptoms of mental illness have persisted in the individual for a continuous period of at least two- (2) years.<br>• The individual has been hospitalized for mental illness more than once in the last two- (2) years.<br>• There is a history of one or more episodes with marked disability and the illness is expected to continue for a two-year period of time |

The 1999 federal methodology for estimating adults with serious mental illness requires states to use the national estimate of 5.4 percent for the prevalence of adults with severe mental illness, and a rate of 2.6 percent for adults with severe and persistent mental illness (SMI).

**Criterion 2: Estimates of Prevalence of SED among the Child Population**

*Narrative Question: An estimate of the incidence and prevalence in the state of severe emotional disturbance among children.*

In Kentucky, criteria for determining whether a child has SED were included in the enabling legislation (KRS 200.503) for the Kentucky IMPACT program in 1990. There criteria include s child who meets the following:

1) Is under age 18, or under age 21 and was receiving services prior to age 18, and for who the services must be continued for therapeutic benefit; and

2) Has a clinically significantly disorder of thought, mood, perception, orientation, memory, or behavior that is listed in the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders; and presents substantial limitations which have persisted for at least one year, of 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 the following 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 (Child welfare agency) and has been unable to be maintained in a stable setting due to a behavioral or emotional disability.

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., SAMHSA, 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 disturbances are greatly underserved, a conclusion that the Department shares.

When a child is identified by a clinician, a "marker" is placed in the DBHDID MIS client data system and thus identifies the child as having SED. Data concerning the services received by children with a marker may then be compiled and analyzed.

**Criterion 3: Integrated Services – Children with SED**

**1) System of Integrated Services**

*Narrative Question: Provides for a system of integrated services appropriate for the multiple needs of children without expending the grant under Section 1911 for the fiscal year involved for any services under such system other than comprehensive community mental health services. Examples of integrated services include:*

- *Social services;*
- *Educational services, including services provided under the Individuals with Disabilities Education Act;*
- *Juvenile justice services;*
- *Substance abuse services; and*
- *Health and mental health services.*

DBHDID continues to promote activities that build the infrastructure for coordinated and optimally integrated services for children with SED, and their families. Model examples of collaborative efforts found in the regions are often shared with others through technical assistance by the department. The State Interagency Council for Services to Children with an Emotional Disability (SIAC) is a group of representatives, from the primary child-serving agencies, and a parent of a child with an emotional disability, who maintain and oversee a framework of collaborative services for children with emotional disabilities. The hallmark program of this framework is Kentucky IMPACT, but other programs and initiatives may also fall under their auspices. There are eighteen Regional Interagency Councils among the fourteen Regional Board service areas and these Councils work under the umbrella of the SIAC. The table below illustrates the composition of the SIAC and RIACs. Some RIACs also have developed Local Interagency Councils (LIACs) at the county level to mirror the composition of the SIAC and RIACs, but to enhance the ability to develop resources at the local level and to problem solve when systemic issues may arise. The Chair of SIAC rotates each year but the Chair for RIACs is legislatively mandated as the DCBS (child welfare) representative.

## Composition of IMPACT Interagency Councils

| SIAC Representative | Domain | RIAC Representative |
|---|---|---|
| Parent of a child with a severe emotional disability | Family Members | Parent of a child with a severe emotional disability |
| Commissioner, DBHDID | Behavioral Health | Director of Children's Services, Regional MH/MR Board |
| Commissioner, Department for Community-Based Services (DCBS) | Child Welfare | Service Region Administrator, Department for Community-Based Services |
| Commissioner, Department of Public Health (DPH) | Public Health | Representative, County Health Department |
| Commissioner, Department for Medicaid Services | Medicaid | Not mandated as there is no regional/local counterpart. |
| Commissioner, Department for Juvenile Justice | Juvenile Justice | Regional Program Manager Department for Juvenile Justice |
| Executive Director, Dependent Children's Services within Administrative Office of the Courts | Courts/Diversion | Court Designated Worker selected by local district judges |
| Executive Director, Family Resource and Youth Services Centers (FRYSCs) | Prevention and Early Intervention | FRYSC Directors who are located in Elementary, Middle and High Schools across the state |
| Commissioner's Designee, Department of Education | Education | Special Education, Local Education Authority |
| Youth Representative | Youth | Youth/young adult who has received mental health services for an emotional disability |

The Department utilizes recommendations on a regular basis from the State Interagency Council (SIAC), per KRS 200.505. This regulation states that the State Interagency Council (SIAC) shall "consider issues and make recommendations annually to the Governor and the Legislative Research Commission regarding the provision of services for children with an emotional disability." The SIAC submitted the following recommendations for SFY 2010:

- An Executive Order proclaiming that its member agencies embrace a public health approach to children's mental health and substance use services and supports through identification and recognition of how their services and supports promote well-being of children, youth, and families. Further, it is recommended that System of Care values and principles be adopted and operationalized by all child serving agencies who are SIAC members.

- All Kentucky certified and classified personnel in the public school system receive a 3-hour suicide awareness and prevention training entitled Question Persuade and Refer (QPR); or at a minimum, include suicide prevention and postvention (the provision of crisis intervention, support and assistance for those affected by a completed suicide, Suicide Postvention Guidelines) in each school crisis plan and ensure that an adequate number of school staff are trained.

- All human service state agencies make QPR training available and ensure that an adequate number of staff in each agency are trained.

- All community mental health centers ensure that staff clinicians and case managers receive clinical training designed to address competencies which support the assessment, management and treatment of the suicidal client.

- Evidence-based practices in suicide assessment and treatment be included in all human services programs at Kentucky's accredited colleges and universities.

- All state licensing human services boards approve QPR training for continuing education units (CEUs).

- All agencies serving transition age youth that have mental health and/or substance use disorders provide specialized, developmentally appropriate services and supports based on the Transition to Independence Process (TIP) Model (see attached).

- Youth on extended commitment to the Cabinet for Health and Family Services for educational purposes, that Medicaid eligibility be extended to age twenty-one (21).

- The time period to ask for reinstatement of commitment under KRS 620.140(1)(d) for a youth that leaves state custody on the eighteenth ($18^{th}$) birthday be changed to one (1) year.

An integrated service system for the children and families served by Regional Boards is stronger in some areas of the state than in others. Examples of truly integrated services are sometimes found in communities where professionals and community members are well acquainted and have a long history of working together to achieve commonly held goals for their service recipients. Often where resources are the scarcest, creativity is strongest. Larger communities, while generally having the advantage of more resources, may face greater challenges in coordinating their efforts. Human Services Council meetings in many urban and rural counties serve as an opportunity to share agency information and exchange referrals regularly. In addition, there are numerous other networking and case conferencing mechanisms in place at the local level to encourage and support general agency and client specific information exchange and collaborative planning.

Partners learning the details of each others' specific job roles and their designated service areas is generally a beneficial starting place for assuring that children and families are served in the most effective and least restrictive manner. Most agencies do have specified service areas but adjustments are sometimes made to accommodate special circumstances. The fourteen Regional Board service areas do not completely align with any of the partner agency service areas; however all try to learn each others county configurations so that they may best serve shared clients.

The interagency structure of Kentucky IMPACT drills down to the level of the child's service team. When a child is admitted to Kentucky IMPACT, a Service Coordinator is assigned to convene an interagency service team. The team consists of the child (when appropriate), his parent(s), his teacher(s), and other involved parties who work with or may otherwise be involved with the child and his family. A Regional Board is also the substance abuse and mental retardation planning authority for its region and most often provides these services as well, Services may be accessed by the Regional Interagency Councils (RIAC) through the Board's representation on the RIAC. This is generally the Children's Services Coordinator who has knowledge of all programs in the service area.

The RIACs are also staffed by a Regional Board employee, the IMPACT Local Resource Coordinator (LRC). The LRC is generally the IMPACT program manager but in some regions, these are separate staff positions.
Staff within the Department continually strive to develop relationships with staff of partner agencies that serve children with SED and their families. The following provides a bit of detail about some of the current focused partnerships.

**Public Health**
Staff from the Department for Public Health and DBHDID meets regularly as they share oversight of the Early Childhood Mental Health Initiative and the designated Specialists. There is also shared oversight of the Bioterrorism Preparedness program. Most recently, the sharing of aggregated data between the two departments has occurred and there are plans to continue these efforts in various ways, including the sharing of hospital data previously unavailable to mental health.

**Education**
DBHDID staff collaborates extensively with state and local educational agencies in support of IDEA and other initiatives focused on simplifying access to and coordinating services for children and youth with emotional and behavioral needs.

Chaired by the Division of Exceptional Children within the Kentucky Department of Education, the **Kentucky Interagency Transition Council for Persons with Disabilities** is made up of 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 **Kentucky Educational Collaborative for State Agency Children** (KECSAC) was established through legislation in 1992. KECSAC Advisory Group members include representatives from six agencies, including DBHDID. KECSAC is the responsible entity for assuring that the benefits of the Kentucky Education Reform Act (KERA) are extended to children in the custody of state agencies, in day treatment programs, and schools on the campuses of residential programs.

**Child Welfare**
The Department for Community Based Services (DCBS) is now within the same Cabinet as DBHDID and Public Health so the opportunities for data sharing and collaborative planning may become easier in working towards common goals. Most recently, there has been interest in collaboratively planning some training opportunities as well as some discussion about using like assessment and outcomes measurement tools.

**Juvenile Justice**
Juvenile Justice's new system of care has been extremely beneficial to a group of children whose needs are very complex, but there is a growing interest in reaching children at earlier

stages of their involvement with the child welfare and juvenile justice systems. In particular, the Department for Juvenile Justice (DJJ) has reached out to contract directly with Regional Boards and Private Child Care Agencies for community-based services and juvenile sexual offender treatment. However, DJJ also has created programs within their own agency to provide mental health and substance abuse services for their especially difficult to serve youth (e.g., adolescent sex offenders). The rise in the number of youth committed to Juvenile Justice and the historic lack of comprehensive mental health services to children and youth in the juvenile justice system make this desire for earlier intervention even more urgent.

**2) Geographic Area Definition**

*Narrative Question: Establishes defined geographic area for the provision of the services of such system.*

Kentucky is divided into fourteen geographic regions for the purposes of planning and providing publicly funded community mental health services. Together, the Regional Boards serve all 120 Kentucky counties. For each region, a Regional Board has been established pursuant to KRS 210.370-210.480 as the planning authority for community mental health programs in the region. County and municipal governments do not provide community mental health services.

The Department for Community Based Services is organized into nine (9) regional districts, the Department for Juvenile Justice and the Administrative Office of the Courts follow judicial districts, and the independent Health Departments are generally located in each county. There are 174 school districts across the state. The Medicaid Managed Care Organizations are separated into the eight regions outlined in the map below and will thus cross over several Regional Boards.

**Criterion 4: Targeted Services to Homeless, Rural, and Older Adult Populations (Adults with SMI and Children with SED)**

**1) Outreach to Homeless**

*Narrative Question: Describe State's outreach to and services for individuals who are homeless*

DBHDID recognizes the importance of system coordination among the numerous agencies and programs involved with services to this population. At the state level, DBHDID participates in the Kentucky Interagency Council on Homelessness (KICH), a group of state and local providers, consumers and government officials, established as a result of Kentucky's participation in a Homeless Policy Academy funded by the Departments of Housing and Urban Development (HUD) and Health and Human Services (HHS). The goal of this group is to develop statewide systems and policies, and forge partnerships among state agencies and private social service organizations to achieve local solutions to homelessness. The Council drafted a Homelessness

DBHDID, KICH and Kentucky Housing Corporation (KHC) are currently collaborating on two initiatives, the SSI/SSDI Outreach, Access, and Recovery (SOAR) Technical Assistance Initiative, which provides training for case managers and homeless service workers in assisting eligible persons in applying for disability benefits; and the development of a case management training for homeless service providers. Efforts are also underway to increase access and availability of housing options for homeless individuals through the promotion of the "Housing First" model. Most Regional Boards offer individualized services designed to alleviate homelessness as well as to provide "mainstream" mental health treatment to persons who are homeless and mentally ill. Regional Boards report in their system of care plans for adults with severe mental illnesses the following level of participation:

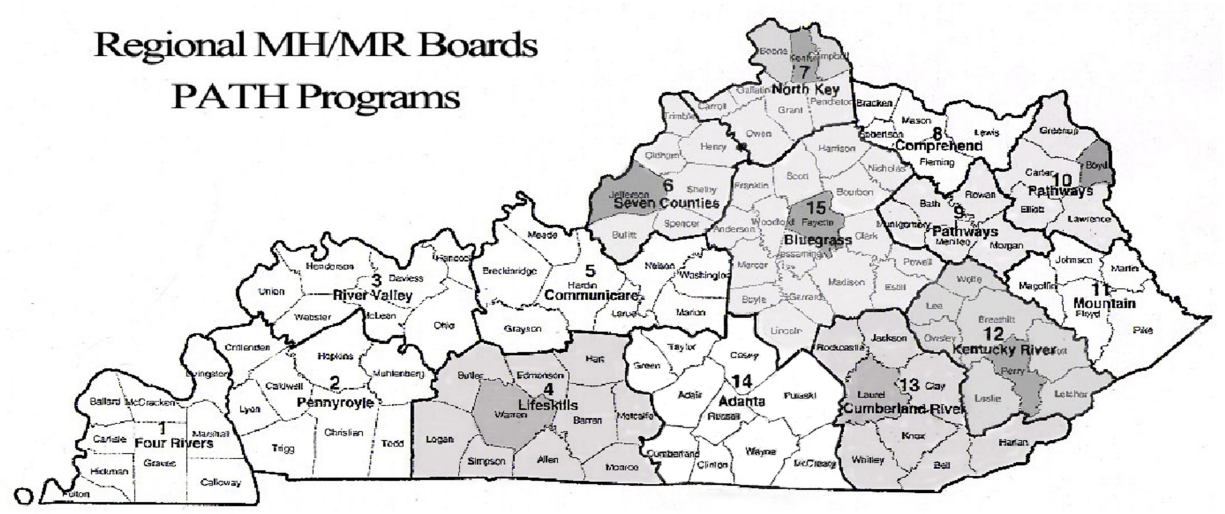
- All Regions give a service priority to homeless individuals;
- Thirteen Regions participate in routine regional Continuum of Care meetings;

- Six have received Continuum of Care funding;
- Eleven Regions do consultation with local shelters;
- Nine Regions regularly visit local homeless shelters;
- Nine Regions provide a walk-in psychiatric clinic;
- Nine Regions have staff dedicated to homeless individuals; and
- Three Regions do street outreach.

DBHDID received $474,000 from SAMHSA/CMHS for SFY 2012 for homeless services through the Projects for Assistance in Transitioning from Homelessness (PATH) Grant. The Department conducted a "Request for Applications" process with the Regional Boards, and awarded contracts to seven Regional Boards, three urban, two rural and two that are a combination of urban and rural, to provide homeless services within their area. The seven PATH regions are:

- Bluegrass Regional MHMR Board, Inc., which subcontracts and works with the HOPE Center, a private non-profit shelter and homeless service provider, to provide outreach, screening and diagnostic services, case management, mental health treatment, rehabilitation and staff training in the Lexington / Fayette County area.
- LifeSkills, Inc., which provides outreach, case management and training in the Bowling Green / Warren County area
- NorthKey Community Care, which utilizes a multidisciplinary outreach team employed by the CMHC to provide screening, treatment, and case management, and subcontracts with Welcome House of Northern Kentucky, a private non-profit shelter and homeless service provider, for case management and payee services. The program serves the northern region of Kentucky, just south of Cincinnati, Ohio. The majority of clients served in the PATH program come from Boone, Campbell, and Kenton counties which are the most urban areas.
- Seven Counties Services, Inc., which provides outreach, assessment, 24 hour crisis intervention, case management, referral and linkage to community resources and supportive services through their Homeless Outreach Team. The program is located in Jefferson County, Kentucky.
- Pathways, Inc., which provides outreach and case management in the Ashland / Boyd County area.

- Kentucky River Community Care, which provides outreach, case management, housing support services, and support for six emergency apartments for homeless persons with a mental illness located in Hazard / Perry County, but which also draws from Breathitt, Knott, Lee, Leslie, Letcher, Owsley, and Wolfe Counties in southeast Kentucky.
- Cumberland River Regional MHMR Board, which provides outreach, case management and housing support services in Laurel County.




*Regions with PATH Programs are shaded in grey. Dark grey indicates a county specific program; medium grey indicates a region-wide or extended service area.*

By combining PATH and other McKinney funds (that support specialized services) with state and federal funds (that support Community Support Services), DBHDID and the Regional MH/MR Boards attempt to provide a statewide system of outreach, community support, and mental health services for persons with severe mental illness who are homeless. The role of the State PATH Coordinator is central to supporting local PATH providers throughout Kentucky. The Coordinator prepares the annual PATH application in collaboration with local providers, insures that annual data collection requirements are met, and insures that fund allocation and contracts are in place. Support is also provided through notification of relevant training, updates on homeless issues, and on-site technical assistance as needed.

The Department is also involved with other homeless initiatives including:

- DBHDID, in collaboration with Lake Cumberland MHMR Board, Inc., the Department of Corrections, the Department for Community Based Services, The Louisville Coalition for the Homeless, and Families and Children Place, administers a Homeless Prevention Pilot Project. This assists persons being discharged from state facilities in accessing housing and mainstream services, in an effort to limit discharges to homeless shelters. This project assists persons serving out of the prison system, persons being discharged from psychiatric institutions, and persons aging out of foster care.

- DBHDID collaborates with the Specialized Housing Resources Department within KHC in the operation of local homeless planning boards ("Continuum of Care Committees") in Kentucky's area development districts (which correspond to the fourteen mental health regions). Regional MH/MR Boards are encouraged to participate in this process for the benefit of individuals with severe mental illness who are homeless or may become homeless in their regions.

- DBHDID provides state funds to the St. Johns' Day Center in Louisville to hire an outreach worker. This staff person provides on-site assessment and links individuals with services at Seven Counties Services, the Regional MH/MR Board for Louisville.

- CMHS Block Grant funds will continue to support a Rural Homeless Outreach program in the Mountain Regional MH/MR Board area. The goal of this program is the identification of individuals with serious mental illness who are homeless and linkage with mainstream mental health services. Consultation and training to homeless service providers is also provided under this initiative.

**2) Rural Area Services**

*Narrative Question: Describe how community-based services will be provided to individuals in rural areas.*

***Adults with SMI***

Using the definition of Standard Metropolitan Statistical Area, and information from the 2010 Census, Kentucky has 32 counties considered urban and 88 considered rural. Population distribution is shown in the chart below.

| Regional MH/MR Boards | Adult Census 2010 | Urban Adult Population | Rural Adult Population |
|---|---|---|---|
| 1. Four Rivers | 161,545 | 81,338 | 80,207 |
| 2. Pennyroyal | 158,100 | 88,909 | 69,191 |
| 3. River Valley | 161,977 | 108,431 | 53,546 |
| 4. LifeSkills | 217,231 | 100,939 | 116,292 |
| 5. Communicare | 200,640 | 78,127 | 122,513 |
| 6. Seven Counties | 730,843 | 699,976 | 30,867 |
| 7. NorthKey | 326,235 | 282,835 | 43,400 |
| 8. Comprehend | 42,757 | 13,225 | 29,532 |
| 9/10. Pathways | 170,601 | 87,533 | 83,068 |
| 11. Mountain | 119,756 | 0 | 119.756 |
| 12. Kentucky River | 89,550 | 0 | 89,550 |
| 13. Cumberland River | 181,110 | 0 | 181,110 |
| 14. Adanta | 160,202 | 19,047 | 141,155 |
| 15. Bluegrass | 595,449 | 506,999 | 88,450 |
| **Total** | **3,315,996** | **2,067,359** | **1,248,637** |

Transportation barriers remain one of the greatest concerns among providers, consumers and family members. The Human Service Transportation Delivery Program pools existing public transportation funds including Medicaid non-emergency transportation. A total of 16 transportation regions statewide operate 24 hours a day/seven days a week with a single broker or broker/provider established in each region. Consumers access transportation services through a toll-free phone number. Ten of fourteen Regional Boards report engaging in initiatives to better coordinate transportation services in their regions. Region 10 (Pathways) has the most developed transportation initiative as they pay staff to transport individuals from almost any location in the Region to outpatient sites or to the crisis stabilization programs in Morehead and Ashland. Transportation remains, however, the number one barrier to accessing services in rural parts of the Commonwealth as reported by the Boards and their Regional Planning Commissions.

Rural communities often have fewer staff and resources to provide mental health services. It is important for rural mental health agencies to develop collaborative agreements with primary care physicians, senior citizens centers, church groups, and government agencies. Rural case

managers have been resourceful in assisting persons with a severe mental illness in meeting their needs through the identification and development of local resources, and are critical linkages to formal and informal services and supports in rural Kentucky. Some changes in Kentucky law over the years have increased the types and numbers of mental health professionals who can be Qualified Mental Health Professionals and created licensure for professional counselors to provide mental health services. The KDBHDID will continue to work with rural communities and other entities in addressing funding, training, and in bringing all stakeholders together at the state and local level to strategize best practices.

Several Regional Boards report delivering or accessing services from the telehealth network. Nine out of fourteen regions have telehealth equipment and utilize it for coordinating some services (e.g., case management assessments regarding state hospital discharge). Some of these uses include:

- Comprehend, Inc. uses the telehealth network for quarterly meetings with Eastern State Hospital and for trainings and other educational activities.
- Pathways, Inc. is developing telemedicine services and has sites in three counties.
- Kentucky River Community Care, Inc., has several sites equipped for video conferencing. Two sites are a part of the Appalachian Regional Healthcare network and one site is a part of the Centernet network. They convene business meetings, Olmstead meetings, case conferences, trainings and other events over these networks.
- Bluegrass Regional MH/MR Board uses Telehealth for discharge planning meetings between ESH and outpatient offices. Bluegrass also utilizes trainings from the University of Kentucky's TeleHealth network for continuing education of staff and general grand rounds.
- Lifeskills currently utilizes the telehealth network for discharge planning between WSH and outpatient offices. Specifically they use this technology to introduce hospital clients to their prospective case managers and outpatient therapists prior to discharge.
- Four Rivers currently utilizes the telehealth network for psychiatric screening and services as well as mental status assessments, case conferences, staff trainings and meetings.

In May of 2009, the regulation regarding telehealth services was rewritten by Medicaid and submitted to CMS for approval. The original teleheath regulation approved only psychiatrists or advanced registered nurse practicitioners as providers. In March of 2011, the telehealth amendment was approved by CMS. Medicaid now approves reimbursement for several other professionals (physicians, licensed psychologists, marriage and family therapists, professional counselors, licensed clinical social workers, psychiatric registered nurses, psychiatric medical residents) to provide the following services under telehealth:

- Consultations;
- Mental health evaluations and management;
- Individual and Group therapy;
- Pharmacological management; and
- Psychiatric/Psychological/Mental Health diagnostic interview examination.;

Regional Boards have begun to expand these reimbursable services into their array and it is hoped that more rural consumers will have better access to services and better continuity of care between providers. Prohibitive factors remain the extensive expense of the necessary equipment and the fact that not every Regional Board has this equipment at this time.

The DIVERTS (Direct Intervention: Vital Early Responsive Treatment System) project in the Western State Hospital catchment area, as well as the onset of reimbursement for telehealth services has spurred the increased utilization of this technology in that region of the state, in

particular. The four Regional Boards that use Western State for inpatient care, have all purchased telehealth equipment with the primary purpose of diverting as many individuals as possible from inpatient care, as well as insuring continuity of care upon discharge from the hospital. Staff from both the hospitals and the CMHCs involved in discharge planning use the technology to provide services as well as to discuss scheduling, clinic referrals, follow-up, and to allow inpatient psychiatrists to consult with local clinical practitioners in pre-screening admission.

***Children with SED***

The Kentucky Interagency Council on Homelessness announced the results of the 2010 Point-In-Time Count of the Homelessness in Kentucky. During the 2010 count, which took place on January 28, 6,623 homeless individuals were identified. Thirty-three of those individuals were unaccompanied youth, up from 24 in 2009. The 2009 count located 5,999 homeless individuals. One of the major findings from the 2010 count was a 31 percent increase (total of 9,833 in 2010) in the number of precariously housed outside of Jefferson and Fayette Counties (Louisville and Lexington, the state's two largest metropolitan areas, where the number of precariously housed are not included in the calculation. Precariously housed means they were doubled- or tripled-up with family or friends, lived in substandard housing conditions, or were expecting eviction within seven days. Precariously housed persons are in danger of becoming homeless because their current housing situation is unstable.

According to the Kentucky Department of Education (KDE), which provides the most accurate number of homeless children, 19,402 children were homeless across Kentucky from the day school started (each district starts on a different day) to the Point-In-Time
Count on January 28, 2010.

To determine if a child is homeless, Kentucky Department of Education uses the Department of Education/McKinney-Vento Education for Homeless Children and Youth definition of homelessness which is broader than the HUD definition. The HUD definition of homelessness excludes those living in substandard housing conditions, doubled-up with family or friends, or expecting eviction within seven days who have a community support network to assist.them. According to HUD, these individuals are precariously housed, not homeless. The Department of Education/McKinney-Vento Education for Homeless Children and Youth definition of homelessness includes children and youth living in one of the above noted precariously housed situations.

According to the National Center on Family Homelessness report, America's Youngest Outcasts, children experiencing homelessness are compared to non-homeless children: 4x more often sick than other children; 4x as likely to have respiratory infections; 2x as likely to have ear infections; 5x more likely to have gastrointestinal problems; 4x more likely to have asthma; 2x more likely than other children to go hungry, yet they have high obesity rates due to nutritional deficiencies; and **3x more likely to have emotional and behavioral problems compared to non-homeless children**.

According to the National Center on Family Homelessness report, America's Youngest Outcasts, one in every 50 American children is homeless each year and do not have a safe place to sleep. The National Center on Family Homelessness 2009 report, America's Youngest Outcasts: State Report Card on Child Homelessness, ranked Kentucky 42nd. This ranking was based on the state's overall performance across four domains: ) Extent of Child Homelessness-adjusted for population size; 2) Child Well-Being; 3) Risk for Child Homelessness; and 4) State Policy and Planning Efforts. Almost 20 percent of homeless households interviewed in the 2010

Point-In-Time Count reported having children with them; national statistics put this number at closer to 50 percent.

The recent release of a publication entitled: *The Rights of the Homeless in Kentucky - A Primer of Homeless Rights* will be made available on the KHC/SHR and KICH websites. It has also been printed in a compact user-friendly booklet that will be available to homeless advocates. This publication is a result of the Regional Strategic Plans to End Homeless brought forth by Lee Alcott, Executive Director of the Barren River Area Safe Space and COC Regions 1 & 2, with the financial support of the Homeless Mini-Grants through KHC and in partnership with KICH and the Services Subcommittee. Region 1 used their mini-grant to publish the primer and to share the finished product with homeless advocates across the state.

Block grant funds are allocated to support services offered at the Recovery Center of Northern KY which focuses its efforts on serving individuals who are homeless and suffer from mental illness. Specifically, they offer assistance with job skills and employment. The state also receives a PATH grant and some of the funded projects do serve families and youth transitioning to adulthood.

**3) Older Adults**

*Narrative Question: Describes how community-based services are provided to older adults.*

According to the 2010 Census, Kentucky's population of persons 60 and older is approximately 829,193 persons, representing approximately 19.1% of the state's population. It is anticipated that this population will increase by 91.4% by the year 2030, due to the aging of the "baby boom" generation. With regards to persons 60 and older with mental health issues, community mental health centers serve approximately 6% on a National level.

Chronic depression is not a normal part of the aging process, but it does occur frequently among older adults. More than 15 percent experience depression at some point in their later years. Nearly 50 percent of people with Parkinson's Disease and 35 percent of those suffering from Alzheimer's Disease become chronically depressed. Diagnosis of mental health conditions can be more complicated with older adults. Many are not treated for their mental health problems due to lack of recognition of the problem, ageism, stigma, and lack of trained professionals who can identify and treat these mental health disorders.

There is a lack of flexibility in funding to provide the services that older adults need. Medicare is a funding source for most of these persons, but Medicare reimburses at 50 percent of an approved cost for mental health services. Medicare will reimburse for acute care, but not for services that might be defined as rehabilitative.

Kentucky is committed to addressing the need of expanded access to mental health treatment for older adults with serious mental illness. In 1999, Kentucky received a SAMHSA grant that eventually led to the development of a state level Mental Health and Aging Coalition. The state level coalition consists of representatives from KDBHDID, Department for Aging and Independent Living (DAIL), Area Agencies on Aging, Office of Vocational Rehabilitation, University of Kentucky, University of Louisville, CMHCs, consumers, caregivers, and other interested stakeholders. Coalition goals for SFY 2012/2013 are:

- To strengthen existing local Mental Health and Aging Coalitions and establish local coalitions in every region across the state;
- To explore how the statewide Mental Health and Aging Coalition can utilize academia more effectively in support of regional initiatives and promotions of evidence based

practices. (To facilitate this objective, the statewide Mental Health and Aging Coalition will dedicate its' 2012 annual meeting to presentations and collaborations with academic entities;

- Continue to explore ways to maximize relationships in order to secure name recognition and partner with other entities to advance mutual goals and objectives;
- Continue to increase awareness/knowledge of regional initiatives by hosting at least one statewide Coalition meeting per year at a regional Coalition event. (meeting or conference);
- Continue outreach to maintain at least three older adult consumers of behavioral health services or caregiver representatives of older adult consumers on the statewide Mental Health and Aging Coalition;
- To develop and implement a statewide training initiative impacting older adults with mental health issues. (Mental Health First Aid, Suicide Prevention); and
- To develop strategies to ensure that all regional Mental Health and Aging Coalitions have the opportunity to replicate/benefit from successful projects/programs initiated by other regional Coalitions.

There are currently ten Mental Health and Aging Coalitions in Kentucky. Mental Health Block Grant funds are used to support the following activities through these coalitions:

- Regional training/conferences for professionals, caregivers and consumers;
- Public education and awareness activities;
- Traveling exhibit boards;
- Development and distribution of resource manuals;
- Health fairs and depression screenings;
- Suicide prevention projects;
- Anxiety reduction programs; and
- Mental Health First Aid training.

In Kentucky there are 15 Area Development Districts (Area Agencies on Aging), which focus on the needs of Older Adults. The Area Agencies on Aging are under the umbrella of the Department of Aging and Independent Living (DAIL). The KDBHDID collaborates with DAIL and the Regional Boards in a variety of ways, including:

- Staffing the statewide Mental Health and Aging Coalition;
- Participating in training events regarding mental health and aging;
- Staffing the Mental Health Planning and Advisory Council;
- Participating in numerous committees such as KinCare Subcommittee, Alzheimer's Disease and Related Conditions Council, Grandparents Raising Grandchildren-Bluegrass chapter, and the Kentucky Elder Readiness Initiative; and
- Grant applications regarding older adults and mental health.

A staff person from the DBHDID serves as a designee for the Commissioner on the NASMHPD Older Person's Division. This is a national group comprised of one designee from each state and territory, as well as a liaison from NASMHPD. This group strives to consistently provide resources and consultation to the state mental health authorities regarding the imperatives in the Surgeon General's Report and the President's New Freedom Commission Report regarding mental health needs throughout the life span. The Older Person's Division keeps abreast of the national agenda in this arena and shares information with membership through monthly conference calls.

## Criterion 5: Management Systems (Adults with SMI and Children with SED)

### 1) Resources for Providers

*Narrative Question: Describes financial resources, staffing, and training for mental health services.*

This criterion addresses three critical components of the overall management of the systems of care that serves adults with SMI and children with SED. These components include Financial, Workforce and Training. Kentucky struggles to maintain and improve performance with serious financial constraints and workforce shortage issues. Thoughtful and collaborative planning is key to moving the system forward in the face of such challenges. Offered below is discussion about the current status of the three components for this Criterion.

**Component 1: Financial**

Regional Boards have been hard hit financially in the past year in several salient ways, including:

- Frozen Medicaid rates for key services, including Case Management;
- Increases in costs to provide health insurance for their employees;
- Increases in the percentage employers must pay towards retirement plans;
- National economic crisis (increased access; increased transportation issues) and
- Changes due to Medicaid Managed Care.

Regional Boards are required by statute and contract to provide a core array of services and are held accountable to selected performance indicators, but are given considerable autonomy in how funds are distributed based on regional priorities.

**Component 2: Workforce**

DBHDID contracts directly with each Regional Board to provide direct services and each Board employs the staff who delivers services. 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 system has also been hard hit by an exodus of retirees in both central office and the Regional Boards. This exodus is occurring because enhanced pension benefits that have been available for several years ended on January 1, 2009. The Boards have experienced many changes in management. Half of the fourteen Chief Executive Officers for the Regional Boards have retired in the past several years, as well as many in other leadership positions.

**Component 3: Training**

***Emergency Service Provider Training***

*Narrative Question: Describe training of providers of emergency health services regarding behavioral health*

Senate Bill 104, which was passed during the 2007 General Assembly, mandated that DBHDID develop a 40-hour Crisis Intervention Team (CIT) training curriculum to be utilized to train law enforcement officers to better respond to persons with mental illness. CIT training was first established in Memphis, Tennessee and has come to be known as “The Memphis Model.” Kentucky’s CIT training curriculum includes modules regarding children’s mental health, suicide prevention, developmental disabilities, severe mental illness as well as substance use disorders. Included in this 40-hour training is a requirement for law enforcement officers to spend an entire day practicing skills taught during the week, while being critiqued from a panel

of experts. DBHDID currently contracts with a retired police lieutenant to organize and implement training of law enforcement officers across the state in the CIT model. This contract requires collaboration with the Department of Criminal Justice Training, which approves the curriculum and trainers for each course. Training events also require the collaboration of the local Regional Board as well as consumers of behavioral health services and their family members. During SFY 2011, five (5) additional CIT officers, in the Western part of the state, were certified as CIT instructors. Local CIT instructors were trained to provide the Memphis Model in their specific regional location and thus increase the number of officers receiving training. Several local trainings have occurred and this process is being supervised carefully, with excellent training being provided to more officers. It is the goal of SFYs 2012 and 13 to continue statewide and local CIT trainings in order to increase the number of CIT officers in Kentucky. During SFY 2011, 239 officers were trained using the CIT model. To date, 793 officers across Kentucky have been trained.

In January 2011, a training course for telecommunicators (dispatchers) was held in Paducah, Kentucky, by a Captain of the Kentucky State Police and a Detective with the Pennyrile Narcotics Task Force. This training developed as a partnership between the Western Kentucky CIT Advisory Committee (which is encouraged for all CIT regions), the Kentucky State Police, Mid-Continent University in Paducah, and the Pennyrile Narcotics Task Force. This training provided information regarding identifying and interpreting situations where, as first responders by phone, they come into initial contact with persons who are suicidal, manic, under the influence of psychotropic medications, or are otherwise in mental health crisis. The goal of the training was to provide education of symptoms to recognize, alternative steps to elicit critical information from episodic callers, and increase awareness of CIT officers as a resource. This training was intended as an adjunct to CIT training, which trains officers but not all first responders. Expansion of this type of training statewide and including as many first responders as possible is the goal for SFYs 2012 and 2013.

The Division of Behavioral Health was awarded a two-year SAMSHA grant in June 2003 to develop regional behavioral health emergency disaster preparedness plans for each of the Regional MHMR Boards. As a continuation of that initiative, the Division continues to receive additional funding (2005-2011) from the Kentucky Department for Public Health to help fund regional and statewide Mental Health/Mental Retardation Disaster Preparedness coordinators. These coordinators have provided a behavioral health focus for Kentucky's 14 regional ASPR (Assistant Secretary of Preparedness and Response) healthcare planning coalitions and ongoing interagency collaboration has resulted in integrated and coordinated responses to emergencies and disasters. Despite a 65% cut in the 2009 FFY funding, regional plans continue to be updated annually and the Department continues to designate a program administrator to coordinate regional and statewide efforts. The regional mental health emergency disaster planners meet at least quarterly with the statewide coordinator and annually as a group to share information and resources.

During SFY 2011, the Division of Behavioral Health Statewide Behavioral Health Disaster Preparedness Coordinator participated in the National Level Earthquake Exercise 2011 which was an 8 state area exercise in which the scenario was a 7.7 magnitude earthquake along the New Madrid fault line. DBHDID staff, regional CMHC staff and teams from the United State Public Health Service were able to work together to develop and test plans for meeting the behavioral health needs of individuals in crisis. The western part of the state that was the focus of the exercise was having a "real-life" crisis of significant flooding while the USPHS teams were deployed in the area. They were able to develop strike teams of local and USPHS officers to go into local areas and offer psychological first aid to the flood victims and provide this information to area first responders. While deployed in the area they were also able to respond with local

CMHC staff to assist a local school district that had sustained a bus crash in which a 6 year old was killed. It was a devastating event to the entire community and the local response was welcomed by the school and the community.

In June of 2011, another team from the USPHS deployed to Pikeville, Kentucky to provide support to a Remote Area Medical (RAM) response. RAM expeditions provide free medical care to remote areas of the United States and other parts of the world. The USPHS service teams provided training in Psychological First Aid in the "Listen, Protect, Connect" model to the local community, special needs populations and the regional CMHC. The Program Coordinator and the Executive Director of the KCCRB were able to attend a special Train the Trainer program that provided Psychological First Aid Training to Red Cross and other workers. The teams also provided Substance Abuse Awareness and Prevention training and outreach to the community during the week.

**Other Training**

DBHDID strives to provide access to on-going training and technical support for all Central Office staff as well as partner agencies and providers statewide. There is a full time Training Coordinator position within the Department to assist with these efforts. The Department seeks to utilize available technology to provide educational/training and consultation opportunities. One example is the TrainingFinder Real-time Affiliate Integrated Network (TRAIN). TRAIN is comprised of the national TrainingFinder.org site and participating TRAIN affiliates. TRAIN is a web-based system allowing anyone with internet capability to access the description and registration process for a number of trainings. DBHDID is developing on-line modules through a software program called LECTORA. These presentations can provide basic information more efficiently as participants can proceed at their own pace in their own locations.

DBHDID provides or sponsors and participates in a variety of other training initiatives. This includes many opportunities for central office staff, as well as contracted and private service providers to increase their knowledge and skill level in various best practices. Many offerings provide participants with needed continuing education units (CEUs) for professional board certification or licensure.

The Department provides scholarships (limited) for consumers, parents/family members, and Regional Board staff to attend training events. Funds are also used to provide Certified Psychiatric Rehabilitation Practitioner (CPRP) examinations from the US Psychiatric Rehabilitation Association (USPRA) for Regional Board staff, as well as to support technical assistance for the development and maintenance of adult and children's programming (e.g., Targeted Case Management, Therapeutic Foster Care). The table below details some available training events.

**Division of Behavioral Health Sponsored/Provided Training Events**

| ***Trainings Relevant to Adult Services*** | | | |
|---|---|---|---|
| **Type of Training** | **Intended Audience** | **# of Participants Anticipated** | **Frequency/ Length of conference** |
| Case Management Certification Training—Level I (required for providers) | Mental Health Case Managers who work with Adults with SMI and their supervisors | Approximately 80 | Online component available continuously plus a 1 day face-to-face training offered 4 times per year |
| **Adult Case Management Training—Level II** | Mental Health Case Managers who work with Adults with SMI and their supervisors | Approximately 80 | 4 per year<br>2 days each |
| Community Support Program (CSP) Directors Technical Assistance Meetings | CSP Directors | Approximately 25 | Quarterly<br>1 Day |
| **Hearing Voices that are Distressing** | Behavioral health providers and administrators, consumers and family members | Maximum of 40 | As requested<br>3 hours |
| Kentucky Peer Specialist Training | Consumers of behavioral health services | Varies depending on location across the state | At least 1 per year<br>5 days |
| Leadership Academy | Consumers of behavioral health services | Approximately 25 | 2 per year<br>3 days |
| SSI/SSDI Access, Outreach and Recovery (SOAR) | Case Managers, Social Service Workers, Homeless Service Providers | Approximately 30 per session | 6-8 per year; 2 days |
| **Working with Adults with SMI who have Hearing Loss: Case Management Level II Training** | SMI Case Managers | Approximately 25 per session | 1.5- 3 hours. Embedded in Case Management training and available by request |

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

***Description of Trainings Relevant to Adult Services***

Adult SMI Targeted Case Management Certification Training
The adult certification program consists of an online training module and an online certification examination administered through TRAIN, and a one day mandatory face-to-face training. The face-to-face training is held four times per year, two in the fall and two in the spring. The curriculum for these trainings has been developed by a team of professionals, consumers and advocates. The faculty seeks to continually improve upon the content and delivery of the information deemed most relevant. This group is enthusiastic about follow-up training and support for case managers and it is hoped that staff retention will be affected by the work being done.
*There are two distinct Case Management/Service Coordination training programs designed separately for adult case managers and child service coordinators.*

Adult SMI Case Management Training—Level II
This two-day training will be open for adult case managers and case management supervisors. This seminar will be offered during SFY 2011, as a statewide event open to all child and adult case managers.

Hearing Voices that are Distressing
This is based on a training module developed by Patricia E. Deegan, Ph.D. This training consists of activities designed to simulate auditory hallucinations. The goal is to foster understanding and empathy in providers.

Kentucky Peer Specialist Training
This five day, thirty hour training prepares participants to pursue employment as Kentucky Peer Specialists. The training is provided primarily by consumers using a curriculum developed from national peer support experts, Ike Powell and Larry Fricks.

Leadership Academy
Since 2003, the Office of Consumer Services within DBHDID has sponsored a Leadership Academy for adult consumers of mental health services. This training prepares consumers to assume a position of strong leadership in changing the system of care. The Leadership Academy provides two levels of education:
Level 1: Participants learn to take the initiative, develop projects, collaborate with others, participate in policy decisions, influence the budgets at the state and local levels, improve services, create new services, and educate the community.
Level 2: Prepares participants to present trainings in their communities. Topics include, Advance Directives, Consumer Rights, Leadership Academy, Recovery and Transitioning Skills.

SSI/SSDI Access, Outreach and Recovery (SOAR)
The Department collaborates with Kentucky Interagency Council on Homelessness and the Kentucky Housing Corporation to provide these trainings in communities across the state. These trainings educate providers about the application process for social security benefits and how best to assist consumers.

Community Support Program (CSP) Directors TA Meetings
These meeting are held quarterly and are open to all Regional Board Community Support Directors as well as other staff working in community programs serving adults with SMI.

| *Trainings Relevant to Children's Services* | | | |
|---|---|---|---|
| **Type of Training** | **Intended Audience** | **# of Participants Anticipated** | **Frequency/ Length of conference** |
| **Ages and Stages Questionnaire – Social Emotional** | Mental Health Practitioners and other clinicians who provide services to the birth to five population | 60 | As needed; 2 days |
| IMPACT Plus Regional Forums | IMPACT Plus Sub providers, CMHC partners (LRCs) (Offered Regionally) | Varies depending on location | 4 Hours<br>As needed |
| **Behavior Institute (Co-Sponsor)** | Educators, administrators, agency service providers, and families | Approximately 1200 | Annually; 2.5 days |
| **Child Targeted Case Management/Service Coordination 101 Certification** (required for providers of TCM) | Prospective providers of Children's Targeted Case Management services (IMPACT and IMPACT Plus and their Supervisors) | Up to 75 per Session | Quarterly<br>2.5 Days |
| **Diagnostic Criteria:0-3R** | Mental Health Practitioners and other clinicians who treat disorders of infancy and early childhood | 60 | As needed; 2 days |
| Effects of Prenatal Drug Exposure/FASD | Behavioral Health service coordinators, clinicians, prevention specialists | 15-20 | As needed |
| Evaluation Webinars | Service Coordinators, LRCs, and LRC Assistants | 15 | Monthly 2 hours |
| Family Leadership Academy | Caregivers of children with behavioral health issues, young adults (16-25) with emotional disabilities | Up to 50 per Session | Biannually<br>3 Days |
| Family Liaison Orientation | New Family Liaisons | The training is typically one-on-one with new Liaisons. | 3-4 Hours<br>As needed. |
| IMPACT Introduction to Deafness | IMPACT Service Coordinators | Approximately 25 per Session | 1.0-1.5 hours embedded in Service Coordination 101 OR available by request 1-3 Hours |

| *Trainings Relevant to Children's Services* | | | |
|---|---|---|---|
| **Type of Training** | **Intended Audience** | **# of Participants Anticipated** | **Frequency/ Length of conference** |
| **IMPACT Plus Behavioral Health Professional (BHPs) Training 101** | IMPACT Plus BHPs and BHPs under Clinical Supervision (Offered Regionally) | Varies depending on location | Quarterly<br>1 Day |
| Introduction to Child Development of Children who are Deaf or Hard of Hearing | Providers of early intervention and children's services, Kentucky School for the Deaf staff, and others by request | Target 10-20 per Session | As requested and tailored to needs of group |
| Introduction to Evaluation Family Interviewer Training | Family Interviewers for RIACs receiving KY SEED funds | 5 | Annually; 1.5 days |
| Kentucky Family Peer Specialist Support Specialist Core Competency Training | Family Leadership Academy Graduates | Up to 30 | 5 Days<br>Biannually |
| KY SEED Monthly Cohort Meeting and Technical Assistance | RIACs that provide ECMH services | Cohort 1 & 2; approximately 25 participants | Monthly; 2 hours |
| KYSEED New Cohort Orientation | Newly funded RIACs that will provide ECMH services. | 4 regions, approximately 45 participants | Annually; 2.5 days |
| KY SEED Regional Interagency Council Technical Assistance Meetings | RIAC members, regional CMHC staff | Cohort 1 & 2; approximately 25 participants | As needed; 1 day |
| **Motivational Interviewing** | IMPACT Program Staff from Regional Boards (Offered Regionally) | Up to 25 per Session | Provided for each Region 1 Time |
| Nuts and Bolts of Collecting EDIF and TRAC data | Service Coordinators, LRCs, and LRC Assistants | 15 | Annually; 1 day |
| **Parent –Infant Dyad Therapy** | Regional Perinatal Depression contacts, Early Childhood Mental Health Specialists | Up to 25 per Session | 3-4 Times per Year<br>2 Days |
| **Parent Child Interaction Therapy (PCIT)** | Mental Health Practitioners and other clinicians who treat disorders of infancy and early childhood | 60 | As needed; 3 days |

| *Trainings Relevant to Children's Services* | | | |
|---|---|---|---|
| **Type of Training** | **Intended Audience** | **# of Participants Anticipated** | **Frequency/ Length of conference** |
| **School Law** | IMPACT Program Staff from Regional Boards & Family Members, Community Partners (Offered Regionally) | Up to 40 per Session | Annually<br>3 Hours |
| **Seven Challenges** | Community Mental Health providers that are under the umbrella license<br>Fidelity visit-same as above | 15 | 1 day as needed<br>Fidelity visits from Seven Challenges llc, 1 x per year |
| School-Based Suicide Prevention | School Administrator, Educators, Staff | 40 | Over 25 annually<br>As requested |
| **Trauma Informed System of Care Training for Trainers** | Trainers within various child serving agencies | 25 | 1 day, plus follow-up sessions,<br>2 per year |
| **Wraparound Facilitation for Agencies Serving Youth & Families** | Mental health staff, educators, child welfare staff, juvenile justice staff, court staff | Approximately 25 per Session | 12 Hours<br>2 per Year |
| Youth/Parent Conference | Youth between the ages of 13 and 24 with emotional, behavioral, mental health, and substance use disabilities and their parents or caregivers. | 100 | 2 Days<br>Annually |

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

***Description of Trainings Relevant to Children's Services***

Ages and Stages Questionnaire: Social Emotional

KY SEED hosted the ASQ and ASQ: SE Train the Train sessions for early intervention program staff, child development specialists, public health professionals, social workers, child care providers and early childhood mental health specialists. Participants were given an introduction to developmental screening, legal mandates, and the benefits of developmental screening; the methods of administering the questionnaires, tracking results, scoring the questionnaires, and communicating screening results to families; how to interpret ASQ-3 scores and how to make referral decisions based on those scores; and implementation issues.

Behavioral Health Professionals Regional Forums

Regional Forums are held to focus on issues related to training needs (some include trainings), resource development and collaboration within regions as well as information dissemination. This year, 1200 educators, school administrators, pupil service personnel, child-serving agency providers, and youth and families attended.

Behavior Institute (sponsor)

The Behavior Institute is a cutting edge two-day behavior conference sponsored by the Kentucky Council for Children with Behavior Disorders, the Kentucky Department of Education, Kentucky's System to Enhance Early Development through Kentucky Division of Behavioral Health, Kentucky Autism Training Center and the Central Kentucky Special Education Cooperative.

Child Targeted Case Management/ Service Coordination (SC 101) Certification Training

The Department is responsible for certifying children's case managers and offers quarterly training in different areas of the state. The faculty consists of regional providers, parents and a Medicaid representative. The content of the training is skills-based. Supervisors are provided a manual to use with staff to cover additional areas of interest and on-line modules are being considered for the coming year. The training is continually evaluated and improvements to the content and delivery are made accordingly. Information about co-occurring mental health and substance abuse and information about deafness are currently being added to the curriculum. *There are two distinct Case Management/Service Coordination training programs designed separately for adult case managers and child service coordinators.*

DC: 0-3R

KY SEED hosted two training sessions about the proper utilization of the DC:0-3R - Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood. This developmentally based system for diagnosing mental health and developmental disorders in infants and toddlers will assist mental health clinicians, counselors, physicians, nurses, early interventionists, early childhood educators, and researchers as they provide ECMH services. The DC:0-3R is an indispensable guide to evaluation and treatment planning with infants, toddlers, and their families. On-going mentoring regarding the utilization of the DC:0-3R is provided to service providers by the KY SEED clinical staff.

Effects of Prenatal Drug Exposure/FASD

The Department's Substance Exposed Infants Workgroup and FASD Prevention Enhancement Site offer trainings quarterly recognizing children who may need an FASD assessment, providing services and supports for these children, and preparing the family and young adult for transition to adulthood.

Family Leadership Academy

The Department has partnered with the statewide family advocacy organization, KPFC to create curriculum and offer quarterly week-long sessions for parents/caregivers of youth with SED.

Family Liaison Orientation

A Kentucky Peer Support Specialist meets with new Family Liaisons to conduct a 3-4 hour OFL 101 training. Newly hired Liaison's are provided with books on diagnoses, advocacy and other topics to assist them in carrying out their role.

IMPACT Introduction to Deafness

This training can be adapted from 1-3 hours as an introduction to working with Deaf-member families. Focus is on understanding the cultural and linguistic implications of hearing loss, adapting services, and knowing the appropriate resources.

IMPACT Plus Behavioral Health Professionals Training 101

Training is provided to BHPs and BHP under clinical supervision to provide information on the wraparound model, developing goals that focus on the strengths of the child and family as a way to address unmet needs. The sessions also include information on boundaries and ethics as well as documentation as outlined in the IMPACT Plus regulations.

Introduction to Child Development with Children Who Are Deaf or Hard of Hearing

This workshop challenges providers to think about the psychosocial development of children with hearing loss and how best to provide wraparound services that meet the needs of the whole child.

Introduction to Evaluation - Family Interviewer Questions
These are trainings given to Family Interviewers as part of the KY SEED project.

Kentucky Family Peer Support Specialist Core Competency Training
The Department partnered with the statewide family advocacy organization, KPFC, in 2009 to provide this intensive, skills-based five (5) day training. Parents/caregivers must be a graduate of the Family Leadership Academy and complete an application process and to qualify for this training. The Department continues to work with Medicaid Services to make Specialists' services Medicaid billable.

KY SEED Monthly Cohort Meeting and Technical Assistance
RIACs that receive funding from KY SEED participate in monthly conference calls with KY SEED staff to discuss implementation issues including accomplishments, challenges, best practices or possible solutions, staff needs, budget execution and monitoring, and clinical information to enhance ECMH services. KY SEED staff provide technical assistance or identify resources to support the RIACs.

KY SEED New Cohort Orientation
KY SEED staff and other organizational partners conduct a 2 ½ day orientation session for newly funded RIACs. This session includes information about the concepts and philosophy of system of care and its history in KY, early childhood development, social marketing, evaluation, and cultural and linguistic competency. Practical information about implementation of this initiative is also provided including reporting requirements, budget administration, technical assistance, and community readiness.

KY SEED Regional Interagency Technical Assistance Meetings
Meeting/training held to orient new cohorts to the early childhood system of care grant initiative.

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

Nuts and Bolts of Collecting EDIF and TRAC Data

Parent-Infant Dyad Therapy
This two-day training is skills-based and offered to the Regional Board staff who are designated as the Perinatal Depression "point persons" and the Early Childhood Mental Health Specialists.

Parent-Child Interaction Therapy (PCIT)
KY SEED provides quality training and support to ECMH service providers which can improve the quality of mental health services provided to children and families. Parent-Child Interaction Therapy (PCIT) is a proven parent-child treatment program that assists parents of children with behavioral problems (aggression, non-compliance, defiance, and temper tantrums). This unique treatment program focuses on promoting positive parent-child relationships and interactions while teaching parents effective child management skills. It is our goal to increase the number of trained and qualified mental health providers in rural and urban areas with the expertise to comprehensively respond to the special needs of children and families through the delivery of PCIT services.

School-Based Suicide Prevention
Participants leave this workshop with practical information on how to implement evidence-based universal and targeted suicide prevention programs, the issue of suicide contagion in Kentucky schools, and suicide postvention procedures.

School Law
The Department partners with Protection and Advocacy to offer a three-hour overview seminar that provides audience with basic knowledge of IDEA, NCLB, and KDE disciplinary actions protocol. Participants are provided with an array of resources for additional further study and tools for advocating in school meetings for their own or other children.

Seven Challenges
The Department carries an umbrella license for the Community Mental Health Agencies to use the Seven Challenges Model. The trainings that occur will be for providers who need to train agency staff as providers but will need to have one person in their agency designated as a "leader" and have attended the "leader training" that is only offered by Seven Challenges LLC. Seven Challenges LLC also requires that there is a once a year fidelity visit that all leaders and providers must attend in which not only is fidelity issues discussed and reviewed but also continued support and education/training is given to those in attendance around the Seven Challenges model and philosophy

Technical Assistance Meetings for IMPACT Local Resource Coordinators, Early Childhood Mental Health Specialists, Children's Crisis Program Directors, Therapeutic Foster Care Providers, Children's Services Directors, Family Liaisons, Kentucky Family Peer Support Specialists, State Family Advisory Council Members,
These meeting are held quarterly for 1-1½ days and are open to all Regional Board staff belonging to one of these peer groups.

Trauma Informed System of Care Training for Trainers
A cross-agency training to train child serving agency trainers on a "Trauma Informed System of Care Basics Training" so that they, in turn, can train their agencies on a general overview of trauma and trauma informed care.

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

Youth/Parent Conference
An annual 2 ½ day conference that offers tracks for youth between the ages of 13-17 years old that have an emotional, behavioral, mental health, and/or substance use disability; young adults (transitional age: 18-25 years old) that have an emotional, behavioral, mental health, and/or substance use disability; and parents of these youth and young adults.

| *Additional Trainings Relevant for Both Adult and Children's Services* | | | |
|---|---|---|---|
| **Type of Training** | **Intended Audience** | **Number of Participants Anticipated** | **Frequency/ Length of conference** |
| Access Options for Consumers with Hearing Loss | Each CMHC Region and other Providers Upon Request | Ranges from 5-125 per Session | As Requested; In Partnership with Hamilton Relay |
| **American Sign Language Interpreter Peer Supervision Groups on Mental Health Interpreting** | Certified, Licensed Interpreters and interns working in mental health settings across the state. Groups exist or are forming in Lexington/Danville, Louisville, Northern KY, and Bowling Green | Target 5-10 per Session | Every 4-6 weeks One Day |
| **Assessing and Managing Suicide Risk: Core Competencies for Mental Health** | Behavioral Health Clinicians | Target-30 per Session | As requested One Day |
| Adapting Substance Abuse Treatment for Deaf or Hard of Hearing Consumers | Any provider currently or interested in serving consumers with hearing loss. | Target 8-25 per Session | As requested. Tailored to needs of audience. |
| Brown Bags | DBHDID Central Office Staff | Average 5-20 | As Scheduled One Hour |
| **Cognitive Behavior Therapy for Consumers who are Deaf with Language and Learning Challenges** | Therapists, case managers, rehabilitation counselors for the deaf, and others. | 40 | As needed |
| **Cognitive Behavior Therapy for Perinatal Depression** | Regional Perinatal Depression contacts, Early Childhood Mental Health Specialists | 30-50 per Session | 3 Times per Year 2 Days |
| **Crisis Intervention Team Training (CIT)** | Law Enforcement Officers | Approximately 180 Total | 6 per year 5 Days (40 hours) |
| **Cultural Competency Training of Trainers** | Current and prospective providers of Cultural Competency Training at the DBHDID operated or contracted facilities and Regional Board staff and DBHDID central | Varies depending on location across the state | As requested 2-3 Days |

| *Additional Trainings Relevant for Both Adult and Children's Services* | | | |
|---|---|---|---|
| **Type of Training** | **Intended Audience** | **Number of Participants Anticipated** | **Frequency/ Length of conference** |
| | office staff | | |
| **Deaf and Hard of Hearing Providers' Symposia** | DHHS Specialists and other CMHC staff with consumers with hearing loss. | 20 | Quarterly |
| **Deafness 101** | Overview of Cultural and Linguistic Issues in Serving Deaf or Hard of Hearing Consumers for any interested providers of mental health, developmental disability, or addiction services | Varies depending on interest and location – available statewide. Target is 100. | As Requested by Any Provider or Educational Institution across the State. Goal is to have it offered at every CMHC and facility.<br>1.5 to 3 hours |
| **Deafness 102** | 1.5 to 3 hour Overview of adapting clinical practices to be culturally and linguistically affirmative for those with hearing loss. Available to current or prospective providers | Varies depending on interest and location. Available statewide. Goal is 100. | As Requested by Any Provider or Educational Institution Across the State. Goal is to have it offered at every CMHC and facility.<br>1.5 to 3 hours |
| Department of Psychiatry Grand Rounds | Department staff | 5-110 | 1 ½ - 2 Hours Bimonthly |
| **Emergency Services Training** | Behavioral health providers and administrators, community providers and leaders, local interest groups. | Available statewide | As needed |
| **Evidenced Based Care for the Client At-Risk for Suicide** | Behavioral health clinicians | Target-80 | As requested<br>One Day |
| **Heal the Healer Training and Retreat** | Behavioral health clinicians, case managers, supervisors | 20-25 | 2 days<br>Annually |

| *Additional Trainings Relevant for Both Adult and Children's Services* | | | |
|---|---|---|---|
| **Type of Training** | **Intended Audience** | **Number of Participants Anticipated** | **Frequency/ Length of conference** |
| **Kentucky Registry of Interpreters for the Deaf (RID)** | DHHS Interpreters from across the state | 17-40 | Annually |
| DBHDID Orientation | Newly Hired Central Office Staff | Average 4-8 | Quarterly and as needed<br>1 Day |
| Kentucky Mental Health Planning and Advisory Council Member Orientation | New and current members. | 15 | Annually |
| **Kentucky School of Alcohol and Other Drug Studies** (Co-Sponsored by DBHDID) | Behavioral health providers and administrators, consumers and family members | Approximately 800 | Annually<br>4.5 Days |
| **Law Enforcement Response to Individuals with Special Needs** | Police Officers, Deputies, School Resource Officers | 25 | 5 Days<br>40 Hours |
| Let's Talk Safety for Families: Access to Lethal Means | General Audience | New offering for suicide prevention | As requested<br>1.5 Hours |
| **Let's Talk Safety: Clinical Issues Associated with Access to Lethal Means** | Behavioral Health Clinicians | New offering for suicide prevention | As requested<br>1.5 Hours |
| Mental Health Interpreting Peer Supervision Groups | A supervision group for clinicians serving clients who are deaf or hard of hearing. | 5-15 | Monthly |
| Question, Persuade, and Refer Training (QPR) | Behavioral health service providers, state operated or contracted facilities, consumers, local interest groups and central office staff | Varies depending on location across the state | Quarterly and as Requested<br>1.5 Hours |
| Therapists' Retreat for those Serving Consumers with Hearing Loss | Behavioral health service providers, state operated or contracted facilities, consumers, local interest groups and DBHDID central office staff | Ranges from 4-25 | 4 per year |

| *Additional Trainings Relevant for Both Adult and Children's Services* | | | |
|---|---|---|---|
| **Type of Training** | **Intended Audience** | **Number of Participants Anticipated** | **Frequency/ Length of conference** |
| Transition Age Youth Launching Realized Dreams | Adult Case Managers and Children's Service Coordinators | 60 | 1 Day<br>As requested |
| Understanding Self-Harming Behavior | General audience as well as educators | New offering | As requested<br>2 Hours |
| **Working with the Suicidal Client** | Behavioral health clinicians | Target-200 | As requested<br>2 Hours |
| Workshops for the Deaf Community | Existing consumers and others who may be in need of mental health services. | 10-55 | Monthly and as needed |

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

### *Trainings Related to Both Adult and Children's Services*

Brown Bags
These are "in-house" training/information sharing events held over the lunch hour. They focus on various topics of interest to central office staff across the Department. Presenters may be co-workers, outside presenters, or facilitated viewing and discussion of printed materials.

Creating Community Connections: A Behavioral Health Case Management Conference
It has been many years since the Department sponsored a conference specifically to address the needs of behavioral health case managers. This conference will be held December 7-8, 2010. Besides meeting the continuing education and networking needs of this workforce, the conference will provide an opportunity to recognize case managers who are providing excellent services.

Crisis Intervention Team
In collaboration with the National Alliance for the Mentally Ill (NAMI), DBHDID provides training for law enforcement officers regarding how to better respond to encounters with individuals who may be experiencing a behavioral health crisis. In SFY 2008, 204 officers were trained. The target for SFY 2009 is 180 additional officers. In SFY 2009, there will also be one "Train the Trainers" event.

Cultural Competency
Training regarding cultural competency issues is part of the initial orientation package for each Department employee. The Regional Boards are also required to provide cultural competency training for all staff members. The Cabinet also offers training through the Office of Diversity and Equality. Cabinet trainings are offered once a month.

Cultural Competency Training for Trainers
Department trainers provide this 2-3 day training to trainers in state-run or contracted facilities and community mental health centers on an as-needed basis.

Deaf and Hard of Hearing Services Providers' Symposia
Offered quarterly, these trainings bring together DHHS specialists as well as other CMHC staff who have consumers with hearing loss. Due to the lack of training in contiguous states, we have had participants from Ohio and Indiana as well.

Department of Psychiatry Grand Rounds
The Department accesses via video-conference the Department of Psychiatry Grand Rounds presentations for both the University of Louisville and University of Kentucky Schools of Medicine. The Department facilitates access to these presentations by the state facilities and the Community Mental Health Centers, often offering CEUs to staff who participate.

DDCAT/DDMHT Training and Technical Assistance
Our Department continues to develop a treatment delivery system in which all publicly-funded Mental Health and Substance Abuse treatment facilities across the state are co-occurring diagnosis capable, as measured by the Dual Diagnosis Capability in Addiction Treatment (DDCAT) and DDMHT (Mental Health Treatment) Fidelity Instruments. Trainings and technical assistance is being offered to Department and CMHC to learn the following:

- To have an understanding of Addiction/Mental Health Only Services vs Dual Diagnosis Capability vs Dual Diagnosis Enhanced Programs;
- To comprehend the program requirements for achieving DDC and DDE;
- To become competent in conducting DDCAT/DDMHT assessments;
- To be able to utilize DDCAT/DDMHT results in strategic planning; and
- To recognize the potential statewide impact of utilizing the DDCAT/DDMHT.

Emergency Services Training
Each Regional Board is encouraged to educate emergency services personnel (the courts, peace officers, inpatient psychiatric facilities, Rape Crisis Centers, etc.) in their area, as to applicable statutes concerning involuntary hospitalization and how to access evaluation services on a 24-hour per day, seven days a week basis. In collaboration with the Kentucky Association of Regional Programs (KARP), suicide risk assessment training (QPR) at each local mental health center is provided.

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

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

Kentucky Registry of Interpreters for the Deaf Conference
Deaf and Hard of Hearing Services provides a mental health track at the Interpreters' Conference, 3 workshops.

Kentucky School of Alcohol and Other Drug Studies

The annual "Kentucky School" is the premier training event for Kentucky's substance abuse prevention specialists, substance abuse treatment providers, and persons in recovery. It has grown to include a wider audience and a broader focus to include mental health and professionals from a variety of disciplines including child welfare, corrections, and juvenile justice. There are intensive sessions on a variety of topics including Adolescent Substance Abuse and Co-Occurring Disorders.

Law Enforcement Response to Individuals with Special Needs
This 40-hour training is offered biannually to law enforcement officers and school resource officers. The focus of the training is how to provide a sensitive, appropriate response to adults and youths with mental illness, diagnosed with an autism spectrum disorder, deaf, who have a substance-related disorder, or dementia.

Mental Health Interpreting Peer Supervision Groups
Training provided in Northern Kentucky and Louisville areas (statewide as requested). This peer supervision group is the only ongoing training of its kind in the country. We will be initiating an interpreting mentoring program in FY2011 to take it to the next level

Suicide Prevention Training
In keeping with the state suicide prevention plan, the Department offers a series of trainings related to suicide prevention, across the state, to train providers, educators, consumers, family members and the public about suicide prevention, awareness, intervention and evaluation. Specific suicide modules are listed in the training grid above.

QPR Community Suicide Prevention Presentation.
QPR stands for Question, Persuade and Refer. This is a basic community oriented presentation designed to create greater awareness, recognition of warning signs and knowledge of what to do if someone you know is struggling with a potential suicidal crisis. This program is 90 minutes in length and includes PowerPoint, video, and group interaction. Each participant receives a booklet containing the basic program information.

Transition Age Youth Launching Realized Dreams
A specialized training for providers who work with transition age youth focusing on best practices and resources for this population.

Understanding Self-Harming Behavior
This workshop can be designed for either clinical audiences or school staff and family members. The school and family presentation is 2hrs and the clinical version is a 3hr presentation. Both workshop formats explore the issue of prevalence and understanding the phenomenon of self harm itself in the context of developmental issues associated with adolescents and young adulthood. In the school and family format there is a consideration of appropriate school protocol and what family members can do. For the clinical format, focus is directed to evidence-based treatment and working with a client who engages in this behavior. Approved CEU's can be provided for mental health providers.

Working with the Suicidal Client
This is a clinical training appropriate for mental health providers, case managers or those working in the healthcare field. This workshop is flexible - 2hr, 3hr and full day lengths. The material can be utilized to earn approved CEUs. Specific content can be flexed to meet the needs a given group. Modules include: Prevalence; Risk & protective factors; Issues of provider competence; Understanding the suicidal mind; How to conduct a solid risk assessment; establishing a therapeutic connection; and what we know about effective treatment. The

workshop presentation includes PowerPoint, video, group exercises and interactive dialogue; each participant receives a notebook with a generous number of resources.

Workshops for the Deaf Community

Most states focus on existing consumers; we are doing case finding as well as reducing stigma by presenting in diverse environments such as the KY Association for the Deaf, KY School for the Deaf's Family Learning Vacation, and with VR counselors in their regions ("Taking Care of Yourself in Tough Economic Times").

# II: Planning Steps

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

Page 22 of the Application Guidance

Narrative Question:

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Footnotes:

## II. Planning Steps

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

*Identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.*

*Priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.*

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In an effort to identify unmet needs and critical gaps in the publicly funded behavioral health system, the Department has drawn upon data and information from a variety of sources at the local, regional and state level and compared it with data available nationally. The Department and stakeholders have participated in a number of activities to address the need for comprehensive data to drive their planning efforts, including:

- Mental Health Planning and Advisory Council Priority Setting Sessions;
- Legislative Research Commission Program Reviews;
- Priorities and Supporting Research from federal funders, including SAMHSA;
- Technical Assistance from three different sources; and
- Current utilization and outcomes data available to the Department through its own and other state agency data systems.

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

- State Budget Deficits and a Poor State Economy;
- Implementation of Managed Care (including behavioral healthcare), Slated to "Go Live" later this Calendar Year;
- Legislative Actions (including unfunded mandates);
- Construction of a State Psychiatric Hospital to Replace Eastern State Hospital;
- Gubernatorial Election in November 2011; and
- Military Involvement (domestic and abroad).

The remainder of this section (Step 2) will provide information under the subheadings of Mental Health, Substance Abuse Prevention and Substance Abuse Treatment, and will attempt to address the requested items in the instructions above.

**Mental Health**

The Finance Committee of the Kentucky Mental Health Planning and Advisory Council recommended the following nine (9) priorities for Block Grant funding and in May 2010, the full Council chose the top three (3) priorities for the coming year:

- **Develop specialized services and supports for youth transitioning to adulthood.** *Council agreed this includes training for staff as well as direct services and supports for youth;*
- **Promotion of recovery-oriented services across all Regional Board programs;** *Particularly use carry over funds for this as they are one-time expense projects;*
- **Increased funding for family member and consumer-run support programs;**
- Increased funding for an anti-stigma and anti-discrimination campaign to educate the public;
- Promotion of early intervention and increased access to community-based services (to prevent higher levels of care);
- A self-identified, active parent, youth & consumer representative on every Center's Board of Directors;
- Increased access to transportation services;
- Increased education about services available at the Regional Boards; and
- Increased training for staff on evidence-based practices, trauma-informed care, and on cultural competency.

The Planning Council and the Department also participated in a Mental Health Block Grant monitoring visit (March 2009) and remain aware of their report that noted the following:

- A need to rebalance mental health system resources between State Hospital and community services;
- A need to be more effective in soliciting and responding to consumer and family input into the service system;
- A need to hire a self-identified consumer as the Director of the Office of Consumer Affairs at the Division of Behavioral Health. It was noted that this action would introduce a consumer perspective into policy making as well as serve as a role model for other agencies; and
- A need to develop a statewide set of client rights and method to track client grievances at the state level.

The Kentucky Legislative Research Commission's Program Review and Investigations Committee is currently revisiting their Research Report (previously released in June 2007), entitled; *Kentucky's Community Mental Health System is Expanding and Would Benefit from Better Planning and Reporting.* The follow-up study is due for release in the Fall of 2011. The major objectives of the original study were to describe the Regional Boards' mission, activities, and resources; analyze needs and services; and examine the processes of treatment, monitoring and outcome evaluation. It is anticipated that the follow-up report will focus on progress made and potential changes due to the current environment.

In 2007, a behavioral health consultant was secured through the National Association of State Mental Health Program Directors/National Technical Assistance Center, regarding financial strategies in promoting mental health transformation. Leslie Schwalbe, MPA, provided her final

report in August of 2007, entitled, "Promoting Mental Health Transformation: Development and Implementation of Financing Strategies for Kentucky's Mental Health System." This report noted the following:

- Kentucky spends significantly more than the national average on state psychiatric hospital inpatient care (57% vs. 28%) and significantly less than the national average on community mental health services (43% vs. 69%). State hospital and community budget allocations should be structured in order to increase the mental health treatment and support capacity for persons living in the community.
- Use of performance measures and performance based contracting should be part of an overall quality management system that is used to improve outcomes.
- A need exists to coordinate administrative requirements and coordination of care with the Department for Medicaid Services.

In late 2010, the Kentucky Department of Behavioral Health, Developmental and Intellectual Disabilities (KDBHDID) contracted with Health Management Associates (HMA) to assess the current behavioral health system and recommend changes to the state's Medicaid behavioral health service, financing and benefits structure in order to help position the state to leverage the opportunities and understand the challenges posed by newly enacted legislation at the federal level (Affordable Care Act). HMA's project tasks were intended to assist DBHDID prioritize service coverage and methods for financing consistent with the needs and goals of the state. Although the technical assistance was cut short due to budget constraints, HMA suggested that Kentucky should seek to remedy some of the key infrastructure, oversight and financing weaknesses within its system and provided the following recommendations:

- Align Medicaid infrastructure and policy to ensure the state's ability to advance behavioral health coverage and ensure long-term compliance with federal regulations;
- Ensure resource allocation decisions are rational (e.g., based on consumers' level of need and ability to benefit from services).;
- Fully leverage Medicaid;
- Remove unexplained variation among provider base;
- Instill best practices in the service delivery system;
- Re-balance the service system to create community-based alternatives to inpatient or provider-controlled residential care;
- Develop a continuum of services;
- Pursue opportunities to increase collaboration and coordination between primary care and behavioral health care providers.

In May 2011, Leslie Schwalbe, MPA, provided consultation to DBHDID regarding preparing for managed care in the public mental health system. Several recommendations were made focusing on these major areas: 1) DBHDID updating CMHC contract language to accommodate managed care concerns; 2) DBHDID oversight regarding Managed Care Organizations' (MCO) contracts with the Department for Medicaid Services and with the CMHCs; and 3) Maintaining a safety net for the remaining state behavioral health funds for persons in the public system who do not have Medicaid benefits or other insurance coverage.

DBHDID also received consultation from Acumen consultants in 2011 to assist with Medicaid State Plan Amendment development. At present this has consisted of face to face and telephone consultation. Acumen consultants are scheduled to return in September 2011 to

continue assisting the Department with this task. The Department continues to work on these issues and make every effort possible to provide needed services to persons in the public behavioral health system.

The Department is interested in learning from the results of two surveys distributed by KY STARS and NAMI-Lexington and will incorporate data from these in their planning processes.

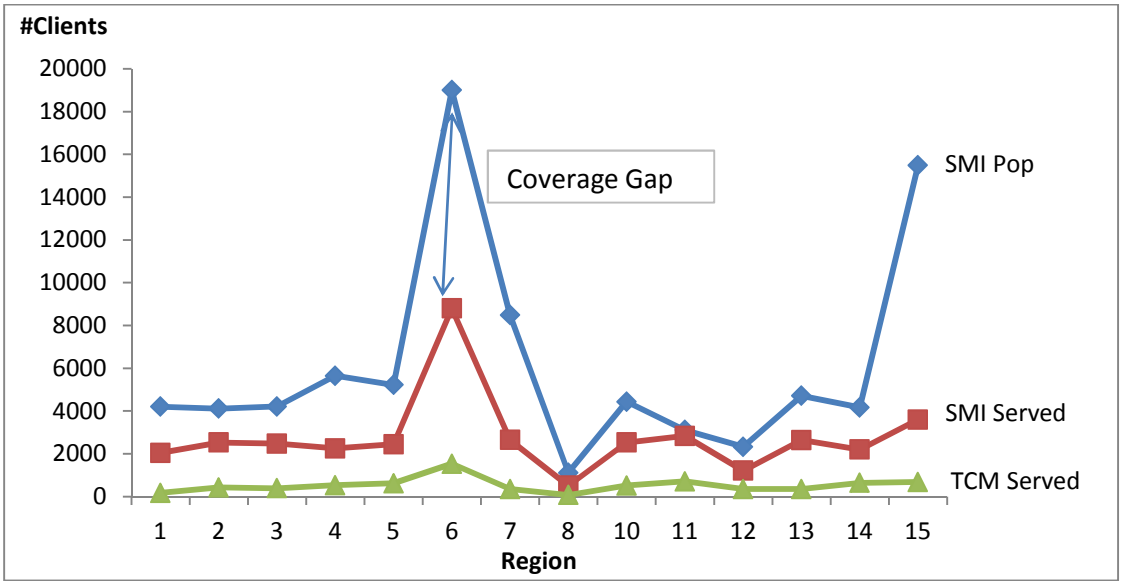
A Gap Analysis was calculated by DBHDID in 2011 based on 2010 Census numbers (newly available) and certified 2010 KY MIS Client/Event data. This data was based on prevalence data regarding adults with SMI and children with SED. It was noted that about 45% of adults with SMI in Kentucky receive services from the Regional Boards, and about 9.5% of adults with SMI served by the Regional Boards received targeted case management services. It was also noted that about 47% of children with SED received services from the Regional Boards and about 16% of the children with SED served by the Regional Boards received targeted case management services.

Adult Gap Analysis (SFY 2010 Certified Data)

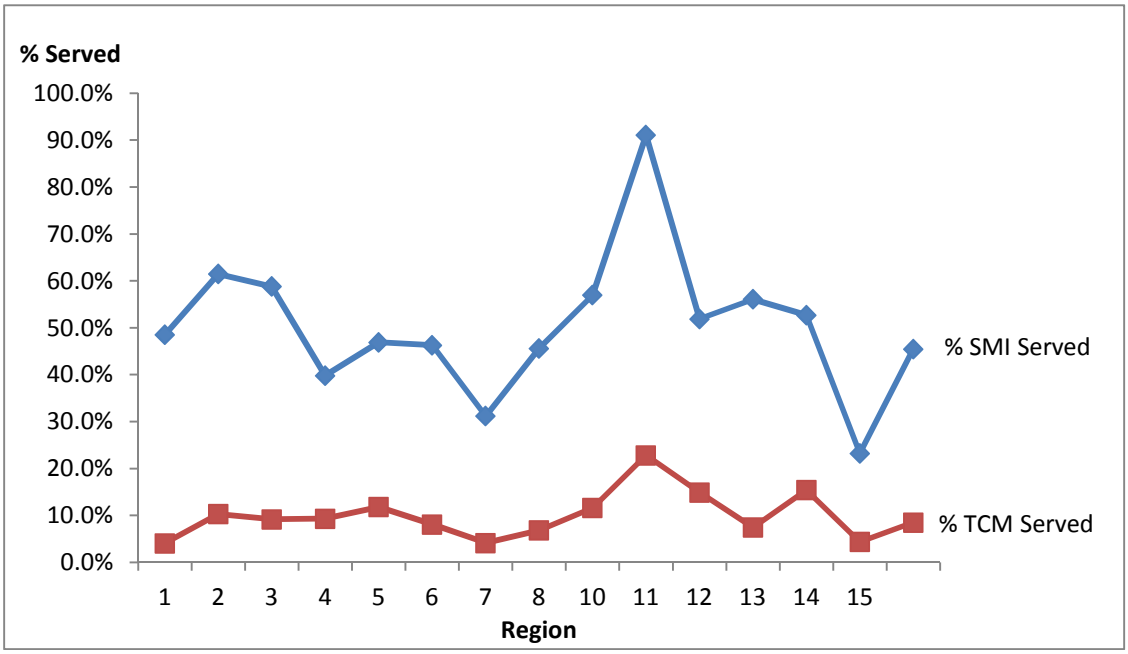
| Region | SMI Pop | SMI Served | SMI w/TCM | SMI Gap | TCM Gap | %SMI Served | %TCM Served |
|---|---|---|---|---|---|---|---|
| 1 | 4200 | 2038 | 171 | 2162 | 4029 | 48.5% | 4.1% |
| 2 | 4111 | 2527 | 424 | 1584 | 3687 | 61.5% | 10.3% |
| 3 | 4211 | 2476 | 386 | 1735 | 3825 | 58.8% | 9.2% |
| 4 | 5648 | 2249 | 527 | 3399 | 5121 | 39.8% | 9.3% |
| 5 | 5217 | 2446 | 616 | 2771 | 4601 | 46.9% | 11.8% |
| 6 | 19002 | 8793 | 1535 | 10209 | 17467 | 46.3% | 8.1% |
| 7 | 8482 | 2646 | 351 | 5836 | 8131 | 31.2% | 4.1% |
| 8 | 1112 | 507 | 76 | 605 | 1036 | 45.6% | 6.8% |
| 10 | 4436 | 2527 | 515 | 1909 | 3921 | 57.0% | 11.6% |
| 11 | 3114 | 2836 | 711 | 278 | 2403 | 91.1% | 22.8% |
| 12 | 2328 | 1208 | 347 | 1120 | 1981 | 51.9% | 14.9% |
| 13 | 4709 | 2641 | 350 | 2068 | 4359 | 56.1% | 7.4% |
| 14 | 4165 | 2195 | 642 | 1970 | 3523 | 52.7% | 15.4% |
| 15 | 15482 | 3597 | 677 | 11885 | 14805 | 23.2% | 4.4% |
| Total | 86216 | 39201 | 7328 | 47015 | 78888 | 45.5% | 8.5% |

1. SMI population is estimated based on 2010 US. Census total population.
2. SMI population = Total Population * 0.026 (SMI Prevalence: 2.6%)
3. The denominator of "% SMI Served" and "%TCM Served" is "SMI Population".
4. SMI Gap = SMI Pop - SMI Served SFY 2010
5. Targeted Case Management Gap = SMI Pop - TCM Served SFY 2010
6. % SMI Served = "SMI Served" / "SMI Pop" * 100
7. % Targeted Case Management Served = "TCM Served" / "SMI Pop" * 100

Coverage Gap Analysis using Frequency




Coverage Gap Analysis using Percentage (SFY 2010 Certified Data)
(Denominator: Estimated SMI population, 2.6% of total population)



Using 2010 census data and the state's agreed upon prevalence rate estimate of five percent, Regional Boards are aware of the number of children in potential need of services. However, they 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. (Contact site is www.kyyouth.org.)

The following denotes the child population and the estimated number of children with a severe emotional disability (SED) and thus percentage served.

Estimated 2010 Child Census – 1,023,371
Estimated Number of Children with SED (5%) – 51,169
Kentucky MH Children Served SFY 2011 – 55,623 or 5.4% (of Kentucky's child population)
Kentucky SED Children Served SFY 2011 – 26,228 or 51.2% (of the 5% SED population)

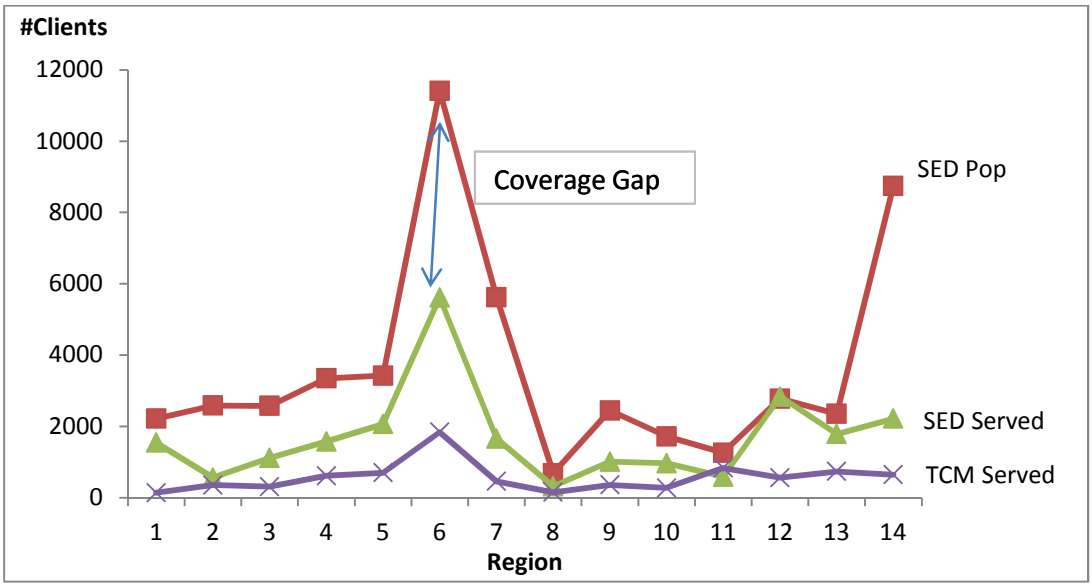
*Note: Data for 2011 are not certified until October 15, 2011and thus may change slightly.*

Children Gap Analysis (SFY 2010 Certified Data)

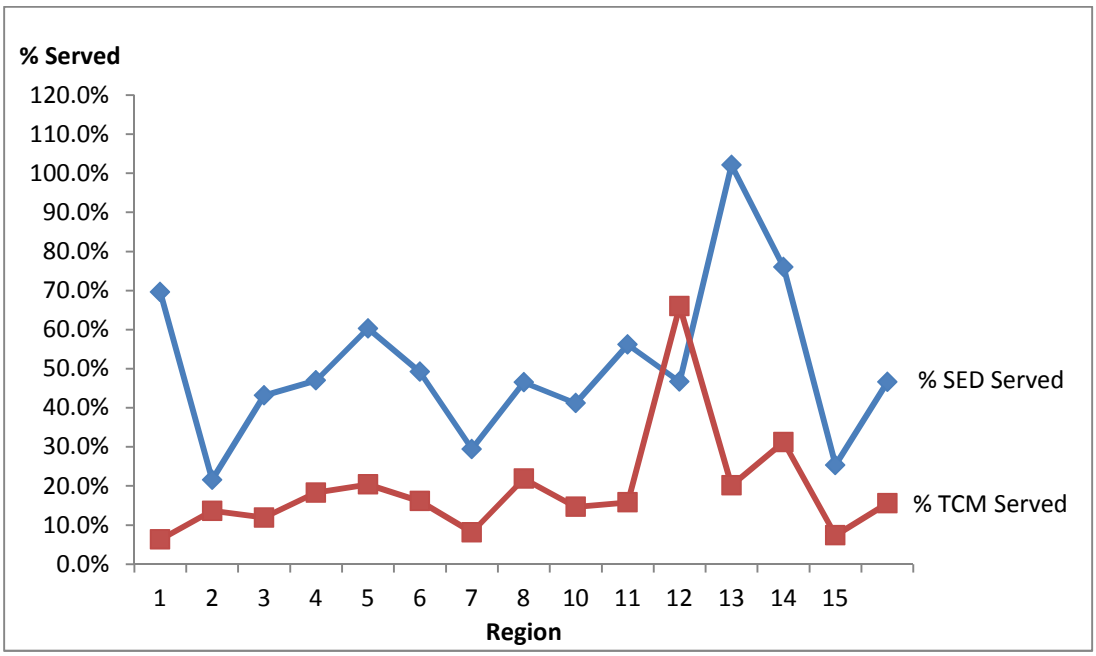
| Region | SED Pop | SED Served | SED w/TCM | SED Gap | TCM Gap | %SED Served | %TCM Served |
|---|---|---|---|---|---|---|---|
| 1 | 2218 | 1544 | 140 | 674 | 2078 | 69.6% | 6.3% |
| 2 | 2584 | 558 | 352 | 2026 | 2232 | 21.6% | 13.6% |
| 3 | 2575 | 1111 | 307 | 1464 | 2268 | 43.1% | 11.9% |
| 4 | 3348 | 1574 | 613 | 1774 | 2735 | 47.0% | 18.3% |
| 5 | 3424 | 2065 | 698 | 1359 | 2726 | 60.3% | 20.4% |
| 6 | 11412 | 5615 | 1841 | 5797 | 9571 | 49.2% | 16.1% |
| 7 | 5621 | 1654 | 457 | 3967 | 5164 | 29.4% | 8.1% |
| 8 | 686 | 319 | 150 | 367 | 536 | 46.5% | 21.9% |
| 10 | 2447 | 1008 | 359 | 1439 | 2088 | 41.2% | 14.7% |
| 11 | 1717 | 964 | 271 | 753 | 1446 | 56.1% | 15.8% |
| 12 | 1261 | 588 | 832 | 673 | 429 | 46.6% | 66.0% |
| 13 | 2775 | 2833 | 559 | -58 | 2216 | 102.1% | 20.1% |
| 14 | 2353 | 1787 | 735 | 566 | 1618 | 76.0% | 31.2% |
| 15 | 8748 | 2217 | 644 | 6531 | 8104 | 25.3% | 7.4% |
| 2010 Total | **51169** | **23837** | **7958** | 27332 | 43211 | 46.6% | 15.6% |

1. SED population is estimated based on 2010 US. Census total population.
2. SED population = Total Population * 0.05 (SED Prevalence: 5%)
3. The denominator of "% SED Served" and "%TCM Served" is "SED Population".
4. SED Gap = SED Pop - SED Served
5. Targeted Case Management Gap = SED Pop - TCM Served
6. % SED Served = "SED Served" / "SED Pop" * 100
7. % TCM Served = "TCM Served" / "SED Pop" * 100

Coverage Gap Analysis using Frequency (SFY 2010 Certified Data)




Coverage Gap Analysis using percentage. (Denominator: Estimated SED population, 5% of total population)




In November 2009, the Children, Youth, and Families Branch of the Division of Behavioral Health created goals to present to a newly appointed DBHDID Commissioner, including the following priorities:

Operationalizing the System of Care for Children in Kentucky

- Align desired outcomes with partner agencies

- Standardize the wraparound approach among agencies
- Standardize assessments and outcomes tools
- Utilize data to demonstrate shared population
- Ensure full continuum of care, including special populations – transition age youth, early childhood, homeless, co-occurring
- Shared financing strategy that matches SOC services with billable services.
- Shared understanding of SOC using social marketing
- Increase family and youth involvement at all levels of the system

Suicide Prevention

- School-based suicide prevention programs, i.e. Signs of Suicide
- Support the National Suicide Prevention Hotline
- Train additional gatekeepers in Question, Persuade & Refer (QPR)
- Increase awareness and reduce stigma using a social marketing media campaign

Utilize a Public Health Approach for Behavioral Health Services

- Include promotion, prevention and aftercare in the treatment model
- Early intervention

System Integrity

- Dashboard Performance Indicators
- QA Monitoring
- Improve data collection and analysis
- Performance Based Contracting

Data Sources Used:

- Kentucky MIS Client/Event Data Set
- Kentucky State Data Center/US Census Bureau 2010
- KY STARS 2011 Statewide Needs Assessment
- NAMI KY 2011 Statewide Needs Assessment
- http://www.nasmhpd.org/general_files/publications/POPS%202_2010%20final.pdf (2010 Pillars of Peer Support - 2 "Expanding the Role of Peer Support Services in Mental Health Systems of Care and Recovery."
- http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Technical%20Report%20on%20Morbidity%20and%20Mortaility%20-%20Final%2011-06.pdf (2006 "Morbidity and Mortality in People with Serious Mental Illness".
- SAMHSA's Strategic Initiatives 2010-2014
- http://www.mhmr.ky.gov/mhsas/files/Suicide%20Prevention%20Plan.pdf (2007 Kentucky Suicide Prevention Plan)
- http://www.mhmr.ky.gov/mhsas/HB843_Commission/Reports/2007%20Progress%20Report.pdf HB 843 Commission On Services and Supports For Individuals with Mental Illness, Alcohol and Other Drug Abuse Disorders and Dual Diagnoses 2007 Report "Template for Change".
- 2011 Gap Analysis of Adults with SMI served/Received Targeted Case Management
- Kentucky's 10 Year Plan to End Homelessness

- http://oas.samhsa.gov/2k11/025/WEB_SR_025.cfm 2011 National Survey on Drug Use and Health (NSDUH) Report. "Sources of Payment for Mental Health Treatment for Adults."
- Mental Health Planning and Advisory Council Recommendations (2007 & 2010)

**Substance Abuse Prevention**

Substance Abuse Prevention services are delivered through Kentucky's network of 14 Regional Prevention Centers (RPCs). The RPCs are housed with Kentucky's Community Mental Health Centers and serve prevention coalitions in all 120 counties of the state. RPC staff are required to obtain their International Certified Prevention Specialist (ICPS) certification within two years of their hire date. Every RPC has at least one Strategic Prevention Framework (SPF) master trainer, certified by the state to train other RPC staff on SPF implementation. The RPCs provide training and technical assistance on 1) addressing needs, resources and readiness for substance abuse prevention planning, 2) mobilizing/building capacity, 3) planning, 4) implementation of evidence-based programs and strategies, 5) monitoring and evaluation, 6) sustainability and cultural competency, and 7) promotion and support of behavioral health and suicide prevention among populations at high risk.

Other state agencies that play a role with respect to the delivery of substance abuse prevention services are:

- The Alcoholic Beverage Control Commission (performs annual Synar compliance checks and ongoing compliance checks of tobacco and alcoholic beverage retailers);
- The Tobacco Prevention and Cessation program in the Department for Public Health (assists tobacco prevention efforts through their network of tobacco control coordinators who work in Kentucky's health departments);
- The Kentucky Office of Drug Control Policy (coordinates statewide drug prevention, treatment and enforcement efforts);
- Kentucky State Police (assists in the delivery of DARE program and coordinates UDL grants); and
- The Kentucky Department for Agriculture (KYASAP – monitors and maintains a network of 75 local boards in 113 of 120 counties in Kentucky. During SFY 2011, KYASAP Local Boards received $1,638,000.00 in funding to implement plans to reduce the prevalence of tobacco, alcohol and other drugs in the community).

Kentucky, while not as ethnically diverse as many states, boasts a diverse patchwork of rural, urban and Appalachian culture. Rural Kentucky is moving from predominantly agrarian culture to a more diverse economic base, and is more connected to urban and suburban areas due to improvements in transportation and communication. As of 2006, 90.0% of Kentuckians were White/Caucasian, 7.7% Black/African American, and 1.0% Asian. People of Hispanic ethnic origins comprised 2.2 % of Kentucky's citizens. Notably, while Caucasian and African American subgroups grew 2000-2007 at a modest rate (3.4% & 6.0%) the Hispanic population grew by 43.3%, to an estimated 85,938 (the number of undocumented Hispanics is likely to more than double this figure).

Social norms and attitudes vary significantly from county to county even among counties that are contiguous. As part of their ICPS certification process, all RPC staff are required to participate in cultural diversity workshops. Kentucky's SFP grant provided the state with new

resources with which to promote high quality training to its cadre of master trainers on subgroups throughout the state and their emerging needs with respect to substance abuse. Many of the resultant cultural competence tools and processes developed throughout the course of the SPF have been standardized so they inform our state prevention planning efforts. Subsequent to CSAP's publication of Strategic Initiative #1, the Prevention Branch began planning to incorporate more training on Kentucky's LGBTQ, Military and Native American populations.

In May of 2011, the Kentucky State Epidemiology Workgroup (SEOW), in collaboration with key prevention staff, conducted a needs assessment for the Strategic Prevention Framework Enhancement (SPFE) Grant Application. The following ***gaps were identified***:

- Need to focus more efforts on diverted prescription drugs and underage drinking, both of which emerged as priorities in the most recent SEOW needs assessment;
- The capacity for engaging with behavioral health issues (e.g. indicators of social, emotional, and behavioral well-being) is minimal and has not received emphasis heretofore;
- There is a need for a more systematic and comprehensive system for disseminating information about Evidence Based Practices (EBP) and Programs and for providing related training and technical support to the field. Kentucky proposes to form an Evidence-based workgroup to help translate the findings of the SEOW with meaningful and appropriate preventive interventions at community level;
- There is a need for renewed effort toward integrating and focusing sparse resources in high-need communities. This will require broad systemic effort at the state level, but also focused coordination and planning at the community (regional) level with the full engagement of stakeholders;
- There remain some major gaps in terms of problems and populations, including the state's growing Hispanic population, adult substance abuse (especially older adults), emerging adults in the 18-24 age range, data on substance abuse and mental health difficulties in the workplace, LGBTQ youth and military families and children (Kentucky hosts two of the nation's largest military posts, with Fort Knox and Fort Campbell). There is a need for data development in these areas;
- There remain significant issues with respect to Appalachian life and culture that must be considered when targeting those geographic areas;
- Need to update and expand the functionality of Kentucky's Data Warehouse (e.g., mapping and charting capacities), improve its attractiveness and usability (e.g., data visualization, infographics), and provide much more extensive training and support in its use within active planning processes; and
- Several areas that would bear strengthening through workforce development and training include: (1) basic knowledge about the SPF framework; (2) knowledge and skills in planning processes, including data integration and goal formulation; (3) more knowledge about EBPs in prevention and the capacity to thoughtfully select strategies; (4) skill in data distillation and synthesis for the purposes of planning and evaluation; (5) skill in program management and implementation; (6) general knowledge and skills related to program evaluation, including instrument design, data analysis, and portrayal; (7) skills related to coalition-building; and, (8) skill in utilizing the enhanced data warehouse.

In the event that Kentucky does not receive Strategic Prevention Framework (SPF) Enhancement funding, the Prevention Branch intends to use the findings of the SEOW gap

analysis as a blueprint for improving both the state infrastructure and service delivery to local communities. Block grant dollars will be used to fill these gaps to the extent possible. If Kentucky is awarded SPF enhancement funding Block Grant resources will be used to support SPE efforts.

The SEOW, formed upon Kentucky's receipt of SPF-SIG funding in October of 2005, continues to be a key resource for the substance abuse prevention program. Membership of the SEOW has varied over the six years of the project, but it has always included prominent researchers, epidemiologists, statisticians, and demographers, each bringing a unique perspective on substance abuse and specific to the process. The following individuals serve on the Kentucky SEOW for substance abuse prevention: Dr. Richard Clayton (Professor & Assoc. Dean for Research, University of KY College of Public Health), Dr. Richard Wilson (Professor & Chair, Univ. of Louisville Dept. of Health Promotion & Behavioral Science), Mr. Ronald Crouch (State Demographer, Kentucky State Data Center), Irene Centers (Kentucky Department for Public Health), and Dr. Robert Illback (Senior Evaluation Researcher, REACH of Louisville & Professor of Psychology, Spalding University). Staff support to the committee included Dr. Daniel Sanders, Jr. (statistician/methodologist), Margaret Pennington & Dr. Benjamin Birkby (senior evaluation researchers), all from REACH of Louisville.

Starting with this core, the group will be expanded to reflect the broader mission now envisioned. At a minimum, we anticipate adding a prevention-oriented mental health expert and an additional epidemiologist. Agency representatives from behavioral health, public health, drug enforcement, criminal and juvenile justice, education and mental health will also be added.

The SEOW meets quarterly. SEOW findings determine prevention planning priorities and have lead to the creation of a statewide initiative to address underage drinking and misuse and abuse of prescription medication. The initiative is called "Changing Social Norms and Policy" and is implemented through the Regional Prevention Centers. The SEOW is has just completed a review of all available Kentucky behavioral health data to select indicators that will best assist the Prevention Branch to implement goal 1.1 and 1.3 of CSAP's Strategic Initiative # 1. The SEOW has also completed a regional epi-profile of Appalachia which will serve as a template for other regions in the state.

| Priority | Goal | Strategy | Performance Indicator | Target Population |
|---|---|---|---|---|
| With primary prevention as the focus build emotional health, prevent or delay onset of, and mitigate symptoms and complications from substance abuse and mental illness. | Integrate the prevention of mental illness into state and local substance abuse prevention efforts as appropriate. | Provide training to Prevention staff state and regional regarding strategies/ resources to address the prevention of mental illness, including cultural training on high risk population, LGBTQ & military & Native American<br><br>Include relevant mental health data as indicated in the | Number of trainings provided, number of state and RPC staff trained. Increased knowledge of mental illness prevention as measured by training evaluations.<br><br>The number of mental health promotion activities performed by the RPCs as measured by the prevention data set. | RPC Staff and Prevention Professionals |

| Priority | Goal | Strategy | Performance Indicator | Target Population |
|---|---|---|---|---|
| | | KY SEOW Epi-profile to the data warehouse | | |
| Prevent or reduce consequences of underage drinking | Reduce 10th grade, 30 day binge drinking by at least 1% in targeted counties each year. | Supporting/strengthening the enforcement of existing laws regarding adults providing alcohol to minors.<br><br>Implement local policies that target social access of alcohol to youth (social host & unruly gathering ordinances) | Increase in enforcement of UAD laws as measured by local law enforcement data and reports to coalitions<br><br>An increase in RPC time spent on UAD environmental strategies as measured by the prevention data set.<br><br>Number of polices passed | 9th-10th grade youth in targeted counties<br><br>Parents & community at large. |
| Prevent suicides and attempted suicides among populations at high risk. | Integrate the prevention of suicide among high risk populations into state and local substance abuse prevention efforts as appropriate. | Provide training to state and regional level prevention staff on the need for, and strategies and resources to address, suicide prevention, including cultural training on high risk population (LGBTQ, Native American and military families). | Number of trainings provided, number of state and RPC staff trained.<br><br>Increased knowledge of suicide prevention strategies and of the high risk populations as measured by training evaluations<br><br>Number of suicide awareness activities conducted by the RPCs as measured by the Prevention Data Set | RPC Staff and Prevention Professionals |
| Reduce prescription drug misuse and abuse | Increase in parental awareness of youth Rx drug abuse<br><br>Decrease in 10th grade 30 day Rx drug abuse In targeted counties | Parental Rx education & awareness programs that stress proper storage, monitoring and disposal of Rx drugs. | Number of flyers delivered, number of distribution points as measured in the prevention data set. Increase in RPC time of spent on environmental strategies relating to | Adults in the community |

| Priority | Goal | Strategy | Performance Indicator | Target Population |
|---|---|---|---|---|
| | | Determine 3 main misperceptions of students garnered from RPC Conducted focus group information around Rx drug misuse. Enlist the partnership of local high schools to participate in a youth contest that develops media messages that address of the 3 identified misperceptions. | Rx drugs in selected counties, as measured by the Prevention Data Set.<br><br>Number of contest winners<br><br>Number of youth who see the media messages | 9th Graders in targeted counties |
| Reduce prescription drug misuse and abuse | Expand indicators related to prescription drug abuse | Revise KIP Survey to include questions on perceived availability peer usage, perception of risk of Rx drugs and favorable attitudes toward Rx drugs. | # of new questions added to KIP concerning prescription drug abuse and misuse | 6th, 8th, 10th and 12th graders<br><br>Tobacco Retailers |
| Reduce access of tobacco products to underage youth<br><br>Smokeless tobacco | A decrease of 2 percentage points in perceived availability of tobacco products to underage youth in 6th, 8th, 10th 12th<br><br>Increased knowledge of Synar program, methodology goals and outcomes and KY youth tobacco use trends. | Develop a tobacco vendor education program consistent with new FDA guidelines.<br><br>Begin phase I of tobacco retail licensing initiative<br><br>Issue report on Reward and Remind outcomes and lessons learned to RPC Staff and partner agencies<br><br>Organize an annual Synar conference ,<br><br>Regular e-mail | Number of students who respond "very hard" or "sort of hard " to the question " If you wanted to get some cigarettes how easy would it be for you to get some " or (KIP Survey 2012)<br><br>Distribution of report<br><br>Evaluation results from conference<br><br># of participants at conference<br><br>Number of email | Tobacco Retailers<br><br>State and RPC staff, and agency stakeholders<br><br>RPC staff and Prevention Professionals<br><br>RPC Staff and Prevention Professionals |

| Priority | Goal | Strategy | Performance Indicator | Target Population |
|---|---|---|---|---|
| | Increase state-level smokeless tobacco prevention efforts | updates to field<br><br>Update RPC's and prevention professionals on current smokeless data trends, and related information.<br><br>Increase resources to address Smokeless tobacco.<br><br>Work with ABC to increase number of smokeless tobacco compliance checks | updates<br><br>Number of smokeless tobacco presentations, made at RPC meetings, and other prevention venues<br><br>Number of Smokeless related e-mails sent to RPC staff and other prevention professionals.<br><br>Number of new resources created or existing resources made available to RPC's and Prevention Professionals.<br><br>Number of smokeless tobacco checks performed by ABC during FFY 2012 | RPC Staff and Prevention Professionals<br><br>RPC Staff and Prevention Professionals<br><br>Tobacco Vendors |
| Make the data warehouse a more useful prevention planning tool | Update and expand the functionality of the KY data Warehouse | upgrade to the operating system to include more high-end, but user-friendly, graphic component to make data more accessible to the average user, and more instructive to the prevention professional and members of community-level prevention coalitions, as well as other sectors. | Increase in number of data warehouse users<br><br>Feedback from online user surveys | Prevention Professionals, Agency partners and substance abuse and mental health planners |

***Data sources***:

- The (KIP) Kentucky Incentives for Prevention Survey (modeled after the Monitoring the Future Survey and conducted in grades 6,8,10,12). KIP is implemented every two years on even numbered years. Approximately 150 out of 170 school districts across the state participate in the KIP survey;
- Behavioral Risk Factor Surveillance System (BRFSS);
- CDC Wide-ranging Online Data for Epidemiologic Research;
- National Survey on Drugs and Health (NSDUH) is an annual survey that collects comprehensive information on substance abuse and mental health. Two-year prevalence rates from the NSDUH are used based on small area estimation procedures that combine state-level data with a national model. Like the KIP and MTF, the NSDUH asks respondents about past-month alcohol and tobacco use. For nonmedical use of pain relievers, illicit drug abuse/dependence, and alcohol abuse/dependence, prevalence rates are based on the past year;
- Kentucky All Scheduled Prescription Electronic Reporting System (KASPER) tracks controlled substances dispensed in Kentucky. Data are primarily intended for physicians, pharmacists and law enforcement officials;
- Kentucky Cancer Registry (KCR) is the centralized population-based cancer registry for the Commonwealth of Kentucky. Mandatory reporting to KCR began in 1991;
- Dartmouth Atlas of Healthcare (DAHC) documents variations in how medical resources are distributed and utilized;
- The Gallup-Healthways Well-Being Index Survey (WBI) surveys roughly 1,000 Americans a day, 350 days a year about health and well-being. Based on their responses individuals and communities receive an overall well-being composite score and a score for each of six sub-indices including life evaluation, emotional health, physical health, healthy behavior, work environment, and basic access; and
- The United States Census Bureau.

## Substance Abuse Treatment

The table below offers a snapshot of the estimated prevalence (10% of the population) and the number of clients served by the Regional Boards in SFY 2009 to demonstrate the potential gap in service need.

Measures of Access for Substance Abuse Treatment Clients in FY2009 from Lowest to Highest Penetration Rate

| | Estimated Population in Need of Treatment | Clients Served in FY09 | Penetration Rate |
|---|---|---|---|
| CMHC Region | 2008 Census population X NSDUH percent of regional estimated need | Unduplicated count of clients who received substance abuse treatment | Percent of persons in need of treatment who accessed services[1] |
| Region 07-NorthKey Community Care | 38,536 | 581 | 1.5% |
| Region 06-Seven Counties Services | 82,966 | 2,006 | 2.4% |
| Region 02-Pennyroyal Center | 17,255 | 535 | 3.1% |
| Region 05-Communicare | 21,081 | 700 | 3.3% |
| Region 03-River Valley Behavioral Health | 17,236 | 771 | 4.5% |
| Statewide | 357,763 | 17,597 | 4.9% |
| Region 15-Bluegrass | 67,396 | 3,430 | 5.1% |
| Region 14-Adanta | 15,591 | 796 | 5.1% |

| | | | |
|---|---|---|---|
| Region 04-Lifeskills, Inc | 21,311 | 1,298 | 6.1% |
| Region 13-Cumberland River Comprehensive Care Center | 18,756 | 1,212 | 6.5% |
| Region 01-Four Rivers Behavioral Health | 16,576 | 1,466 | 8.8% |
| Region 11-Mountain Comprehensive Care Center | 11,639 | 1,054 | 9.1% |
| Region 12-Kentucky River Community Care | 8,717 | 837 | 9.6% |
| Region 08-Comprehend, Inc | 5,077 | 602 | 11.9% |
| Region 10-Pathways | 16,250 | 2,309 | 14.2% |

[1]*Total Number of clients receiving any type of substance abuse treatment service unduplicated within regions during the fiscal year are divided by the number of clients estimated to need treatment as determined by each regions' National Survey on Drug Use and Health (DSDUH) estimated percent of persons meeting DSM-IV criteria to reach a penetration rate. Admission to treatment could have occurred prior to the fiscal year as long as the client was continuing in treatment during the fiscal year in which the data were compiled.*

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

In Kentucky, pregnant women are the only adult population with a Medicaid benefit covering substance abuse treatment and prevention. Pregnant women are identified as a priority population in accordance with CSAT regulations. Most of the CMHCs screen at initial contact and provide care within twenty-four (24) hours, the remainder within forty-eight (48) hours.

Kentucky has four (4) publicly funded substance abuse programs designed specifically for pregnant women.

1. **KIDS NOW Plus Substance Abuse and Pregnancy Program** provides Universal and Selective Prevention education and identifies, assesses, and links pregnant and postpartum women to addiction and/or mental health treatment, case management, and other community resources**.** Engaging women in intensive case management provides an opportunity to increase readiness for treatment. Evidence Based Practices (EBP) used include Screening, Brief Intervention, Referral and Treatment (SBIRT), Intensive Case Management, Motivational Interviewing, and Motivational Incentives. In SFY 2010 the following services were delivered to pregnant women:
    i. Universal prevention to 1,525 women;
    ii. Selective and Indicated Prevention to 290 women;
    iii. Intensive case management to 395 women; and
    iv. Baseline and postnatal data gathered on 159 women.

2. **Project LINK** provides intensive case management to pregnant and postpartum women in the seven counties including and surrounding Louisville. The program offers outreach and case management services designed to identify, assess, and link pregnant and postpartum women to addiction treatment, case management, and other community resources**.**

3. **PRIDE Program** provides outpatient services for pregnant women in Lexington/Fayette County.

4. **Independence House** provides long term residential substance abuse treatment and case management for women during pregnancy and one year postpartum with their newborns. Located in Corbin, in Southeastern Kentucky, it serves women from all over the state.

Four (4) additional long term residential treatment programs and eleven (11) short term (approximately 30 days) residential programs accept pregnant women. Only one (1) residential program accepts pregnant adolescents.

Intensive outpatient treatment is available in eleven (11) of the fourteen (14) regions for pregnant women and in four (4) regions for pregnant adolescents. Four (4) of the residential programs that accept pregnant women (including Independence House) also accept the woman's dependent children.

The Division of Behavioral Health (DBH) **Trauma Informed Care Initiative** includes training for CMHCs across the state. DBH has also trained many CMHC staff on Seeking Safety, an EBP standardized trauma treatment for co-occurring trauma and substance abuse which, in Kentucky's CMHCs, is primarily used with women.

University of Kentucky Medical Center in Lexington has a high risk pregnancy clinic that provides medical detoxification and stabilization on methadone. All eleven (11) Opiate Treatment Centers accept pregnant women and all (including the nine (9) private programs) consider pregnant women a priority population. They all coordinate well with the one hospital that provides medical stabilization on methadone for pregnant women.

In collaboration with the Department for Public Health (DPH), DBH initiated the **Perinatal Depression Project** (2007), a statewide effort to increase capacity to identify and treat pregnant women with perinatal mood disorders. Each CMHC selected a mental health outpatient clinician to receive one day training and act as the region's contact. Partners (eg. Private doctors, Early Childhood mental health providers at the CMHC, Perinatal home visiting program staff) were trained to screen and refer pregnant women. The project was funded for two (2) years. Currently twelve (12) of the fourteen (14) CMHCs have a perinatal contact with some training and several counselors in outlying counties who have received some limited training.

DBH programs described above have collaborative relationships with DPH, Administrative Office of the Courts (AOC), the Department of Education's Family Resource and Youth Services Centers (FRYSCs), Department for Community Based Services (child protective services) as well as private OB/GYNs.

***Unmet needs/data sources/prevalence data*** for this population include:

1. Using **national prevalence estimates and outdated state surveys**, an estimated 11.6% of pregnant women use alcohol at some point in their pregnancies and approximately 3.9% use illicit drugs. There were 58,376 live births in Kentucky in 2008 (CDC). If 10% of pregnant women used alcohol or drugs, then approximately 5,838 infants were born prenatally exposed. The number of pregnant women who received substance abuse services at the14 CMHCs during SFY 2008-2009 was 935, or 16% of pregnant women who needed are estimated to have needed services.
2. Out of a population of 4,339,367 (2010 census), 935.
3. A new statewide prevalence study for substance use during pregnancy is needed. The most recent study was in 1990.
4. Even with the pregnancy and postpartum Medicaid benefit, funding for residential Substance Abuse treatment is largely unavailable to pregnant women due to the federal Institute for Mental Disease (IMD) exclusion. The benefit also extends only to 60 days

postpartum, leaving new mothers without resources for supportive services during the crucial first three years of the child's life.

5. Some CMHCs don't ask about pregnancy on first contact (continue to address through site visits and corrective action planning).
6. Effective screening of pregnant women for Substance Abuse by medical providers is minimal in Kentucky.
7. Due to fears of losing custody of their children, as well as repeated incidences of arrests and efforts to enact legislation criminalizing substance use by pregnant women in Kentucky, many women do not feel safe disclosing their need for help.
8. Public schools do not currently provide prevention education related to substance use during pregnancy.
9. Substance Abuse treatment programs do not currently provide prevention education related to pregnancy and substance abuse.
10. Additional treatment resources are needed for pregnant women, especially outside of the "Golden Triangle" of the three largest cities (Louisville, Lexington and Covington). Funding for the two specialized pregnancy programs that serve a wide geographic area, KIDS NOW Plus and Independence House, is not secure: 73% of KIDS NOW Plus funding is allocated annually by the Kentucky Early Childhood Development Authority, and Independence House's SAMHSA Pregnant and Postpartum Women grant will end in October, 2011. Current funding for KIDS NOW Plus is insufficient, affording only 12 case management FTEs and 5 Prevention FTEs who serve approximately half of the state.
11. Further funding is needed to increase treatment capacity and utilization for perinatal mood disorders. The remaining clinicians trained during the 2007 Perinatal Depression Project anecdotally report that they continue to receive some referrals, but find limited client follow-through on scheduled appointments. Strategies need to be identified and implemented which address the issue of engagement with this difficult client population. Additional training may also be a need.
12. 27.4% of pregnant women in Kentucky smoke. Other than the 1-800-Quit Now, a national help line for smokers, virtually no smoking cessation services are available to pregnant women in Kentucky.

***Priorities for SFYs 2012 and 2013***

- Continue to monitor and correct the CMHCs compliance with screening for pregnancy on the first contact, through site visits and sample intake phone calls;
- Expand the KIDS NOW Plus Substance Abuse and Pregnancy Program so that women in every county have access to specialized outreach, prevention and case management services;
- Provide continued funding for the Independence House residential program;
- Expand treatment capacity for pregnant women and strengthen the use of Evidence Based Practices in women's treatment;
- In collaboration with the Department for Public Health, devise a strategy to address the issue of smoking during pregnancy;
- A statewide prevalence study is a priority. Kentucky's cross-agency substance Exposed Infants workgroup has a committee chaired by a neonatal physician which is prepared to do such a study when funding is available;
- In collaboration with the Kentucky Chapters of the American College of Obstetrics and Gynecology, the American Medical Association, and a statewide initiative is needed to

promote 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;

- Seek a Medicaid waiver to reimburse for residential substance abuse treatment at facilities with more than sixteen (16) beds;
- Collaborate with the Department for Community Based Services (child welfare) to adopt a strategy for addressing pregnant women's fears of having their children removed and their resulting reluctance to seek help for their substance use disorders;
- Identify or create a training module for clinicians on providing prevention education on pregnancy and substance abuse, and through the contract process and/or regulation, require providers to give this information to all clients; and
- In collaboration with DPH, provide adequate funding for the Perinatal Depression Project to increase treatment capacity and utilization for perinatal mood disorders statewide. At the same time, strategies for engagement need to be identified and implemented through existing programs such as KIDS NOW plus and DPH's HANDs (home visitation program).

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

Parents are not currently a priority population and so they are provided with the same array of services as the general population. Child protective services (provided by the Department of Community Based Services or DCBS) currently has no standardized method for screening parents for substance use disorders in order to know who to refer for assessment. They do contract with a program (the University of Kentucky Targeted Assessment Program) to provide in-depth holistic assessment for a subset of their population.

DCBS currently contracts with the CMHCs through DBHDID to provide substance use disorder and co-occurring mental health disorder services to the clients participating in a pilot program called Sobriety Treatment and Recovery Teams (START). In this pilot, Family Mentors (people in recovery from addiction) team with child protective service workers to help engage clients in services and keep children in the home if possible. The CMHCs provide quick access to assessment and referral to the appropriate level of care. START has served 322 families thus far in 4 sites: two urban, one small town, and one rural Appalachian county. While the population is small compared to the large number of families in need of services, it is hoped that the practices tested in these sites can be spread to other regions. Outcome data from the START program shows the following:

- 72.4% of families has at least one parent with access to treatment within 4 days of referral;
- In 68% of the families, at least one parent was retained in treatment for 5 sessions or more;
- The average number of services for the mothers in the START program was 114.5;
- In 64.9% of the cases, both parents were provided substance use disorder services;
- Families served fell into the top 10% of DCBS clients in terms of number of risks for child maltreatment;
- Almost 70% of the families had at least one parent with a favorable discharge from treatment by case closure, compared to 18.2% of DCBS-referred clients in general who completed a treatment episode; and

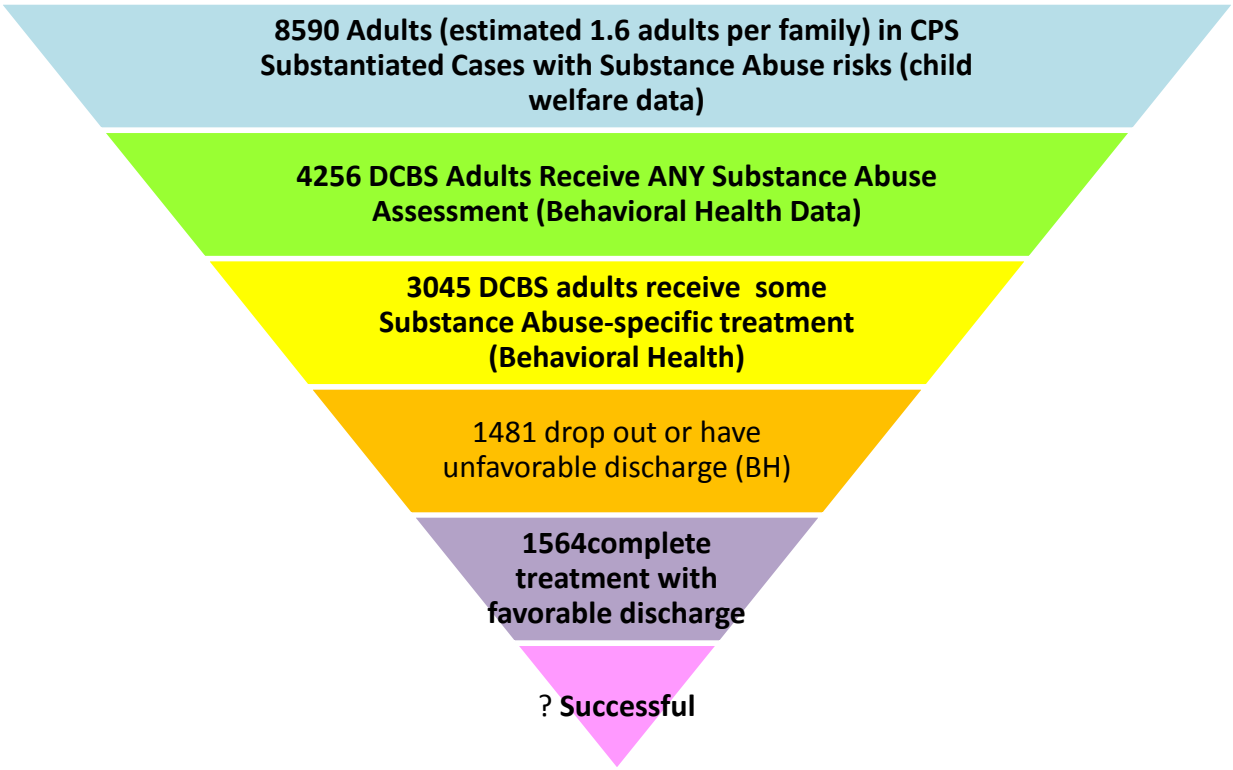
- 20.2% of START clients are African American (mostly from the urban Louisville site), .3% are American Indian, 71.1% are Caucasian, .6% are Hispanic, and 7.8% are of mixed race. DCBS has an initiative to reduce racial disproportionality in foster care and child removals.

The Administrative Office of the Courts contracts with one CMHC through DBHDID to provide substance use and co-occurring mental health disorder services to parents involved in the courts and child protective services due to child maltreatment. Services will also be provided by the CMHC for children in SFY2013. As with START, DBHDID provides a Liaison to the project who provides technical assistance. Because of this collaborative project, progress has been made in increasing the intensity of treatment for parents when needed and breaking down barriers to the use of medication assisted treatment. No outcomes are available yet for this project.

DBHDID is participating in In-Depth Technical Assistance (IDTA) from the National Center on Substance Abuse and Child Welfare, along with DCBS and the courts. Although the National Center is set to complete the IDTA in September of 2011, DBHDID intends to continue collaborating with DCBS and the courts on this project. The IDTA is resulting in several useful products, including practice guides for information sharing, drug testing, medication assisted treatment, assessment, screening, and the service needs of children exposed to family substance abuse. These practice guides will be disseminated to the front line workers of all three systems along with training. They will also likely result in policy changes to support changes in practice.

***Unmet needs***/***Prevalence Data*** for this population include:

- According to a drop-off assessment (see below) done by the Data and Information Sharing Workgroup of the In-Depth Technical Assistance project that DBHDID participates in with DCBS and the Administrative Office of the Courts, only about half of the possible parents being identified within child protective services as having substance abuse risk factors are receiving assessment services within the CMHCs, and of those who receive an assessment, fewer than half receive some substance use disorder specific treatment, and less than a quarter complete treatment with a favorable discharge. ***Data is drawn from the DCBS TWIST (The Worker's Information System) and the TEDS (Treatment Episode Data Set) and NOMS (National Outcome Measures) data set.***




- Based on feedback provided by DCBS and the courts in various regions, it seems that three distinct barriers exist for parents seeking services from CMHCs: 1) the assessment process too often results in a recommendation of no treatment based on client self-report and denial of the need for services. This is frustrating to the referral source and possibly restricts clients in need of services from receiving them. 2) Inadequate services are available in some regions of the state, leaving some clients with long wait lists to enter treatment and sometimes a lower level of care and intensity than is helpful to them. 3) Communication between DCBS and the CMHCs is uneven across regions and providers, with information pertinent to child safety not always provided to DCBS. In addition, many of the CMHCs report that the majority of their clients are court ordered by drug courts or because of convictions for driving while intoxicated. The CMHCs do not have well-developed systems for accepting, assessing, providing services, and reporting on clients referred by DCBS, perhaps partly because there is no specific funding source associated with DCBS clients as there is for drug court and DUI clients. Making DCBS clients a priority population for the use of SAPT block grant funds might help to develop an adequate system for serving this population.

- The START evaluation indicates that around 80% of START clients receive intensive outpatient services, which include parenting, education about the disease of addiction, relapse prevention, and family sessions. An assessment by a Service Coordinator is used to determine the level of care required by the client, and the client's level of care may be adjusted based on their progress in treatment. START is only in 4 sites, and intensive outpatient services and quick access to assessments and treatment are not available in every region of the state. A treatment capacity review is planned as part of the IDTA that DBHDID is participating in. It will focus on the availability of all levels of care but highlight intensive outpatient services in particular.

- Women who are unemployed or those without an employed partner who contributes to the household are most likely to experience poverty and to have no means of health insurance. The 2009 American Community Survey data indicated almost one-fourth (23.5%) of Kentucky children were living in poverty. Current estimates of Kentucky children enrolled in Medicaid programs averaged 386,775 per month, while Kentucky's Children Health Insurance Program (KCHIP) enrollment averaged 60,778 children per month (2009). These state funded insurance programs help to provide women and children with necessary preventative health care and mental health services and are particularly important for families struggling with poverty. Unfortunately, Kentucky has not opted to include substance use disorder treatment in the state plan for services reimbursed by Medicaid, except for pregnant women.

***Goal for SFY 2012/2013***

DBHDID will move toward prioritizing the use of block grant funds for parents with dependent children referred by child protective services who have no other funding source, to ensure this population does not fall through the cracks once the Affordable Care Act has kicked in. DBHDID will include in contract language the requirement that CMHCs begin planning for how parents with dependent children referred by child protective services can be provided with quick access (within one week of referral) to assessment and treatment services for substance use and/or mental health disorders. Plans should include training for staff who work with parents with dependent children, which could include the free online training from the National Center on Substance Abuse and Child Welfare: http://www.ncsacw.samhsa.gov/tutorials/tutorialDesc.aspx?id=1.

***Persons who are Intravenous Drug Users (IDU)***

***Prevalence Data***

According to the Office of Applied Studies, there is a decreasing trend in injection drug use with more persons smoking or inhaling heroin and other drugs, rather than injecting them. This national trend is not being mirrored in Kentucky. Reports of injection drug use are slowly rising among individuals in the state substance abuse treatment sample. The change in the number of individuals reporting ever having injected drugs showed a significant increase ($p<.001$) from SFY 2009 to SFY 2011. Of the 5,549 individuals treated for substance abuse in the Community Mental Health Centers (CMHCs) during SFY 2011, 1,432, or 25.8%, reported having used IV drugs. This is an increase from the SFY 2009 rate of 20.7%.

A total of 1,308 individuals who sought substance abuse treatment services at Kentucky Opiate Treatment Programs (OTP) between SFY 2007 and SFY 2010 reported having an injection drug use history compared to 3,957 individuals in the general substance abuse treatment centers between FY09-FY11 who had a history of injection drug use.

Overall, there were a total of 5,265 individuals over the course of about four years who sought addiction treatment in Kentucky and had a history of injection drug use. Only one-fourth of those individuals were in OTPs during that time period and the numbers across years did not change significantly among the OTP client sample. The increase in individuals reporting a history of injection drug use among the CMHC substance abuse treatment sample is statistically significant.

***Strengths:***

1. Kentucky has 11 licensed OTPs, 2 publically funded and 9 independently owned. Kentucky regulates and monitors its OTPs more stringently than many states, and as a result, the programs provide good quality care, both medical and psychosocial.

2. Kentucky has relatively low rates of HIV AIDS.

***Unmet Needs:***

1. Though the public is aware of the serious opiate addiction problem in the state, many Kentucky communities and CMHCs have been resistant to medication-assisted treatment (MAT). Although no data has been collected on this, CMHC site reviews have revealed that: 1) most CMHCs do not screen for IV drug use on first contact as required for the Block Grant; 2) MAT is seldom presented as a treatment option to patients; and 3) the majority of CHMC programs are abstinence-based and do not accept patients on MAT. Over the past 1-2 years, there has been some loosening of treatment program policies barring any psychotropic medication, so that most programs do now allow prescribed antidepressants, and some allow prescribed anti-anxiety medications.

2. There are very few medically-supported detoxification services in the state, and virtually none available to individuals without insurance. Individuals in the CMHC using IV drugs normally are detoxed in a social setting, without any pharmacological assistance.

3. Most substance abuse clients currently served through Block Grant funds are indigent, which puts the private OTPs out of reach. The two publically funded programs are in the main urban areas, and have such an extensive waiting list that there is normally over a year wait. Because the state is poor, rural, and mountainous, accessibility needs to be a part of any solution.

4. Although Kentucky has a serious Hepatitis C problem substance abuse Prevention efforts do not currently include any education about the dangers of IV drug use and needle sharing because such education is seen as a ”harm reduction strategy.” This is true of Prevention services provided to selective and indicated populations as well as universal. Treatment programs also do not offer education on the dangers of IV drug use and needle sharing.

***Priorities for SFYs 2012 and 2013***

1. All CMHCs should screen for IV drug use on initial contact in order to be in full compliance with Block Grant requirements. DBHDID needs to educate the CMHCs and hold them accountable though the onsite review process.

2. KY needs to follow national standards such as the *NQF Standard of Care regarding Withdrawal Management*: “Supportive pharmacotherapy should be available and provided to manage the symptoms and adverse consequences of withdrawal, based on a systematic assessment of the symptoms and risk of serious adverse consequences of the withdrawal process.” This could be accomplished by increasing the number of detox services so that there is a minimum of one medically supported detox center in each of the 14 CMHC regions, and more where population or geography requires.

3. KY should follow national standards such as the NQF Standard of Care regarding Pharmacotherapy: “Pharmacotherapy should be recommended and available to adult patients diagnosed with opioid dependence and without medical contraindications.” CMHCs should be required to recommend MAT when appropriate, and affordable MAT options need to be increased (see #4).

4. There needs to be a minimum of one publically-funded OTP program in each of the 14 CMHC regions. With the health care changes coming in 2014, some Block Grant funds should be used to provide MAT to indigent urban and rural residents.

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

6. More data needs to be gathered about prevalence of IV drug use and treatment outcomes, and data needs to be shared between DBHDID and other agencies such as the Recovery Kentucky centers, Department for Public Health, Department of Juvenile Justice, Department of Corrections, and Administrative Offices of the Courts.

***Data Sources***

Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (July 19, 2007). The National Survey on Drug Use and Health (NSDUH) Report: Demographic and Geographic Variations in Injection Drug Use. Rockville, MD.

Center on Drug and Alcohol Research (CDAR) University of KY.

***Individuals with Tuberculosis***

The Kentucky Tuberculosis (TB) Control Program is operated through the Cabinet for Health and Family Services (CHFS), Department for Public Health (DPH), and is authorized by state law to coordinate TB control activities in Kentucky. The program’s overarching objective is to eliminate TB as a public health problem. The program works to achieve that objective by focusing its efforts on rendering and maintaining all individuals who have TB disease as non-infectious, ensuring non-infected persons do not become infected, and ensuring that individuals who are infected but who do not have TB disease remain non-infectious.

State employees, local health department employees and private health care providers carry out TB control activities. Funds are allocated to designated local health departments which serve as local lead agencies for the TB Control Program. State level public health personnel provide program planning, implementation and evaluation, program performance standards, technical assistance and consultation including X-ray, nursing, medical, clerical, statistical, financial, and managerial support, and training and disease surveillance.

The Division of Behavioral Health continues to assess for compliance with both contractual and regulatory mandates through the comprehensive, onsite reviews that are conducted biennially at the CMHCs and annually at the licensed Opioid Treatment Programs. Review teams, which include a peer reviewer from the field, examine client service records for documentation of a referral for TB screening and evidence that the client was provided with information and the option to be tested for HIV. Review team members also interview clients and program staff and review personnel records and agency policies to ensure requirements are met and the appropriate services are provided. The DBHDID continues to ensure appropriate training is

available to substance abuse staff and that continuing education is provided that offers the most current information on infectious diseases.

Kentucky continues to show a declining rate of TB, as reported by the DPH. A total of 77 cases of TB were reported for 2009, which is a rate of 1.8 per 100,000. This is lower than the 2008 rate of 2.4 per 100,000 and Kentucky has seen a nearly continual decline since 2000, when the rate was 3.7 per 100,000.

The Division of Behavioral Health continues to work with the DPH to obtain the most current data on Kentucky's rates of newly diagnosed cases of TB, so the most appropriate services may be coordinated.

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

The Kentucky HIV/AIDS Program is operated by the Cabinet for Health and Family Services (CHFS), Department for Public Health (DPH), and is mandated by state law to document and maintain the HIV/AIDS case reports data. The HIV/AID Program's primary goal is to promote the prevention of HIV transmission and associated morbidity and mortality. The program works to accomplish this goal by ensuring that HIV/AIDS surveillance is a quality, secure system, ensuring that all people at risk for HIV infection know their sero-status, ensuring that those who are not infected with HIV remain uninfected, ensuring that those infected with HIV do not transmit HIV to others, ensuring that those infected with HIV have access to the most effective therapies possible, and ensuring a quality professional education program that includes the most current HIV/AIDS information.

According to the DPH reports, the number of new AIDS cases diagnosed in 2008 in Kentucky for persons ages 13 and older was 258. This translates to a rate of 6.9 per 100,000. This is comparatively lower than the US estimated rate of 12.2 per 100,000 for 2008. The reports for 2009 identify 150 cases that have been diagnosed for persons age 13 and older. Only 35 pediatric cases of AIDS have been diagnosed in Kentucky since 1989, with only 3 of those being diagnosed since 2004. The case of pediatric AIDS was diagnosed in 2005.

States that have a prevalence rate of 10 per 100,000 or higher must comply with 45 CFR Part 96.128 Requirements regarding Human Immunodeficiency Virus. Kentucky is exempt from the HIV early intervention set aside requirement due to the AIDS cases being less than 10 per 100,000 for the last several years.

The Division of Behavioral Health continues to assess for compliance with both contractual and regulatory mandates through the comprehensive, onsite reviews that are conducted biennially at the CMHCs and annually at the licensed Opioid Treatment Programs. Review teams, which include a peer reviewer from the field, examine client service records for documentation of a referral for TB screening and evidence that the client was provided with information and the option to be tested for HIV. Review team members also interview clients and program staff and review personnel records and agency policies to ensure requirements are met and the appropriate services are provided. The DBHDID continues to ensure appropriate training is available to substance abuse staff and that continuing education is provided that offers the most current information on infectious diseases.

The Division of Behavioral Health continues to work with the DPH to obtain the most current data on Kentucky's rates of newly diagnosed cases of HIV/AIDS to the most appropriate services may be coordinated. Although Kentucky has been a lower risk state for HIV/AIDS for

several years, DBHDID staff has recognized that there is a need to address Hepatitis C more intensively in substance abuse services as well as increasing education about Hepatitis A and B. Currently there are no free testing services for Hepatitis C in Kentucky and there are very few affordable treatment services. Due to these needs, Kentucky is also beginning to coordinate more with the DPH Viral Hepatitis Prevention Coordinator.

***Adolescents with substance abuse and/or mental health problems***

In Kentucky, youth are being assessed for mental health and substance abuse issues by the Administrative Office of the Courts (AOC) as well as the Department for Juvenile Justice (DJJ). There have been clinical staff trained in assessment methods/tools is most every CMHC and there are state and national trainers within Kentucky to continue to provide training and coaching on the use of the Global Assessment of Individual Needs (GAIN) family of screening and assessment tools. However, there is a need to encourage the use of the assessment tool as it is not being utilized by all CMHSs consistently.

The State Interagency Council (SIAC) meets monthly to oversee coordinated policy development, comprehensive planning and collaborative budgeting for Kentucky's system of care for children. In addition to representatives from sister agencies from within the Cabinet, there are representatives from AOC, DJJ, Department of Education and parents and youth. SIAC has developed formal recommendations for state and local community changes to support youth with substance use and co-occurring disorders and within the realm of case management services.

There are two nationally recognized Reclaiming Futures sites and two sites that are working as state Reclaiming future sites. Reclaiming Futures is a proven national model working toward systems change to address youth with substance abuse and juvenile justice issues. Working with the National Reclaiming Futures Office and Kentucky Youth Advocates a "Kentuckyized" version of the model and implementation guide has been completed to address youth with complex issues, who may be status offenders that are being detained and the disproportionate minority contact of youth within our juvenile justice system.

A survey of residential treatment facilities was initially conducted between December 4, 2009 and December 7, 2009, by the University of Kentucky Center on Drug and Alcohol Research. The information on residential treatment and recovery beds was then updated to include all facilities in operation by August 2010. Data showed 223 inpatient psychiatric beds available for adolescent substance abuse treatment and are included in this report since they constitute the majority of publicly funded inpatient care for adolescents. There are 231 non-medical residential beds for adolescent substance abuse in the state. The male/female distribution is flexible depending on admission needs. The state does not operate any inpatient facilities for children and youth under eighteen years of age. There are no Recovery Center beds for adolescents. (2010 Report from Center for Drug and Alcohol Research at University of Kentucky, "*Residential Treatment Bed Capacity for Kentucky: Adult Substance Abuse Residential Treatment*).

Services for adolescents are provided by CMHCs, private providers, Psychiatric Residential Treatment Facilities, and Juvenile Justice facilities and treatment branches, for both outpatient, intensive outpatient and residential services.

**Unmet needs/Prevalence Data/Data Sources** for this population include:

- Based on the National Survey on Drug Use and Health, 2008 (https://www.oas.samhsa.gov/nsduh.htm) , Ages 12-25 49,000 youth needed but did not receive treatment for illicit drug use and ages 12-25 64,000 youth needed but did not receive treatment for alcohol use.

- On March 31, 2009, only 1,386 youth under the age of 18 were in treatment for substance abuse or mix of mental health and substance abuse services.

- The definition of a person needing but not receiving treatment for an illicit drug problem is that the person meets the criteria for abuse of or dependence on illicit drugs according to the DSM-IV, but has not received specialty treatment for an illicit drug problem in the past year. Specialty treatment is treatment received at a drug and alcohol rehabilitation facility (inpatient or outpatient), hospital (inpatient only), or mental health center.

**Table B.1 *Illicit Drug Use in Past Month,* by Age Group and State: Percentages, Annual Averages Based on 2004 and 2005 National Survey on Drug Use and Health (NSDUH) (https://www.oas.samhsa.gov/nsduh.htm.**

| State | Total | | AGE GROUP (Years) | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | 12-17 | | 18-25 | | 26 or Older | |
| | Estimate | 95% Prediction Interval | Estimate | 95% Prediction Interval | Estimate | 95% Prediction Interval | Estimate | 95% Prediction Interval |
| Kentucky | 8.39 | (7.09 - 9.90) | 11.30 | (9.40 - 13.54) | 18.21 | (15.27 - 21.57) | 6.35 | (4.91 - 8.17) |

- Main barriers to improving adolescent substance abuse services are a lack of state funds, a lack of service options, and a lack of community awareness about the problem.

- In terms of adolescent services, the Division of Behavioral Health conducted a survey in February, 2002, of licensed Alcohol and Drug Entities (AODEs) in the state and found that, of the 300+ licensed programs in Kentucky, only 55-or less than 20%- had ongoing structured programming for adolescents. This hasn't changed in any great leaps for better or for worse. A structured program was defined as, at minimum, a weekly therapy group. Other examples included intensive outpatient programs, residential and inpatient treatment. In short, structured programs for adults were found to be more consistently available in the state than programs for adolescents.

- Kentucky detains youth charged with status offenses ***at the second highest rate in the nation***,

- Some 1,746 youth charged with status offenses were locked up in secure detention facilities in 2009, accounting for ***nearly 20% of all youth incarcerated*** in Kentucky. (http://kyyouth.org/issue_areas/Juvenile_Justice/)

- Secure detention is the most expensive option available. Counties pay $94 per day for each youth detained for a status offense and added to that is the cost for the Sheriff to

transport the youth to the regional facilities. (https://kyyouth.org/issue_areas/Juvenile_Justice/)

- While the access to community based services for adolescents with substance use disorders has improved slightly, the recognition and concern for parity with child and adolescent Medicaid reimbursed mental health services is recognized and a focus for change.

**Goals for SFYs 2012 and 2013:**

- Statewide Use –especially the CMHCs of a common tool for their initial screening/assessment process i.e., the GAIN Family of instruments—since this is already being used in some form by other child serving agencies. With all CMCHs using and conducting standard screening and assessment for trauma and substance use/abuse on all youth whom enter their doors

- Using The Louisville Adolescent Network for Substance Abuse Treatment (LANSAT) project as a model to assist with the development of a process for providing assessment and referral for youth needing substance abuse and co-occurring disorders treatment across providers.

- Continue to work with the Reclaiming Futures National Program Office and AOC, DJJ and communities across the state to move towards Kentucky becoming a "Reclaiming Futures State" with implementing the "Kentucky-ized "version with at least three new sites in the coming year

- Kentucky has provided access to training/coaching in the GAIN, Cannabis Youth Treatment (CYT), and Seven Challenges. Kentucky has provided training to partner agencies in adolescent development, stages of change, and trends in adolescent substance abuse through Motivational Interviewing basics. We would like to continue to provide support and coaching as well as begin to move the adolescent programs more toward a co-occurring model by use of the Dual Diagnosis Capability in Addiction Treatment (DDCAT) and would like to provide DDCAT and Dual Diagnosis Capability in Mental Health Treatment (DDMHT) assessments for adolescent programming both in Substance Abuse and Mental Health child serving programs in the CMHCs with at least 6 sites assessed.

- Continue to provide specific training and coaching on the identification, diagnosis and treatment planning for adolescents with substance use and co-occurring disorders to CMHCs as a cross training for child/adolescent mental health staff as well as for substance abuse clinicians who treat adolescents, then increase the amount of programming in the state for adolescents with co-occurring so that each CMHC will have at least one IOP and feel competent to treat adolescent substance abuse and co-occurring issues.

- Conduct a new survey in an effort to ascertain views on the strengths, as well as the needs and barriers to more effective adolescent services in local communities and in the state and to look at tying in prevention efforts with Adolescent treatment needs.

- Strengthen training and consultation resources so that there is a greater clinical presence regarding adolescent treatment in state-funded programs. In addition, gather and use intake and follow-up data to help clinicians and policy makers better understand the characteristics of clients entering treatment and their needs.

- Need to more clearly identify adolescents as a priority treatment population in the state and clearly target expectations for adolescent treatment providers by mandating the use of best practices

- Provide clinicians with adolescent specific client-level data on characteristics of adolescents entering treatment as well as follow-up outcomes on clients who have received treatment to strengthen the use of data in guiding treatment efforts and to compare outcomes for adolescents with those of adults.

- Assist with the ongoing work of the Kentucky Adolescent Substance Abuse Consortium (KASAC). KASAC currently has a Board of Directors, bylaws and regional contacts in each of the 14 Regional Mental Health/Mental Retardation regions of the state. In the past, Consortium meetings have been held bi-monthly at varying locations around the state so that providers could more easily attend a meeting. KASAC's annual meeting is held in conjunction with the Kentucky School of Alcohol and Other Drug Studies. Now the Consortium provides an Annual Adolescent Specific Two day Conference supporting evidence based adolescent specific practices and DBHDID could provide a "boost" to the Consortium by providing technical assistance, some limited financial support and by introducing new opportunities to carry out their mission.

***Military Personnel and Their Families***

Kentucky is home to two military bases, Fort Knox and Fort Campbell. Fort Knox is located in northern part of central Kentucky and Fort Campbell is located on the Tennessee border in southwestern Kentucky.

Fort Campbell is home to the 101st Airborne Division, which saw first combat during World War II. At present, more than 20,000 Fort Campbell soldiers have cycled through Afghanistan and 131 have been killed. More than 10,000 soldiers have returned to the base in recent months from Afghanistan, where they fought in some of the bloodiest battles of the Afghanistan war.

More Service members than ever before are returning home from war with Traumatic Brain Injuries (TBI), as well as mental health and substance abuse disorders. Family members are

often ill-prepared or ill-equipped for the changes they find in their loved ones suffering from these disorders. No services were available that directly targeted family members to increase their knowledge about TBI. Operation Headed Home (OHH) workgroup began in 2008 with a core group of just three (3) individuals and has grown to almost sixty-five (65) organizations/programs who are committed to providing Service members, Veterans, military families, and behavioral health professionals with information, resources, and support.

Operation Headed Home focused its work on gathering and organizing information to assist wounded Service members and their families in better understanding TBI and ultimately aid them in their transition home and into our communities. Information was gathered from military groups, Veterans' Affairs, family readiness groups, the public health and mental health systems, experts in TBI, Brain Injury Alliance of Kentucky (BIAK), and media experts. An assessment of specific needs and the best method for communicating information was developed.

Additionally, OHH is continuing its partnership with the Mid-Atlantic Addiction Technology Transfer Center (ATTC) and successfully hosted a conference in 2010 to address the needs of returning Service members with brain injuries in Kentucky. The conference engaged 114 individuals from the following disciplines: Veterans' Hospitals, public hospitals, healthcare professionals, Branches of the Military, Military Bases, Community Mental Health Centers, Public Health Departments, Federal, State and Local Governments, Veterans and their families and friends. Through evaluations of the conference it was ascertained that additional trainings would be a necessity and Post Traumatic Stress Disorder (PTSD) would be more prominent in future trainings.

Service members and Veterans in Kentucky are seeking services at Community Mental Health Centers (CMHCs) and private providers to keep a diagnosis and treatment information out of their military records. This is occurring because of the fear of stigma and hindering career advancement of the Service member. Often the Service member is paying out of pocket and in cash to hide the visit from the military insurance.

Unmet needs/**Prevalence Data** for this population:

- Kentucky has 4.3 million residents with a Veteran population of 335,000.
- The Kentucky Veteran population under the age of 25 is approximately 9,000.
- Also, 22,000 of Kentucky's Veterans are women; unfortunately women are not aggressive in seeking services.
- During the 2011 fiscal year, the CMHCs in Kentucky reported treating 797 active duty Service members.
- During the 2011 fiscal year, the CMHCs in Kentucky reported treating 2,216 Veterans.
- A figure from the Kentucky Army National Guard says that "If the war actually ended today… we would have 5,000 Service members show up in Kentucky needing behavioral health services". Kentucky is not prepared.
- The Military and CMHCs are adapting and working harder to provide services, but they are currently understaffed to meet the needs of Service members, Veterans and their families in Kentucky.

**KY Veteran and Active Duty Military Receiving Services by Region**

**State Fiscal Year 2011**

| Region | Active Duty | Veterans | Total Clients Served | 2010 Census |
|---|---|---|---|---|
| 01 - Four Rivers | 56 | 188 | 9,124 | 205,912 |
| 02 - Pennyroyal | 100 | 221 | 13,132 | 209,786 |
| 03 - River Valley | 47 | 39 | 9,429 | 213,472 |
| 04 - LifeSkills | 123 | 46 | 12,064 | 284,195 |
| 05 - Communicare | 13 | 136 | 11,349 | 269,117 |
| 06 - Seven Counties | 69 | 269 | 39,625 | 959,091 |
| 07 - NorthKey | 43 | 147 | 10,464 | 438,647 |
| 08 - Comprehend | 46 | 58 | 5,101 | 56,478 |
| 10 - Pathways | 45 | 281 | 18,244 | 219,536 |
| 11 - Mountain | 92 | 63 | 10,481 | 154,093 |
| 12 - Kentucky River | 32 | 39 | 12,968 | 114,762 |
| 13 - Cumberland River | 1 | 164 | 18,062 | 236,618 |
| 14 - Adanta | 45 | 199 | 11,589 | 207,256 |
| 15 - Bluegrass | 85 | 366 | 25,030 | 770,404 |
| **Total** | 797 | 2,216 | 206,662 | 4,339,367 |

IPOP Report Date: August 1, 2011

Kentucky communities have recognized an increase in the number of Service members returning from Operation Enduring Freedom and Operation Enduring Freedom with undiagnosed mild, traumatic brain injuries (TBI). As the need for TBI treatment increases, the knowledge of resources will increase. As people become more aware of the resources, the assumption is that they will use the resources and get treatment. At the same time, as more resources are used, the service quality could experience a temporary decrease. As the resources are used, the resources become more fragmented which can decrease the service quality. Also as the resources become fragmented, the time spent on collaboration will need to increase which can also decrease resources. Without new resources coming in and with additional people accessing the same pot of resources, additional money will be required and the demand for emergency resources will increase. The additional demand for the same pool will leave fewer monies available for the family which will lead to increased crises.

Due to the popularity of the OHH conference and need for additional information in Kentucky the decision was made to host a second conference at Ft. Knox on October 14, 2011. Conference participants will include: Past and present military Service members (all branches) and their families, local, state and national leaders, subject matter experts, and those serving on the “front lines” of behavioral healthcare and supportive services. The conference is in the final planning stages and will address the following needs of the audience: reintegration, family and caregiver support, available resources and benefits, suicide prevention, transitioning to work and school,

Polytrauma, Polypharmacy, substance abuse prevention and treatment, hearing loss and tinnitus from blast injuries. We estimate attracting over 300 attendees at this year's conference.

The conference will strive to strengthen the community-based resources for returning Service members with TBI/PTSD and identify additional access points for care. The resources gained after the previous conference has helped to build relationships across the state and fill tremendous gaps. It has also laid the groundwork for future community collaboration around TBI/PTSD in our state.

The OHH Conference in October of 2011 is planned as an event to inform Service members, their families and community professionals about the current status of Traumatic Brain Injury/PTSD in the military, provide them with information about current treatment and resources, and inspire them through examples of how other Veterans have successfully coped with the effects of Traumatic Brain Injury/PTSD. Other goals for this and future conferences include:

- Addressing the zero to three years age group of children in military families and explain steps to develop the bond with parents who are deployed or have been deployed;
- Providing a Sesame Street workshop for children ages two and up that deals with grief and deployment;
- Involving the Kentucky 4-H program to promote programs for Service members, Veterans and their children, including activities and counseling;
- Developing and linking Family Readiness Centers from military bases to the CMHC and Regional Prevention Centers;
- Partnering with state organizations to bring attention to suicide prevention programs;
- Requesting that a United Service Organization (USO) be started in Kentucky;
- Partnering with the Yellow Ribbon programs;
- Identifying homeless housing options for Veterans;
- Hosting days for individuals to visit the Warrior Transition Units;
- Hosting days for the individuals to visit the TBI clinics to see the new technology being used;
- Hosting a free concert (with a big name entertainer) to draw Service members, Veterans and their families, with the intent to distribute information;
- Creating programs for schools with a high concentration of military children;
- Encouraging drug courts for Veterans;
- Creating peer to peer groups;

- Creating family support groups; and
- Creating support groups for military children.

Operation Immersion is another goal for SFY 2012/2013. Operation Immersion refers to establishing a 2.5 day training event, to engage the behavior health providers in exploring issues unique to Service members, Veterans who have served in combat, and those who have experienced lengthy deployments. The focus on this program will be to allow professionals who work with Service members a chance to experience "Basic Training" and some of the challenges faced by using military virtual reality training simulators that Service members use to prepare for combat. This will give providers attending this training military knowledge from a different perspective. The target population for this training will be mental health professionals who treat Service members and healthcare providers and college students in the respective areas of study.

A Veterans Pocket Resource Guide was developed specifically for Kentucky Veterans, to date over 7,000 have been distributed. These cards provide easy access to State and National resources for Veterans in need.

A central access point for resources in Kentucky is being reviewed in the form of a website. The site will provide information for State and National resources and possibly provide training for providers in Kentucky.

Data Sources Used:

- Kentucky MIS Client/ Event Data Set
- http://www.washingtonpost.com/politics/obama-to-order-home-10000-troops-from-afghanistan-officials-say/2011/06/22/AGUuRCgH_story.html
- KY State Data Center http://ksdc.louisville.edu/
- 2011 SAMHSA Military Families Fact Sheet

  https://www.samhsa.gov/militaryfamilies/factsheet.aspx

Kentucky plans to use a minimum of 20% of the SAPT Block Grant funds to support the RPCs to assist in implementation of primary prevention activities on the local level, including all of the six primary prevention strategies.

# II: Planning Steps

## Table 2 Step 3: Prioritize State Planning Activities

Page 23 of the Application Guidance

Start Year:

2012

End Year:

2013

| Number | State Priority Title | State Priority Detailed Description |
|---|---|---|
| 1 | Access | Ensure access to community based behavioral health services and supports across the Commonwealth. |
| 2 | Quality Services | Ensure availability of high quality (science-based) services and supports for all consumers of the publicly funded behavioral healthcare system. |
| 3 | Integrated Health Services | Promote holistic, integrated physical and behavioral health services/supports, utilizing bi-directional models, across Kentucky's publicly funded healthcare system. |
| 4 | Reduce Premature Death | Reduce premature death of individuals with behavioral health disorders. |
| 5 | Priority Populations | Maintain focus on addressing the behavioral healthcare needs of targeted populations, including: • Persons who have mental health or substance use disorders; and are: o Pregnant; o Diagnosed with HIV/AIDS; o Intravenous drug users; o Diagnosed with tuberculosis; o Adolescents; or • Adults with Severe Mental Illness (SMI); • Children with Severe Emotional Disturbance (SED); or • Individuals with co-occurring mental health and substance abuse disorders. |
| 6 | Promotion and Prevention Services | Further develop evidence based substance abuse prevention and mental health promotion and prevention activities across the Commonwealth, particularly with regard to the implementation of programs and strategies aimed at reducing the consequences of under age binge drinking and prescription drug use and misuse among 10th graders in Kentucky. Underage binge drinking and prescription drug misuse and abuse were identified as state priorities in the most recent SEOW needs assesment completed in the spring of 2011. Kentucky is currently addressing these priorities through its statewide "Changing Social Norms and Policy" (CSNaP) initative. |

| | | |
|---|---|---|
| 7 | Criminal Justice Interface | Further develop behavioral health services and supports for adults with SMI and children/youth with SED involved with the juvenile and criminal justice systems. |
| 8 | Services for Military | Expand behavioral health (mental health and substance abuse) prevention and treatment services to military personnel and their families. |
| 9 | Anti-Stigma | Enhance knowledge and skills of behavioral health providers and others that could/do lend support to citizens with behavioral health disorders (first responders, law enforcement, courts, employers, human service agencies, etc.). |

Footnotes:

# II: Planning Steps

## Table 3 Step 4: Develop Objectives, Strategies and Performance Indicators

Page 23 of the Application Guidance

Start Year:

2012

End Year:

2013

| Priority | Goal | Strategy | Performance Indicator | Description of Collecting and Measuring Changes in Performance Indicator |
|---|---|---|---|---|
| Access | Increase the number of individuals served by the Community Mental Health Centers (including their affiliates), who have behavioral health needs (mental health and substance abuse). | Expand capacity to serve those in need of behavioral health services through the state's publicly funded provider network. | Total number of individuals served annually, by the Regional Boards in mental health and substance abuse programs. | KY's MIS client and event data set and prior year service data. |
| Quality Services | Promote Peer Services as a necessary component of Recovery-Oriented Systems of Care for Individuals with Substance Abuse Disorders, Adults with SMI, Children with SED and individuals | Combine core competency training for all Recovery Coaches and Peer Specialists (across populations) and develop population specific modules to address peer services for: • Individuals with substance abuse disorders; • Adults with SMI; • Individuals with co-occurring mental health and substance abuse; or • Individuals with co- | Number of Peer Specialists trained. Baseline Number: Number of Peer Specialists who successfully complete the core training module (40 hours) plus at least one of the available secondary modules. | Division of Behavioral Health maintains data base(s) of all individuals who participate in Peer Support trainings and certifies those who adequately complete and graduate from the core and secondary trainings. |

| | | | | |
|---|---|---|---|---|
| | with co-Occurring Disorders. | occurring behavioral health and physical health concerns. | | |
| Integrated Health Services | Improve coordination between primary care and behavioral health care delivery. | Commit to the KY Primary Care Association to participate in the organization of five (5) stakeholder working forums to identify opportunities and begin planning for integration of physical and behavioral healthcare. | Number of forums and planning meetings attended by DBH staff. | Division of Behavioral Health will ensure that designated staff attends all five (5) Integrated Care Forums planned for 2012-2013. Additional participation in meetings, conducting research or information gathering may be needed. Additionally, staff will examine and pursue methods for gathering data to develop a baseline indicator for the number of individuals who have had a complete annual physical exam in the last year, the number of screenings completed related to physical health needs and the number of referrals to a primary care provider from a behavioral health treatment setting. |
| Reduce Premature Death | Decrease in 10th grade Rx use in targeted Counties | Determine 3 main misperceptions of students garnered from RPC Conducted focus group information around Rx drug misuse. Enlist the partnership of local high schools to participate in a youth contest that develops media messages that address of the 3 identified misperceptions | Number of flyers delivered, number of distribution points Increase in RPC time of spent on environmental strategies relating to Rx drugs in selected counties , number of contest winners, Number of youth who see the media messages | The Prevention data set will be used to capture this data |
| Reduce Premature Death | Decrease the incidence of Suicide among all Kentucky citizens by enhancing public awareness of the signs, symptoms and most effective interventions, as well as vulnerable populations (youth, elderly, military, LGBTQ). | Implement statewide training initiative for behavioral health consumers in long-term care using the SPARK tool kit. | Number of training events conducted annually. | Department will maintain database to track number of participants and number of individuals who are trained. This will begin in SFY 2012 and continue for SFY 2013. This is targeted to older adult population. |

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|---|---|---|---|---|
| Reduce Premature Death | Decrease the incidence of Suicide among all Kentucky citizens by enhancing public awareness of the signs, symptoms and most effective interventions, as well as vulnerable populations (youth, older adults, military, LGBTQ). | Build capacity to provide training to personnel and students in KY's middle and high schools across the Commonwealth. | Percentage of schools in which personnel receive training and percentage of schools in which middle and high school students receive suicide prevention information. | Department will maintain database to track number of middle and high schools in which personnel receive training and students receive suicide prevention information. |
| Reduce Premature Death | Expand indicators related to prescription drug abuse | Revise KIP Survey to include questions on perceived availability peer usage, perception of risk of Rx drugs and favorable attitudes toward Rx drugs. | Number of new questions added to KIP concerning prescription drug abuse and misuse | These questions will be integrated into the KIP School survey. Currently, the only data collected on Rx is lifetime, past year, past 30 day use. |
| Reduce Premature Death | Improve access to nicotine replacement for individuals with behavioral health disorders who use tobacco products. | Commit to participating in the University of Kentucky's effort to develop a mechanism for tracking the number of individuals who receive nicotine replacement under the newly expanded nicotine replacement benefit under the Medicaid pharmacy program. | Establish baseline data on the number of Medicaid eligible individuals who have filled prescriptions for nicotine replacement pharmaceuticals. | Division of Behavioral Health will have access to the UK data. DBH will attend all planning meetings, conduct research and participate in any additional information gathering needed. Footnote: Additionally, staff will examine and pursue methods for gathering data and develop a baseline performance indicator for the number of Medicaid eligible individuals with a behavioral health disorder who have received a prescription for nicotine replacement and have had those filled. |
| Reduce Premature Death | Prevent or Reduce the Negative Consequences of Underage Drinking | Supporting/strengthening the enforcement of existing laws regarding adults providing alcohol to minors. Implement local policies that target social access of alcohol to youth (social host and unruly gathering ordinances). | Reduce 10th grade, 30 day binge drinking by at least 1% annually, in targeted counties. | Percentage of youth reporting use of alcohol in the past thirty days on the annual Kentucky Incentives for Prevention (KIP) School Survey. Footnote: Historical data is available. |

| | | | | |
|---|---|---|---|---|
| Priority Populations | Track the number of individuals from the target populations served by the 14 Regional Boards (including their affiliates) | Track the number of individuals from the target populations served by the 14 Regional Boards (including their affiliates), including: • Individuals with substance abuse disorders (using estimated prevalence rate of 10% of the adult population) • Adults with SMI (using estimated prevalence rate of 2.6% of the adult population-age 18 and above) • Children/youth with SED (using estimated prevalence rate of 5% of the child population-under age 18) Concentrate efforts in FY 2012 and 2013 on data that is reliable and readily available and plan for improved data collection of additional priority populations in subsequent years. | Numerator: Total unduplicated number served in each service category, by the 14 Regional Boards and their affiliates. | KY's MIS client and event data set. National prevalence rate estimate information and available Medicaid data from the KY Department of Medicaid Services (DMS) and the four Managed Care Organizations recently contracted to provide data to DBH. |
| Promotion and Prevention Services | Integrate the prevention of mental illness into state and local substance abuse prevention efforts. | Provide training for Prevention staff (Central office staff and Regional Prevention Center staffs) regarding strategies and available resources to address the prevention of mental illness, including cultural awareness training of high risk populations (LGBTQ, Military & their Families, and Native Americans). | Baseline data will be collected. Number of trainings provided and the number of Central office staff and Regional Prevention Center staff. | Prevention data set will be expanded to collect new data. |
| | To ensure that adults with SMI who are being | | The number of adults | Numerator: Number of adults with SMI who are released from CPTU and PCU prison |

| | | | | |
|---|---|---|---|---|
| Criminal Justice Interface | released from specialized mental health treatment units in prison receive timely behavioral health services in their chosen community. | To work with providers and the Department of Corrections to enhance continuity of care for this vulnerable population. | with SMI who are released from prison programs (CPTU and PCU) and who receive services (in the community), from the Regional Boards. | programs and receive services from a Regional Board. Denominator: Number of adults with SMI in released from CPTU and PCU prison programs. DBHDID is currently working on a Memorandum of Understanding with the Department of Corrections for data sharing to track discharges and Regional Board admissions. |
| Services for Military | To accurately track all individuals served by the Regional Boards who are active duty service members or veterans, or the family member of active duty service members or veterans. | Improve data collection system for capturing individuals served by the Regional Boards who are active duty service members or veterans, or the family member of active duty service members or veterans. | Establish accurate baseline by collecting the number of individuals served by the Regional Boards who are active duty service members or veterans, or the family member of active duty service members or veterans. | KY's MIS client and event data system. Note: During the 2011 fiscal year, the CMHCs in Kentucky reported treating 797 active duty Service members. During the 2011 fiscal year, the CMHCs in Kentucky reported treating 2,216 Veteran. Data collection for family members is in development. |
| Anti-Stigma | Reduce discrimination of individuals with behavioral health disorders by providing additional awareness training to targeted individuals and groups that interface with individuals with behavioral health disorders. | Provide formal training and public awareness campaigns to enhance knowledge and to reduce discrimination. | Develop data base to track the number of Mental Health First Aid trainings provided to targeted individuals and groups that interface with individuals with behavioral health disorders. | Develop data base that includes Mental Health First Aid trainings, as well as other trainings and public awareness campaigns already in existence (e.g., Crisis Intervention Training, Children's Mental Health Awareness Day campaign), and others to be offered in SFYs 2012 and 2013. |

Footnotes:

# III: Use of Block Grant Dollars for Block Grant Activities

## Table 4 CMHS - Services Purchased Using Reimbursement Strategy

Page 29 of the Application Guidance

Start Year:
2012

End Year:
2013

| Reimbursement Strategy | Services Purchased Using the Strategy | Other |
|---|---|---|
| Encounter based reimbursement | 85% | |
| Grant/contract reimbursement | 10% | |
| Risk based reimbursement | 5% | |
| Innovative Financing Strategy | 0% | |
| Other reimbursement strategy (please describe) | 0% | N/A |

### Footnotes:

The overall reimbursement approach used by Kentucky is grant/contract reimbursement which includes payments on a monthly basis to Community Mental Health Centers (CMHCs) who provide services or system improvements. Currently, a 1/12th payment is issued to each CMHC per month for services provided to various clients who have mental health and substance abuse needs. Reimbursement from the Federal Government is accomplished through the Payment Management System (PMS) which involves 'drawing down' funds each Monday for expenditures incurred for the week prior (Monday – Friday). The accounting system utilized by Kentucky is the Enhanced Management Administrative and Reporting System (EMARS). EMARS records the 1/12th expenditures for reimbursement throughout the year. CMHCs are required to report actual expenditures per program at varying intervals required by each program (i.e. monthly, bi-monthly). At the end of the state fiscal year (June), the state 'settles up' with each CMHC for their expense reimbursed projects by comparing the 1/12th payment totals

to actual expenditure totals per program/service as reported by the Regional Boards. This process ensures that only actual expenditures are being reimbursed.

Additionally, payments are made to various agencies for services rendered outside of the Community Mental Health network of providers (sole-source contracts). Invoices are received from each provider and payment made. Thus, the actual expenditures are being reported throughout the year with no cost settlement process needed at year-end.

The following offers an explanation of the current funding of community-based behavioral health programs. Kentucky Medicaid is currently moving to statewide expansion of the managed-care delivery model for Kentucky's Medicaid program and thus overall changes are expected both for Medicaid funded programs and services as well as those funded by the Department for Behavioral Health, Developmental and Intellectual Disabilities.

Community Behavioral Health Funding

Nationally, Kentucky ranks 44th in per capita expenditures for mental health services and 30th in per capita expenditures for substance abuse services.
Regional Boards rely on several funding streams to provide behavioral health services, including:
• State General Funds which are appropriated to DBHDID by the General Assembly, and allocated to the Regional Boards, for "Community Care and Support" and are for a combination of flexible and restricted behavioral health purposes.
• Medicaid dollars which are earned through billings to the state Department for Medicaid Services by staff qualified to serve Medicaid beneficiaries. This will soon move to a Managed Care model and providers will contract directly with one or several Managed Care Organizations. Medicare is also a source of federal revenues through qualified billings although those dollars are very limited. The Medicaid benefit for substance abuse treatment is very limited, and includes services for pregnant and 60 days post-partum, and some services (e.g., intensive out-patient services) under the EPSDT benefit for youth under 21.
• Mental Health Block Grant (federal funds) which are received by DBHDID and allocated to the Regional Boards (81% of the total award);
• Substance Abuse Prevention and Treatment Block Grant (federal funds) which are received by DBHDID and allocated to the Regional Boards (88 % of the total award);
• Other Federal Funds include specific grants awarded to the state for a specific purpose
• Other Local Funds from charitable organizations/foundations or other state and federal funds that are allocated through other Departments or directly to the corresponding Regional MH/MR Board. Some Regional Boards also receive revenues from counties through special taxing districts.

# III: Use of Block Grant Dollars for Block Grant Activities

## Table 4 SAPT - Services Purchased Using Reimbursement Strategy

Page 29 of the Application Guidance

Start Year:
2012

End Year:
2013

| Reimbursement Strategy | Services Purchased Using the Strategy | Other |
|---|---|---|
| Encounter based reimbursement | 80% | |
| Grant/contract reimbursement | 12% | |
| Risk based reimbursement | 0% | |
| Innovative Financing Strategy | 7% | |
| Other reimbursement strategy (please describe) | 0% | N/A |

### Footnotes:

The overall reimbursement approach used is grant/contract reimbursement which includes payments on a monthly basis to Community Mental Health Centers (CMHCs) who provide services or system improvements. Currently, a 1/12th payment is issued to each CMHC per month for services provided to various clients who have substance abuse needs. Reimbursement from the Federal Government is accomplished through the Payment Management System (PMS) which involves 'drawing down' funds each Monday for expenditures incurred for the week prior (Monday – Friday). The accounting system utilized by Kentucky is the Enhanced Management Administrative and Reporting System (EMARS). EMARS records the 1/12th expenditures for reimbursement throughout the year. CMHCs are required to report actual expenditures per program. At the end of the state fiscal year (June), the state 'settles up' with each CMHC for their expense reimbursed projects by comparing the 1/12th payment totals to actual expenditure totals per program/service. This process ensures that only actual expenditures are

being reimbursed.
Programmatic expenditures are reviewed by the Division of Behavioral Health (DBH) in combination with client data and usage statistics to determine if programs are performing well. Funding may be adjusted based on these reviews. The DBH continues to try to improve upon the utilization of funds in every manner possible.

Additionally, payments are made to various agencies for services rendered outside of the Community Behavioral Health network of providers (sole-source contracts). Invoices are received from each provider and payment made. Thus, the actual expenditures are being reported throughout the year with no cost settlement process needed at year-end.

The following offers an explanation of the current funding of community-based BH programs. Kentucky Medicaid is currently moving to statewide expansion of the managed-care delivery model for KY's Medicaid program and thus overall changes are expected both for Medicaid funded programs and services as well as those funded by the DBHDID

Community BH Funding

Nationally, KY ranks 30th in per capita expenditures for substance abuse services.
Regional Boards rely on several funding streams to provide behavioral health services, including:
• State General Funds which are appropriated to DBHDID by the General Assembly, and allocated to the Regional Boards, for "Community Care and Support" and are for a combination of flexible and restricted behavioral health purposes.
• Medicaid dollars which are earned through billings to the state Department for Medicaid Services by staff qualified to serve Medicaid beneficiaries. This will soon move to a Managed Care model and providers will contract directly with one or several Managed Care Organizations. Medicare is also a source of federal revenues through qualified billings although those dollars are very limited. The Medicaid benefit for substance abuse treatment is very limited, and includes services for pregnant and 60 days post-partum, and some services (e.g., intensive out-patient services) under the EPSDT benefit for youth under 21.
• Mental Health Block Grant (federal funds) received by DBHDID and allocated to the Regional Boards (81% of the total award);
• Substance Abuse Prevention and Treatment Block Grant (federal funds) which are received by DBHDID and allocated to the Regional Boards (88 % of the total award);
• Other Federal Funds include specific grants awarded to the state for a specific purpose (e.g., State Prevention Enhancement).
• Other Local Funds from charitable organizations/foundations or other state and federal funds that are allocated through other Departments or directly to the corresponding Regional Board. Some Boards also receive revenues from counties through special taxing districts.

# III: Use of Block Grant Dollars for Block Grant Activities

## Table 5 CMHS - Projected Expenditures for Treatment and Recovery Supports

Page 30 of the Application Guidance

Start Year: 2012

End Year: 2013

| Category | Service/Activity Example | Estimated Percent of Funds Distributed |
|---|---|---|
| Healthcare Home/Physical Health | • General and specialized outpatient medical services<br>• Acute Primary Care<br>• General Health Screens, Tests and Immunization<br>• Comprehensive Care Management<br>• Care coordination and health promotion<br>• Comprehensive transitional care<br>• Individual and Family Support<br>• Referral to Community Services | N/A 6 |
| Engagement Services | • Assessment<br>• Specialized Evaluation (Psychological and neurological)<br>• Services planning (includes crisis planning)<br>• Consumer/Family Education<br>• Outreach | <10% 6 |
| Outpatient Services | • Individual evidence-based therapies<br>• Group therapy<br>• Family therapy<br>• Multi-family therapy<br>• Consultation to Caregivers | 26-50% 6 |
| Medication Services | • Medication management<br>• Pharmacotherapy (including MAT)<br>• Laboratory services | N/A 6 |
| Community Support (Rehabilitative) | • Parent/Caregiver Support<br>• Skill building (social, daily living, cognitive)<br>• Case management<br>• Behavior management<br>• Supported employment<br>• Permanent supported housing<br>• Recovery housing<br>• Therapeutic mentoring<br>• Traditional healing services | 10-25% 6 |
| Recovery Supports | • Peer Support<br>• Recovery Support Coaching<br>• Recovery Support Center Services<br>• Supports for Self Directed Care | 10-25% 6 |
| Other Supports (Habilitative) | • Personal care<br>• Homemaker<br>• Respite<br>• Supported Education<br>• Transportation<br>• Assisted living services | N/A 6 |

| | | |
|---|---|---|
| | • Recreational services<br>• Interactive Communication Technology Devices<br>• Trained behavioral health interpreters | |
| Intensive Support Services | • Substance abuse intensive outpatient services<br>• Partial hospitalization<br>• Assertive community treatment<br>• Intensive home based treatment<br>• Multi-systemic therapy<br>• Intensive case management | 10-25% 6 |
| Out-of-Home Residential Services | • Crisis residential/stabilization<br>• Clinically Managed 24-Hour Care<br>• Clinically Managed Medium Intensity Care<br>• Adult Mental Health Residential<br>• Adult Substance Abuse Residential<br>• Children's Mental Health Residential Services<br>• Youth Substance Abuse Residential Services<br>• Therapeutic Foster Care | <10% 6 |
| Acute Intensive Services | • Mobile crisis services<br>• Medically Monitored Intensive Inpatient<br>• Peer based crisis services<br>• Urgent care services<br>• 23 hour crisis stabilization services<br>• 24/7 crisis hotline services | N/A 6 |
| Prevention (Including Promotion) | • Screening, Brief Intervention and Referral to Treatment<br>• Brief Motivational Interviews<br>• Screening and Brief Intervention for Tobacco Cessation<br>• Parent Training<br>• Facilitated Referrals<br>• Relapse Prevention /Wellness Recovery Support<br>• Warm line | <10% 6 |
| System improvement activities | | <10% 6 |
| Other | | <10% 6 |

Footnotes:

# III: Use of Block Grant Dollars for Block Grant Activities

## Table 5 SAPT - Projected Expenditures for Treatment and Recovery Supports

Page 30 of the Application Guidance

Start Year: 2012

End Year: 2013

| Category | Service/Activity Example | Estimated Percent of Funds Distributed |
|---|---|---|
| Healthcare Home/Physical Health | • General and specialized outpatient medical services<br>• Acute Primary Care<br>• General Health Screens, Tests and Immunization<br>• Comprehensive Care Management<br>• Care coordination and health promotion<br>• Comprehensive transitional care<br>• Individual and Family Support<br>• Referral to Community Services | N/A 6 |
| Engagement Services | • Assessment<br>• Specialized Evaluation (Psychological and neurological)<br>• Services planning (includes crisis planning)<br>• Consumer/Family Education<br>• Outreach | <10% 6 |
| Outpatient Services | • Individual evidence-based therapies<br>• Group therapy<br>• Family therapy<br>• Multi-family therapy<br>• Consultation to Caregivers | 10-25% 6 |
| Medication Services | • Medication management<br>• Pharmacotherapy (including MAT)<br>• Laboratory services | <10% 6 |
| Community Support (Rehabilitative) | • Parent/Caregiver Support<br>• Skill building (social, daily living, cognitive)<br>• Case management<br>• Behavior management<br>• Supported employment<br>• Permanent supported housing<br>• Recovery housing<br>• Therapeutic mentoring<br>• Traditional healing services | 10-25% 6 |
| Recovery Supports | • Peer Support<br>• Recovery Support Coaching<br>• Recovery Support Center Services<br>• Supports for Self Directed Care | <10% 6 |
| Other Supports (Habilitative) | • Personal care<br>• Homemaker<br>• Respite<br>• Supported Education<br>• Transportation<br>• Assisted living services | <10% 6 |

| | | |
|---|---|---|
| | • Recreational services<br>• Interactive Communication Technology Devices<br>• Trained behavioral health interpreters | |
| Intensive Support Services | • Substance abuse intensive outpatient services<br>• Partial hospitalization<br>• Assertive community treatment<br>• Intensive home based treatment<br>• Multi-systemic therapy<br>• Intensive case management | 10-25% 6 |
| Out-of-Home Residential Services | • Crisis residential/stabilization<br>• Clinically Managed 24-Hour Care<br>• Clinically Managed Medium Intensity Care<br>• Adult Mental Health Residential<br>• Adult Substance Abuse Residential<br>• Children's Mental Health Residential Services<br>• Youth Substance Abuse Residential Services<br>• Therapeutic Foster Care | 10-25% 6 |
| Acute Intensive Services | • Mobile crisis services<br>• Medically Monitored Intensive Inpatient<br>• Peer based crisis services<br>• Urgent care services<br>• 23 hour crisis stabilization services<br>• 24/7 crisis hotline services | <10% 6 |
| Prevention (Including Promotion) | • Screening, Brief Intervention and Referral to Treatment<br>• Brief Motivational Interviews<br>• Screening and Brief Intervention for Tobacco Cessation<br>• Parent Training<br>• Facilitated Referrals<br>• Relapse Prevention /Wellness Recovery Support<br>• Warm line | 10-25% 6 |
| System improvement activities | | <10% 6 |
| Other | | <10% 6 |

Footnotes:

# III: Use of Block Grant Dollars for Block Grant Activities

## Table 6 CMHS - Primary Prevention Planned Expenditures Checklist

Page 34 of the Application Guidance

Start Year: 2012

End Year: 2013

| Strategy | IOM Target | Block Grant FY 2012 | Other Federal | State | Local | Other |
|---|---|---|---|---|---|---|
| Information Dissemination | Universal | $ | $ | $ | $ | $ |
| Information Dissemination | Selective | $ | $ | $ | $ | $ |
| Information Dissemination | Indicated | $ | $ | $ | $ | $ |
| Information Dissemination | Unspecified | $ | $ | $ | $ | $ |
| Information Dissemination | Total | $ | $ | $ | $ | $ |
| Education | Universal | $ | $ | $ | $ | $ |
| Education | Selective | $ | $ | $ | $ | $ |
| Education | Indicated | $ | $ | $ | $ | $ |
| Education | Unspecified | $ | $ | $ | $ | $ |
| Education | Total | $ | $ | $ | $ | $ |
| Alternatives | Universal | $ | $ | $ | $ | $ |
| Alternatives | Selective | $ | $ | $ | $ | $ |
| Alternatives | Indicated | $ | $ | $ | $ | $ |
| Alternatives | Unspecified | $ | $ | $ | $ | $ |
| Alternatives | Total | $ | $ | $ | $ | $ |
| Problem Identification and Referral | Universal | $ | $ | $ | $ | $ |
| Problem Identification and Referral | Selective | $ | $ | $ | $ | $ |
| Problem Identification and Referral | Indicated | $ | $ | $ | $ | $ |
| Problem Identification and Referral | Unspecified | $ | $ | $ | $ | $ |
| Problem Identification and Referral | Total | $ | $ | $ | $ | $ |

| | | | | | | |
|---|---|---|---|---|---|---|
| Community-Based Process | Universal | $ | $ | $ | $ | $ |
| Community-Based Process | Selective | $ | $ | $ | $ | $ |
| Community-Based Process | Indicated | $ | $ | $ | $ | $ |
| Community-Based Process | Unspecified | $ | $ | $ | $ | $ |
| Community-Based Process | Total | $ | $ | $ | $ | $ |
| Environmental | Universal | $ | $ | $ | $ | $ |
| Environmental | Selective | $ | $ | $ | $ | $ |
| Environmental | Indicated | $ | $ | $ | $ | $ |
| Environmental | Unspecified | $ | $ | $ | $ | $ |
| Environmental | Total | $ | $ | $ | $ | $ |
| Section 1926 Tobacco | Universal | $ | $ | $ | $ | $ |
| Section 1926 Tobacco | Selective | $ | $ | $ | $ | $ |
| Section 1926 Tobacco | Indicated | $ | $ | $ | $ | $ |
| Section 1926 Tobacco | Unspecified | $ | $ | $ | $ | $ |
| Section 1926 Tobacco | Total | $ | $ | $ | $ | $ |
| Other | Universal | $ | $ | $ | $ | $ |
| Other | Selective | $ | $ | $ | $ | $ |
| Other | Indicated | $ | $ | $ | $ | $ |
| Other | Unspecified | $ | $ | $ | $ | $ |
| Other | Total | $ | $ | $ | $ | $ |

Footnotes:

Mental health did not collect information in prior years in this manner and is unable to project expenditures in these categories for FFY 2012 but will attempt to track and include in planning activities tracking to allow such projections for subsequent years.

# III: Use of Block Grant Dollars for Block Grant Activities

## Table 6 SA - Primary Prevention Planned Expenditures Checklist

Page 36 of the Application Guidance

| Strategy | IOM Target | Block Grant FY 2012 | Other Federal | State | Local | Other |
|---|---|---|---|---|---|---|
| Information Dissemination | Universal | $610,803 | $ | $79,444 | $ | $ |
| Information Dissemination | Selective | $12,575 | $ | $ | $ | $ |
| Information Dissemination | Indicated | $1,231 | $ | $ | $ | $ |
| Information Dissemination | Unspecified | $ | $ | $ | $ | $ |
| Information Dissemination | Total | $624,609 | $ | $79,444 | $ | $ |
| Education | Universal | $451,665 | $ | $79,440 | $ | $ |
| Education | Selective | $7,547 | $ | $186,044 | $ | $ |
| Education | Indicated | $1,733 | $ | $ | $ | $ |
| Education | Unspecified | $ | $ | $ | $ | $ |
| Education | Total | $460,945 | $ | $265,484 | $ | $ |
| Alternatives | Universal | $273,108 | $ | $79,440 | $ | $ |
| Alternatives | Selective | $1,158 | $ | $ | $ | $ |
| Alternatives | Indicated | $ | $ | $ | $ | $ |
| Alternatives | Unspecified | $ | $ | $ | $ | $ |
| Alternatives | Total | $274,266 | $ | $79,440 | $ | $ |
| Problem Identification and Referral | Universal | $219,987 | $ | $79,440 | $ | $ |
| Problem Identification and Referral | Selective | $3,029 | $ | $ | $ | $ |
| Problem Identification and Referral | Indicated | $521 | $ | $ | $ | $ |
| Problem Identification and Referral | Unspecified | $ | $ | $ | $ | $ |
| Problem Identification and Referral | Total | $223,537 | $ | $79,440 | $ | $ |
| Community-Based Process | Universal | $1,300,080 | $ | $79,440 | $ | $ |

| | | | | | | |
|---|---|---|---|---|---|---|
| Community-Based Process | Selective | $12,269 | $ | $ | $ | $ |
| Community-Based Process | Indicated | $295 | $ | $ | $ | $ |
| Community-Based Process | Unspecified | $ | $ | $ | $ | $ |
| Community-Based Process | Total | $1,312,644 | $ | $79,440 | $ | $ |
| Environmental | Universal | $372,496 | $ | $79,440 | $ | $ |
| Environmental | Selective | $1,948 | $ | $ | $ | $ |
| Environmental | Indicated | $ | $ | $ | $ | $ |
| Environmental | Unspecified | $ | $ | $ | $ | $ |
| Environmental | Total | $374,444 | $ | $79,440 | $ | $ |
| Section 1926 Tobacco | Universal | $ | $ | $ | $ | $ |
| Section 1926 Tobacco | Selective | $ | $ | $ | $ | $ |
| Section 1926 Tobacco | Indicated | $ | $ | $ | $ | $ |
| Section 1926 Tobacco | Unspecified | $100,000 | $ | $100,000 | $ | $ |
| Section 1926 Tobacco | Total | $100,000 | $ | $100,000 | $ | $ |
| Other | Universal | $ | $ | $ | $ | $ |
| Other | Selective | $ | $ | $ | $ | $ |
| Other | Indicated | $ | $ | $ | $ | $ |
| Other | Unspecified | $936,091 | $ | $ | $ | $ |
| Other | Total | $936,091 | $ | $ | $ | $ |

Footnotes:

# III: Use of Block Grant Dollars for Block Grant Activities

## Table 7 CMHS - Projected State Agency Expenditure Report

Page 38 of the Application Guidance

Start Year: 2012

End Year: 2013

Date of State Expenditure Period From: 10/01/2011 Date of State Expenditure Period To: 09/30/2013

| Activity | A. Block Grant | B. Medicaid (Federal, State, and Local) | C. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.) | D. State Funds | E. Local Funds (excluding local Medicaid) | F. Other |
|---|---|---|---|---|---|---|
| 1. Substance Abuse Prevention and Treatment | $ | $ | $ | $ | $ | $ |
| 2. Primary Prevention | $8,000 | $ | $160,000 | $10,000 | $ | $ |
| 3. Tuberculosis Services | $ | $ | $ | $ | $ | $ |
| 4. HIV Early Intervention Services | $ | $ | $ | $ | $ | $ |
| 5. State Hospital | | $34,128,000 | $14,247,500 | $ | $3,074,500 | $ |
| 6. Other 24 Hour Care | $ | $19,230,200 | $967,300 | $7,847,900 | $1,910,900 | $ |
| 7. Ambulatory/Community Non-24 Hour Care | $5,255,000 | $33,364,300 | $2,850,000 | $31,646,900 | $ | $ |
| 8. Administration (Excluding Program and Provider Level) | $25,000 | $447,000 | $40,000 | $1,749,400 | $ | $ |
| 9. Subtotal (Rows 1, 2, 3, 4, and 8) | $33,000 | $447,000 | $200,000 | $1,759,400 | $ | $ |
| 10. Subtotal (Rows 5, 6, 7, and 8) | $5,280,000 | $87,169,500 | $18,104,800 | $41,244,200 | $4,985,400 | $ |
| 11. Total | $5,288,000 | $87,169,500 | $18,264,800 | $41,254,200 | $4,985,400 | $ |

### Footnotes:

Projected SFY 2013 Expenditures (FFY 2012 Award-Budget Period 10/1/11-9/30/13)

Complete information not available in some categories

## III: Use of Block Grant Dollars for Block Grant Activities

### Table 7 SA - Projected State Agency Expenditure Report

Page 38 of the Application Guidance

| Activity | A. Block Grant | B. Medicaid (Federal, State, and Local) | C. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.) | D. State Funds | E. Local Funds (excluding local Medicaid) | F. Other |
|---|---|---|---|---|---|---|
| 1. Substance Abuse Prevention and Treatment | $16,325,642 | $ | $ | $13,840,968 | $ | $ |
| 2. Primary Prevention | $4,092,660 | $ | $ | $762,688 | $ | $ |
| 3. Tuberculosis Services | $ | $ | $ | $ | $ | $ |
| 4. HIV Early Intervention Services | $ | $ | $ | $ | $ | $ |
| 5. State Hospital | $ | $ | $ | $ | $ | $ |
| 6. Other 24 Hour Care | $ | $ | $ | $ | $ | $ |
| 7. Ambulatory/Community Non-24 Hour Care | $ | $ | $ | $ | $ | $ |
| 8. Administration (Excluding Program and Provider Level) | $45,000 | $0 | $0 | $1,028,944 | $0 | $0 |
| 9. Subtotal (Rows 1, 2, 3, 4, and 8) | $20,463,302 | $0 | $0 | $15,632,600 | $0 | $0 |
| 10. Subtotal (Rows 5, 6, 7, and 8) | $45,000 | $0 | $0 | $1,028,944 | $0 | $0 |
| 11. Total | $20,463,302 | $0 | $0 | $15,632,600 | $0 | $0 |

Please indicate the expenditures are actual or estimated.

Actual Estimated

Please identify which of the information in Table 4a is estimated rather than actual:

Identify the date by when all estimates can be replaced with actual expenditures:

Footnotes:

## III: Use of Block Grant Dollars for Block Grant Activities

### Table 8 Resource Development Planned Expenditure Checklist

Page 40 of the Application Guidance

Start Year: 2012

End Year: 2013

| Activity | A. Prevention-MH | B. Prevention-SA | C. Treatment-MH | D. Treatment-SA | E. Combined | F. Total |
|---|---|---|---|---|---|---|
| 1. Planning, Coordination and Needs Assessment | $ 48,000 | $ | $ 40,000 | $ | | $88,000 |
| 2. Quality Assurance | $ 15,000 | $ | $ 1,362 | $ 45,000 | | $61,362 |
| 3. Training (Post-Employment) | $ 15,000 | $ 40,000 | $ 168,000 | $ 105,000 | | $328,000 |
| 4. Education (Pre-Employment) | $ 10,000 | $ | $ 30,000 | $ | | $40,000 |
| 5. Program Development | $ 70,000 | $ 207,676 | $ 817,787 | $ 181,383 | | $1,276,846 |
| 6. Research and Evaluation | $ | $ 217,572 | $ 38,263 | $ | | $255,835 |
| 7. Information Systems | $ | $ 9,000 | $ 100,000 | $ | | $109,000 |
| 8. Total | $158,000 | $474,248 | $1,195,412 | $331,383 | $ | $2,159,043 |

Footnotes:

# IV: Narrative Plan

## D. Activities that Support Individuals in Directing the Services

Page 41 of the Application Guidance

Narrative Question:

SAMHSA firmly believes in the importance of individuals with mental and substance use disorders participating in choosing the services and supports they receive. To achieve this goal, individuals and their support systems must be able to access and direct their services and supports. Participant direction, often referred to as consumer direction or self direction, is a delivery mode through which a range of services and supports are planned, budgeted and directly controlled by an individual (with the help of representatives, if desired) based on the individual's needs and preferences that maximize independence and the ability to live in the setting of his/her choice. Participant-directed services should include a wide range of high-quality, culturally competent services based on acuity, disability, engagement levels and individual preferences. The range of services must be designed to incorporate the concepts of community integration and social inclusion. People with mental and substance use disorders should have ready access to information regarding available services, including the quality of the programs that offer these services. An individual and their supports must be afforded the choice to receive services and should have sufficient opportunities to select the individuals and agencies from which they receive these services. Person centered planning is the foundation of self-direction and must be made available to everyone. The principles of person centered planning are included at www.samhsa.gov/blockgrantapplication. Individuals must have opportunities for control over a flexible individual budget and authority to directly employ support workers, or to direct the worker through a shared employment model through an agency. People must have the supports necessary to be successful in self direction including financial management services and supports brokerage. In addition, individuals and families must have a primary decision-making role in planning and service delivery decisions. Caregivers can play an important role in the planning, monitoring and delivery of services and should be supported in these roles. In the section below, please address the following:

- Either summarize your State's policies on participant-directed services or attach a copy to the Block Grant application(s).
- What services for individuals and their support systems are self-directed?
- What participant-directed options do you have in your State?
- What percentage of individuals funded through the SMHA or SSA self direct their care?
- What supports does your State offer to assist individuals to self direct their care?

Footnotes:

## IV. Narrative D. Activities that Support Individuals in Directing the Services

*SAMHSA firmly believes in the importance of individuals with mental and substance use disorders participating in choosing the services and supports they receive. To achieve this goal, individuals and their support systems must be able to access and direct their services and supports. Participant direction, often referred to as consumer direction or self direction, is a delivery mode through which a range of services and supports are planned, budgeted and directly controlled by an individual (with the help of representatives, if desired) based on the individual's needs and preferences that maximize independence and the ability to live in the setting of his/her choice. Participant-directed services should include a wide range of high-quality, culturally competent services based on acuity, disability, engagement levels and individual preferences. The range of services must be designed to incorporate the concepts of community integration and social inclusion. People with mental and substance use disorders should have ready access to information regarding available services, including the quality of the programs that offer these services. An individual and their supports must be afforded the choice to receive services and should have sufficient opportunities to select the individuals and agencies from which they receive these services. Person centered planning is the foundation of self-direction and must be made available to everyone. The principles of person centered planning are included at www.samhsa.gov/blockgrantapplication. Individuals must have opportunities for control over a flexible individual budget and authority to directly employ support workers, or to direct the worker through a shared employment model through an agency. People must have the supports necessary to be successful in self direction including financial management services and supports brokerage. In addition, individuals and families must have a primary decision-making role in planning and service delivery decisions. Caregivers can play an important role in the planning, monitoring and delivery of services and should be supported in these roles. In the section below, please address the following:*

- *Either summarize your State's policies on participant-directed services or attach a copy to the Block Grant application(s).*
- *What services for individuals and their support systems are self-directed?*
- *What participant-directed options do you have in your State?*
- *What percentage of individuals funded through the SMHA or SSA self direct their care?*
- *What supports does your State offer to assist individuals to self direct their care?*

### CMS Money Follows the Person Grant/ Kentucky Transitions

The federal Centers for Medicaid and Medicare Services (CMS) announced May 14, 2007 that Kentucky would receive more than $49 million over five years to build Medicaid long-term care programs that will help keep people at home and out of institutions. Kentucky was one of only 13 states chosen by CMS. Kentucky's Operational Protocol received conditional approval from CMS effective June 30, 2008.

The focus of this Money Follows the Person Rebalancing Demonstration Grant is to help shift Medicaid's traditional emphasis on institutional care to a system offering greater choices that include home and community-based services. This "Money Follows the Person" initiative was included in the Deficit Reduction Act of 2005 (DRA), currently being implemented by CMS. It is a component of the administration's New Freedom Initiative, a nationwide effort to remove barriers to community living for people of all ages with disabilities or chronic illnesses.

The federal government estimates that states will be able to move more than 14,000 people into community settings using these grant awards. Under Kentucky's plan, all Medicaid eligible individuals who are receiving Medicaid services in an ICF/MR or a Nursing Facility and who have been in the institutional setting ( or a combination of hospitalization and institutionalization) for a minimum of six (6) consecutive months are eligible to transition. Individuals who are elderly and/or physically disabled; individuals who have intellectual or developmental disability; and individuals who have an acquired brain injury are targeted for Kentucky's initiative.

### Current Waivers

Sixteen (16) counties in the Louisville region of Kentucky are currently operating under a 1115 waiver administered by **University Healthcare, Inc. (Passport Health Plan).** This waiver

allows members residing in those counties to be served by a managed care organization. There are approximately 160,000 Medicaid recipients covered under Passport. Passport will receive no increase in the rates for services but will receive additional funding for new eligible participants as they come into the program.

Beginning on July 1, 2011 (SFY 2012), Kentucky's Department for Medicaid Services (DMS) accepted contract bids for behavioral health/physical health services for all residents in the state with Medicaid eligibility. Contracts were awarded to three (3) Managed Care Organizations. (Passport Health Plan is the 4th company and continues to administer managed care services to the aforementioned sixteen (16) counties.)

Beginning on October 1, 2012, Managed Care Organizations are expected to manage behavioral health public health services for all Medicaid card holders. Community Mental Health Centers are in the process of meeting with the Managed Care companies and working out contractual language regarding behavioral health services. It is expected that individuals with behavioral health issues will be able to choose between managed care providers and decide which available services they would like to obtain.

In addition to Passport and the new Managed Care Organizations, Kentucky currently has four (4) 1915c waivers serving various populations within the Medicaid program as outlined below. The current behavioral health 1915c waivers include: **Acquired Brain Injury (ABI)** (provides rehabilitative home and community based services to individuals with brain injuries as an alternative to nursing home facility services and to support efforts to return to a community setting with existing resources); **Home and Community Based (HCB) Waiver** (provides services and support to elderly people or children and adults with disabilities to help them to remain in or return to their homes); **Supports for Community Living (SCL) Waiver** (provides various home and community based services as an alternative to receiving services in an intermediate care facility for individuals with intellectual or developmental disabilities); and the **Michelle P. Waiver** (developed as an alternative to institutional care for individuals with developmental or intellectual disabilities).

**The Michelle P. Waiver (MPW)** is a home and community- based waiver under the Kentucky Medicaid program developed as an alternative to institutional care for individuals with mental retardation or developmental disabilities. MPW allows individuals to remain in their homes with services and supports. Currently MPW services are being offered to individuals with urgent needs or who have been on the SCL waiting list the longest. Individuals eligible for assessment will receive a letter from the Department for Medicaid Services and their names will be given to their local Community Mental Health Center, who will conduct the assessments. Once individuals who meet urgent need criteria and individuals on the SCL waiting list have been offered an opportunity to enroll, other individuals who meet Michelle P. waiver eligibility criteria may receive waiver services.

**The Consumer Directed Option (CDO)** allows people eligible for Medicaid waiver services to choose their own providers for nonmedical waiver services. Provider choice gives members greater flexibility in the delivery of services received. Kentucky Medicaid members may participate in CDO if they currently receive or are eligible for services through the Home and Community Based Waiver (HCB), Supports for Community Living Waiver (SCL), the Acquired Brain Injury Waiver (ABI), the Long-term Care Brain Injury Waiver (LTC) or the Michelle P Waiver (MP).

Case managers can help eligible current recipients of HCB, SCL, ABI or MP waiver services enroll in CDO.

Those not currently served under an eligible waiver, but who may qualify, can get help from home health agencies, adult day health centers, SCL providers or ABI providers. Regional Area Agencies on Aging (AAA) and Regional Community Mental Health Centers can provide help to eligible recipients interested in enrolling with CDO. Support brokers are available 24 hours per day, seven days per week. Once enrolled in the CDO program, participants' case managers are replaced by support brokers who help arrange for needed services. Support brokers also help develop plans of care and budgets, direct participants to training and help with hiring service providers.

CDO participant responsibilities:

- Work with assigned support brokers to develop individual plans of care that include support spending and emergency backup plans;
- Hire, train, schedule and fire staff;
- Follow the plan of care and support spending plan and stay within budget limits;
- Choose a representative, if needed or desired;
- Submit paperwork correctly and on time; and
- Follow CDO rules and guidelines.

If a CDO participant discovers this option does not meet expectations and personal preferences in care and service delivery, he or she may return to former traditional services without loss of eligibility. The Department for Medicaid Services may also terminate a CDO participant should the member not continue to meet regulatory criteria. The support broker will help the participant regain former services.

# IV: Narrative Plan

## E. Data and Information Technology

Page 41 of the Application Guidance

Narrative Question:

Regardless of financing or reimbursement strategy used, unique client-level encounter data should be collected and reported for specific services that are purchased with Block Grant funds. Such service tracking and reporting is required by SAMHSA to be reported in the aggregate. Universal prevention and other non-service-based activities (e.g. education/training) must be able to be reported describing the numbers and types of individuals impacted by the described activities. States should to complete the service utilization Table 5 in the Reporting Section of the Application. States should provide information on the number of unduplicated individuals by each service purchased with Block Grant Funds rather than to provide information on specific individuals served with Block Grant funds. In addition, States should provide expenditures for each service identified in the matrix. If the State is currently unable to provide unique client-level data for any part of its behavioral health system, SAMHSA is requesting the State to describe in the space below its plan, process, resources needed and timeline for developing such capacity. States should respond to the following:

- List and briefly describe all unique IT systems maintained and/or utilized by the State agency that provide information on one or more of the following:
  - Provider characteristics
  - Client enrollment, demographics, and characteristics
  - Admission, assessment, and discharge
  - Services provided, including type, amount, and individual service provider
  - Prescription drug utilization
- As applicable, for each of these systems, please answer the following:
  - For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?
  - Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?
  - Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?
  - Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?
  - Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?
- As applicable, please answer the following:
  - Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?
  - Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?
  - Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?
  - Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?
  - Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?

In addition to the questions above, please provide any information regarding your State's current efforts to assist providers with developing and using Electronic Health Records.

Footnotes:

## IV. Narrative

### E. Data and Information Technology

*Regardless of financing or reimbursement strategy used, unique client-level encounter data should be collected and reported for specific services that are purchased with Block Grant funds. Such service tracking and reporting is required by SAMHSA to be reported in the aggregate. Universal prevention and other non-service-based activities (e.g. education/training) must be able to be reported describing the numbers and types of individuals impacted by the described activities. States should to complete the service utilization Table 5 in the Reporting Section of the Application. States should provide information on the number of unduplicated individuals by each service purchased with Block Grant Funds rather than to provide information on specific individuals served with Block Grant funds. In addition, States should provide expenditures for each service identified in the matrix. If the State is currently unable to provide unique client-level data for any part of its behavioral health system, SAMHSA is requesting the State to describe in the space below its plan, process, resources needed and timeline for developing such capacity. States should respond to the following:*

- *List and briefly describe all unique IT systems maintained and/or utilized by the State agency that provide information on one or more of the following:*
    - *Provider characteristics*
    - *Client enrollment, demographics, and characteristics*
    - *Admission, assessment, and discharge*
    - *Services provided, including type, amount, and individual service provider*
    - *Prescription drug utilization*
- *As applicable, for each of these systems, please answer the following:*
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    - *Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?*
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    - *Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?*

*In addition to the questions above, please provide any information regarding your State's current efforts to assist providers with developing and using Electronic Health Records.*

The Department for Behavioral Health, Developmental and Intellectual Disabilities contracts with the University of Kentucky, Institute for Pharmaceutical Outcomes and Policy, (IPOP) to manage data collection and reporting. This system is an online system that securely allows for the submission, collection and editing of all inpatient and outpatient case level data from the state facilities (state psychiatric hospitals, state nursing homes, specialized personal care homes, etc.) and the fourteen Regional Mental Health and Mental Retardation Boards (CMHCs/Regional Boards), as required by statute and administrative regulation.

**DATA SYSTEM OVERVIEW**
Data is collected from the Regional Mental Health and Mental Retardation Boards, and other individual entities as described above, in three distinct data sets; client, event, and human resources. The data sets are interrelated and each one is required to attain a complete picture of the service delivery system.

**Client Data**
The client data set consists of several fields which provide basic demographics along with a clinical snapshot of the client, including diagnoses and substance use information. Applicable data is to be submitted on all status 1 clients of each Regional Board or individual entity. A status 1 client is defined to be a person for whom a treatment plan has been established. A full definition of the different Client Status codes may be found in the Client Data Set, Field 6. This data is to be submitted electronically on a monthly basis.

**Event Data**
The event data set includes information on individualized services provided by each Regional Board or individual entity. **ALL** such services are required to be submitted. Each event must have a corresponding client record in the client data set.

**NOTE: ALL** services / events provided by the Centers shall be reported in this data submission, regardless of the payer source. This data is to be submitted electronically on a monthly basis.

**Human Resources**
The human resources data set provides information on who is providing clinical services at the Regional Board or individual entity. This data links directly to the event data set field NTE02, columns 19-33 - Rendering Professional ID. This data is to be submitted electronically on an annual or as needed basis.

Changes to the Data Submission Guide will only be made annually effective July 1 of each year. Changes must be submitted for review to the Joint Committee for Information Continuity (JCIC) no later than the preceding November JCIC meeting. JCIC will approve or deny the request no later than the January JCIC meeting. Changes approved by JCIC effective for the upcoming Fiscal Year (beginning July 1st) by the January meeting. All regions will be notified of any changes no later than the end of February. **(*See Narrative F for more information about JCIC)***

There are various mechanisms by which state and local planners access data to address current status, performance and service delivery with regard to public behavioral health services

in Kentucky. Federal funders, the Kentucky General Assembly and partner agencies and organizations, including contracted providers, routinely request data from the Division of Behavioral Health (DBH). Within the Division, there are several data sets that are utilized to evaluate the public behavioral health system. Shared data collection and analyses across agencies is ultimately needed to ensure that consumers in Kentucky receive services that are proven to work in a timely manner.

There are several federally and state funded programs that require specific data collection including:

*Federal*

- Mental Health Block Grant
- Data Infrastructure Grant
- System of Care Grant (KEYS)
- Youth Suicide Prevention Grant (SPYCE)
- Projects for Assistance in Transitioning from Homelessness (PATH) Grant

*State*

- Early Childhood Authority- Early Childhood Mental Health
- General Assembly --Crisis Stabilization
- General Assembly-- IMPACT
- DIVERTS Program
- Community Medication Support Program
- Peer Support Program
- Criminal Justice Reintegration Project
- Supported Employment Grant

There are numerous data sets utilized within the department as well as outside of the department.

***Within the Department:***
Client and Event Data Set –UK/IPOP
IMPACT Outcomes Management System – UK/IPOP
Early Childhood Mental Health Outcomes Management System– UK/IPOP
IMPACT Plus Outcomes Information System – IMPACT Plus Staff

***Outside the Department*:**
**Department for Public Health**
Hospital Inpatient Discharge Database (Utilization Reports)
BRFSS
Child Mortality
Vital Statistics Surveillance System
Youth Risk Management Surveilleance
Youth Tobacco Survey
Prescription Assistance Program (PAP)

**Department for Medicaid Services**
Medicaid Claims Data

**Children's Alliance**
Time and Cost Study Reports Collection System

**Kentucky Youth Advocates**
Kids Count Annual Report

**Kentucky State Data Center**
Census

**Statewide Health Information Exchange Grant**
On August 12, 2011, Kentucky was awarded an "Exchange Establishment" grant in order to create Affordable Insurance Exchanges that will provide individuals and small businesses with a "one stop shop" to find and compare affordable, quality private health insurance options. These Exchanges are designed to bring transparency to consumers and allow comparison of health plans based on price and quality.

Kentucky had already received an Exchange Planning Grant earlier this year to conduct studies on the feasibility of Exchanges, and to assess consumer input regarding this process. The current grant will be used to continue planning efforts, create Information Technology (IT) systems to support the definition of business requirements, assist with the procurement of an IT planning vendor, and assistance with drafting a Request for Proposal (RFP) for procurement of IT updates and/or new systems.

Table 5 can be found in Section III of this Block Grant application, under *Use of Block Grant Dollars for Block Grant Activities.*

# IV: Narrative Plan

## F. Quality Improvement Reporting

Page 43 of the Application Guidance

Narrative Question:

SAMHSA expects 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 that will describe the health of the mental health and addiction systems. These measures should be based on valid and reliable data. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, reflect their evidence of effectiveness. The State's CQI process should also track programmatic improvements; and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to critical incidents, complaints and grievances. In an attachment, please submit your State's current CQI plan.

Footnotes:

Cabinet for Health and Family Services

Kentucky Department for Behavioral Health, Developmental & Intellectual Disabilities

# QUALITY PLAN

August 1, 2009

**MISSION STATEMENT**
Our mission is to provide leadership, in partnership with others, to ***prevent*** disability, build ***resilience*** in individuals and their communities, and facilitate ***recovery*** for people whose lives have been affected by mental illness, intellectual disability or other developmental disability, or substance abuse.

**VISION STATEMENT**
Our vision is to be recognized as the leader and innovator in the development, administration and delivery of ***evidence-based*** services and supports that are ***individually focused*** and ***cost efficient.***

Draft

# KDBHDID
# QUALITY PLAN

## INTRODUCTION

Over the past several decades, the quality revolution has been sweeping America. It started in the production industry, then progressed into the service industry, finally reaching healthcare and thereupon behavioral health. Known by many names including Total Quality Management (TQM) and Continuous Quality Improvement (CQI), it is a management philosophy that has assisted organizations in improving performance through the elimination of poor quality during manufacture of a product or delivery of a service, rather than through the correction of the results after the product has been made or the service has been rendered. Briefly, it calls upon top management to commit to constant organizational self-assessment and improvement.

In July 1997, the formerly named Department for Mental Health and Mental Retardation Services started to investigate the application of this management philosophy to its services. The Department developed a comprehensive Strategic Plan with participation of stakeholders and constituents of the Commonwealth of Kentucky. Part of that process included the development of the Department's Vision of the future, its Mission in present day, and the Values that were believed to drive any departmental effort (see above for current edition). This Strategic Plan was intended to be a fluid document that guided the Department into the future. Seven groups were organized to address Goals and Objectives identified in the Strategic Plan.

The Quality Management/Performance Improvement Steering Team was one of these seven groups. It was designated to lead in the development of the Quality Plan, which consisted of seven members representing each of the divisions, the Commissioner's Office, and the Research and Data Management Center (RDMC). This team approached improvement-planning from a consumer-driven, business-type method. It succeeded in the development of the Continuous Performance Enhancement Plan (CPEP) in 1999. This Quality Plan is a continuation of that original work initiated over a decade ago.

## PREAMBLE

The combined workforce of the Department, now named the Department for Behavioral Health, Developmental & Intellectual Disabilities, believes that excellence is achieved through the cooperative integration of ideas. Each employee has his/her own specific area of expertise. Through an active participative process of collaboration, all personnel will be able to construct a foundation for the department, based on the Quality Improvement (QI) process. They will be able to utilize the CQI process based on an organized integrated customer-focused system, and aimed at achieving and exceeding the needs and expectations of our consumers, providers, staff, and the community served.

At the foundation of TQM is teamwork. The role of the teams within the department is in the development of programs and processes aimed at improving department quality which includes care/service, customer and staff relations, community relations and other pertinent aspects consistent with the department’s strategic plan and our values of Respect, Excellence, and Choice & Self-Determination.

**METHODOLOGY**

The methodology behind this quality initiative is the ongoing study and improvement of processes in providing behavioral healthcare services to meet the needs of consumers. The "Quality Management (or QM) Cycle" or sometimes called the "Quality Trilogy" or "Quality Triangle", are three processes that form the cornerstones of QM.

The QM Cycle does not work in a linear, specific event or time order, with, for example, quality planning always occurring first. Rather, the approach is circular, and each part of the cycle is dependent upon the other for information. The order of events depends upon organizational priorities and the timing of discovery of the information. The cycle is dynamic and concurrent, hopefully not restricted to an annual review.

1. Quality Planning (QP) by an executive group looking at global issues, uses information generated by Quality Assurance (including customer perceptions, processes, and outcomes) and Quality Improvement to identify important priorities, determine if a process exists, and to monitor the effectiveness of any new process. Quality Planning incorporates design, development, and initial implementation efforts of a process and/or the redesign of existing procedure.

2. Quality Assurance (QA) (also known as Quality Control (QC) in the production industries) is the "backbone" of QM and performed by a sole QA Branch or organization-wide by all divisions. It encompasses planned, systematic, ongoing activities designed to measure actual performance, including the effectiveness of actions taken through Quality Planning and Quality Improvement. QA activities include data collection, initial summarization and analysis functions, and coordination of data collected both internally and by external agencies. Findings are provided to everyone involved in analyzing, understanding, interpreting, and acting upon measurement information. The information may relate either to a particular existing or new process or to global indicators of organizational performance. Based on such assessment of findings, organizational functions, related processes, and/or the measurement, indicators themselves may change over time.

3. Quality Improvement (QI) teams/committees use QA information, collecting additional information and performing in-depth evaluation as necessary, either to achieve specific performance goals determined in Quality Planning, improve an existing process, or develop an innovation. Depending upon its membership and task at hand, QI might redesign a new process first implemented by the Quality Planning group.

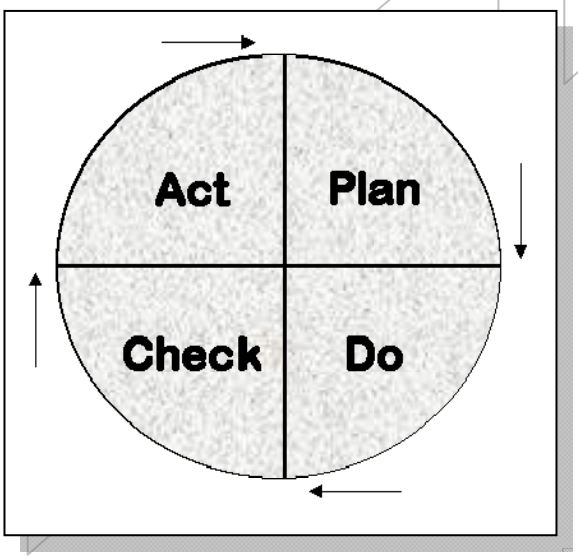
**THE QI PROCESS**

Proper QI starts with planning and data collection. Statistical analysis on the wrong or incorrect data is useless; the analysis must be appropriate for the data collected. The key to any improvement program is the proven QI process. One of the most successful is the PDCA Cycle first described by Walter Shewart in the 1920's. A further enhancement of PDCA is the Focus-PDCA method to help teams narrow attention to a specific opportunity for improvement.

**Focus-PDCA**

- **F**ind a process to improve;
- **O**rganize a team that knows the process;
- **C**larify current knowledge of the process;
- **U**nderstand causes of process variation, &;
- **S**elect the process improvement.

After Focus is completed, the PDCA Cycle is initiated.




- **Plan** the necessary action steps:
  Collect data and establish a baseline. Identify the problem and the possible causes. The tools listed below in this plan can help organizations identify problems and possible causes, and to prioritize corrective actions.

- **Do** all that is necessary to implement the plan:
  On a small scale, sometimes known as Beta Testing, make changes designed to correct or improve the situation.
- **Check** the results of the action:
  Collect data on the new process and compare to the baseline. Control charts are often useful by illustrating the effects of changes on a process over time.
- **Act** to fully implement the improvement or rework:
  If the results are favorable, implement on a larger scale. If the outcome is unproductive, it is time to "go back to the drawing board", another QI tool!

**QI TOOLS**

As stated above, information driven team decision-making is critical. While Statistical Process Control (SPC) is necessary for valid and reliable data, it is not essential for all members of the team to have that expertise. However, there is typically a QI Leader who is an expert in the field of Healthcare Quality and can foster in others, a basic understanding of simple group-process and data tools, as needed. These tools include (but are not limited to):

1. Group Process Tools:
   - Brainstorming;
   - Affinity Diagram
   - Delphi Technique;
   - Multi-voting/Normal Group Process
   - Prioritization Matrix;
   - Cause-and-Effect (Ishikawa; Fishbone) Diagram;
   - Flowchart, and;
   - Force Field Analysis.
2. Data Tools:
   - Run Chart;
   - Control Chart
   - Histogram;
   - Pareto Chart, and;
   - Scattergram

**ORGANIZATIONAL STRUCTURE & FUNCTIONS**

The structure described below is designed to facilitate:

1. Bi-directional communication among the various organizational levels, such that QM information is disseminated from Executive Management to QA Branch staff and vice-versa and;

2. Participation of QA staff and other Department staff who are designated as essential for accomplishing goals. Accordingly, the roles of QA Branch staff and Quality Steering Committee (QSC) membership will change as new Quality Planning priorities and corresponding initiatives are identified.



Kentucky OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 154 of 264

**GOVERNANCE**

**<u>Executive Management Team (EMT)</u>**

**Chair: Commissioner (or designee)**

**Members: Deputy Commissioner, Executive Staff, Clinical Director, Division Directors, Quality Steering Committee Chair, QI Leader**

The EMT is responsible for Quality Management which provides the foundation for QM activities. QM includes ensuring:

- The availability of necessary resources;
- That staff have requisite knowledge and skills and understand what is to be achieved and how to go about it;
- Those barriers that hinder achievement of desired outcomes are either prevented or removed;
- The EMT has final responsibility for approval and oversight of the management and direction of the QM and actively provides direction, guidance, and staff support, as needed, and;
- EMT members also ensure that QM information is communicated, as needed, to staff under their direction.

**<u>Quality Steering Committee (QSC)</u>**

**Chair: QA Branch Manager**

**Members: QI Leader, Chairs of the Quality Improvement Teams (QIT)**

The QSC is a multi-divisional team that oversees all aspects of the QM effort throughout the department. This shall include, but not be limited to:

- Implementing the QM process;
- Oversight to guide, facilitate and charter QIT's;
- Receiving recommendations from various sources regarding QM efforts;
- Acting on reports from QIT activities;
- Overseeing education of staff and the ongoing quality participation rewards and recognition program, and;
- Facilitating communications of team progress and improvements throughout the department.

The QSC will meet at least quarterly.

The QSC oversees the work of the QI Teams/Committees to ensure activities are comprehensive and systematically implemented and provides direction as needed. The QSC develops the annual Quality Assurance and Improvement Surveillance Plan and provides monthly updates and progress reports to the EMT. The QSC also offers direction, guidance, and resources to the QI Teams/Committees.



Kentucky OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 155 of 264

## QUALITY IMPROVEMENT TEAMS

### TYPES OF TEAMS

1. *CHARTERED TEAMS:* have been approved by the QSC to address a specific issue or process. Representation on these teams is cross-functional and represents varying levels of managers and staff who are familiar with or affected by the process selected. This team provides a formal report to the QSC after each step of the Focus-PDCA cycle or at least quarterly. Teams may be program and/or process oriented. Their composition, size, and longevity will be determined accordingly.

2. *DEPARTMENT TEAMS:* are standing and formal with each team/committee's scope of work; and objectives are determined by its membership with oversight and guidance provided by the QSC.
   - **Quality Assurance Branch**
     Chair: QA Branch Manager
     Members: Relevant QA Branch members
   - **Risk Management Advisory**
     Chair: Department Commissioner Designee
     Members: At least one representative from each division and relevant QA Branch members
   - **Joint Committee on Information Continuity (JCIC)**
     Chair: QA Branch Data Infrastructure Grant PI
     Members: At least one representative from each department branch and community mental health centers (CMHC)
   - **Quality Management Outcomes Team (QMOT)**
     Chair: Behavioral Health Division Director
     Members: At least one representative from each division and relevant QA Branch members, and outside agencies, i.e., CMHC's, DPH, KPFC, DMS, RDMC, CDAR, KARP, ARC of Ky.
   - **Data Users Group (DUG)**
     Chair: QA Branch Manager
     Members: At least one representative from SA, MH, MR, Web Design Committee, RDMC and CDAR, and relevant QA Branch members
   - **Monitoring Group**
     Chair: QA Branch Manager
     Members: At least one representative from each service area requiring onsite visits, and relevant QA Branch members

3. *DIVISION/BRANCH/PROGRAM TEAMS:* are informal and typically designed by a manager to work on a specific task using a team approach and problem solving tools within the division, branch or program. This type of team is very limited in scope. Staff at all levels is encouraged to participate. This team provides a formal report of their activities to the QSC quarterly as scheduled by the QI Leader.



Draft

***(Each initiative below will be detailed after approval to move forward with this plan.)***

- **Behavioral Health**
  - KY Treatment Outcomes Study (KTOS) & Opiate Replacement (KORTOS)
  - NOM's: Outcome Measures for SA & Outcome Measures for MH
  - Early Childhood Mental Health Outcomes Management System
  - IMPACT Outcomes Management System
  - IMPACT Plus Outcomes Management System
  - Externally Funded Grant Projects
  - MH Plan & Budget Performance Indicators
  - MH And SA Program Periodic Reporting Data
  - Program Site Visit Teams:
    - CMHC Regional Prevention Centers
    - CMHC Substance Abuse Treatment Services
    - Opiate Replacement Treatment Programs
    - DUI Services
  - NIATx (CQI model)
  - DDCAT (Dual Diagnosis Capability Assessment Tool) - fidelity monitoring
  - Supported Employment Initiative - fidelity monitoring
  - Motivational Interviewing – Evidence Based Practice (EBP) - fidelity scale
  - "Seeking Safety" – EBP with fidelity scale (trauma informed care)
  - MHSIP Adult Satisfaction Survey
  - YSS-F Child Satisfaction Survey
  - Division Sponsored Standardized Training Evaluation Data
  - KPFC Youth and Family Involvement
  - START Collaborative Project between DCBS and DBH
  - Recovery Training and Technical Assistance Team
  - Perinatal Depression Study in collaboration with DPH

- **Developmental and Intellectual Disabilities**
  - Community Supports Branch
  - Supported Employment Stakeholder Group
  - PASRR
  - Monitoring of CMHC and GH contracts
  - Crisis Services
  - Incident Management
  - Medication Error Reviews
  - Project SAFE
  - 202B Process
  - SCL Quality Initiatives
    - Provider Development Team
    - Autism Team
    - QA Team
    - Certification and Technical Assistance Area Administrator Teams



Kentucky OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 157 of 264

All levels of QIT's when appropriate, will invite stakeholder participation to increase involvement and breadth of initiatives to ensure that teams/committees are well informed of the needs and strengths of our systems of care/service. QIT's membership will change as new priorities and corresponding initiatives are identified.

## OTHER PRESENT AND FUTURE QUALITY-RELATED INITIATIVES

The following facilities operated under the auspices of the Department for Behavioral Health and Developmental and Intellectual Disabilities, have their own facility-specific "quality plans".

- Psychiatric Hospitals
  - Appalachian Regional Healthcare Psychiatric Center – Hazard
  - Central State Hospital
  - Eastern State Hospital
  - Western State Hospital
- Forensic Psychiatric Hospital
  - Kentucky Correctional Psychiatric Center
- Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR)
  - Central ICF/MR
  - Hazelwood Center
  - Del Maria ICF/MR
  - Meadows ICF/MR
  - Windsong ICF/MR
  - Outwood ICF/MR
  - Oakwood ICF/MR
- Nursing Facilities or Intermediate Care Facilities (ICF)
  - Glasgow State Nursing Facility
  - Western State Nursing Facility
- Residential Substance Abuse Program
  - Volta House

Draft

## APPENDIX

Accuracy: Accuracy of measurements refers to the closeness of agreement between observed values and a known reference standard. Any offset from the known standard is called bias.

Assessment: The appropriate analysis and interpretation of collected data to provide information about the organization's level of performance along many dimensions, over time, and compared among organizations.

Average: See Mean

Benchmark: A comparative "best" as baseline for improvement.

Benchmarking: The continual process of measuring practices and services against the performance of recognized leaders at a particular function, regardless of "industry standard".

Common Causes: Problems with the system itself that are always present, influencing all of the production until found and removed. These are “common” to all manufacturing or production output. Also called chance causes, system causes or chronic problems. Common causes contrast to special causes.

Control Chart: A graphical mechanism for deciding whether the underlying process has changed based on sample data from the process. Control charts help determine which causes are “special” and thus should be investigated for possible correction. Control charts contain the plotted values of some statistical measure for a series of samples or subgroups, along with the upper and lower control limits for the process.

Data: Numbers or measurements (related facts) collected as a result of observations.

Design: The intentions, plans, or stated expectations for systems and processes of care and service delivery, incorporating organizational mission, vision, and strategic plan; customer needs and expectations; knowledge-based information; and current performance in the field.

Evaluation: The in-depth assessment of the quality of an important aspect of care (or service) when a threshold (trigger point) for further evaluation was reached, a compliance level was not met, or control limits were exceeded. In performance improvement, evaluation is included in the "Assessment" process.

Indicator: An objective tool used to measure, over time, an organization's performance of functions, processes, and outcomes. The term “indicator” has now been expanded to address important governance, management, and support, as well as clinical functions and processes within a healthcare organization. Indicators may be based on practice guidelines. They may include criteria to further define or specify what is being measured.

Key Performance Area: A performance area that is important in the delivery of quality care or service, e.g., infection control or emergency services.

Mean: A measure of the location or center of data; also called the average. The mean is calculated by summing all of the observations and dividing by the number of observations.

Measurement: The planned, systematic, continuous collection, compilation, and organization of data.

Median: The "middle" value of a group of observations, or the average of the two middle values. The median is denoted by x tilde ($X^{\%}$).

Outcome: The result(s) or effect(s) of the performance or nonperformance of one or more functions or processes. An outcome represents the cumulative effect of one or more processes on a patient at a defined point in time.

Process: In performance improvement, a goal-directed, interactive series of actions, events, mechanisms, or steps related to a function of care or service; a sequence of steps that transforms inputs into outputs or outcomes.

Random Sampling: A subset of the population chosen such that each member of the population has an equal probability of being included in the sample.

Risk Management: A clinical and administrative program or group of activities developed and implemented to prevent and reduce, or identify, evaluate, and intervene with, risk of injury or loss to clients/patients, staff, visitors, and the organization. Standards specifically apply to activities associated with patient care and services.

Sample: A subset of data from a population that can be analyzed to make inferences about the entire population.

Standard: A statement of expectation that defines the structures and processes that must be substantially in place in an organization to enhance the quality of care.

Standard of Practice: An acceptable level of performance or an expectation for professional intervention or behavior, generally formulated by practitioner organizations based upon clinical expertise and the most current research findings. Standards of care and practice are the building blocks of practice parameters, critical/ clinical paths, patient care policies and procedures, and indicators for quality management activities.

Statistic: A value calculated from or based on sample data which is used to make inferences about the population from which the sample came. Sample mean, median, range, variance and standard deviation are commonly calculated statistics.

Threshold: The level or point at which a stimulus is strong enough to signal the need for organization response to indicator data and the beginning of the process of determining why the threshold has been approached or crossed.

Utilization Management: The examination, evaluation, and appropriate use of organization resources.

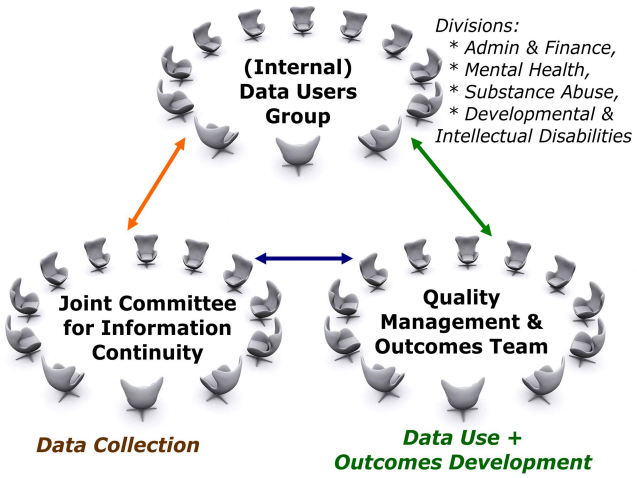
Final Draft

## BHDID Coordination of Data Collection, Quality and Use

- Three Critical Forums (DUG - JCIC -QMOT)
  The BHDID has three critical forums that facilitate communicate about and resolution of Departmental data issues which supports BHDID's mission of basing decisions on high quality data.

  These three standing committees are led by Department staff and are intentionally interwoven to cover data use, data collection, and data quality improvement. In the following graph, the links between the groups are the data issues to be resolved and overlapping staff involvement. Through experience, the BHDID has learned that communication between these three groups is critical for best resolution of data issues

**Figure 1: Critical Forums (DUG – JCIC – QMOT)**




- Data Users Group (DUG) (internal Departmental staff)
  This group meets monthly to study data quality and resolve data integrity problems; recommendations are made the BHDID Commissioner's Office. One recently resolved issue included reducing duplication of service/event records which had multiple payer sources. The group regularly makes effort to involve data in BHDID decisions; recently the group developed an ad-hoc reporting tool that gives BHDID staff access to community-based data. Additionally, as liaisons to the BHDID's divisions, the members serve as educators about data and data quality.

- Quality Management and Outcomes Team (QMOT)
  This is our critical forum for data quality issues that involves the quality assurance specialists employed by the Boards and Department staff. One annual QMOT project is the implementation of the statewide MHSIP & YSS-F perception of care surveys. The team also adopts projects in other areas of work such as evidence-based practice implementation and outcomes report card development.

- Joint Committee on Information Continuity (JCIC)
  This critical forum focuses on data quality issues where they related to data collection at the Community Mental Health Centers. The group combines information technology staff employed by the Boards with Department staff to jointly resolve data collection problems and increase data quality. One recent success was the modification of existing fields to collect more informing data about veteran status as it relates to combat duty.

## CHFS / DBHDID Strategic Planning

| DBHDID Key Areas | CHFS Broad Goal |
|---|---|
| (1) Rebalance fiscal and programmatic responsibility to increase access to appropriate and effective community-based services that support community integration. | Expand the continuum of services, supports, and resources to allow individuals to live in their communities |
| (2) Promote trauma-informed services, supports, and environments. | Promote, protect, and preserve the dignity and well-being of individuals and families |

| Governor's GOALS | | | | | |
|---|---|---|---|---|---|
| **Give all children valuable educational opportunities** | **Create and protect 21st Century jobs** | **Improve access to quality & affordable healthcare** | **Ensure safe communities** | **Develop energy resources in environmentally sustainable manner** | **Provide ethical, transparent, and honest state government** |
| Cabinet for Health and Family Services Goals | | | | | |
| Provide opportunities for early intervention, early learning, and quality child care so that children are healthy and ready to learn **(DBHDID Key Area #2)**<br><br>Assure that children in the state's custody have access to quality education | Support individuals to acquire and maintain employment **(DBHDID Key Area #1)**<br><br>Establish practices that create a positive business environment, within applicable statutes and regulations, for all customers<br><br>Enhance the workplace environment to support and retain employees | Increase access to and the exchange of electronic health information<br><br>Support quality physical and behavioral health care as a payor, provider, and regulator of health care **(DBHDID Key Area #1)**<br>Improve consumer access to information about health, health care quality, and the health insurance marketplace<br><br>Expand the continuum of services, supports, and resources to allow individuals to live in their communities | Promote, protect, and preserve the dignity and well-being of individuals and families **(DBHDID Key Areas #1 & 2)**<br><br>Assure that services delivered by providers meet applicable health and safety standards<br><br>Continue to seek additional resources to address the impacts of substance abuse upon the health and welfare of Kentuckians **(DBHDID Key Area #1)** | Increase energy efficiency of Cabinet owned/operated facilities<br><br>Increase the use of electronic resources to enhance efficiency | Increase the use of information technology to support transparency and accountability<br><br>Enhance business processes to maximize resources **(DBHDID Key Area #1)** |

DRAFT

# IV: Narrative Plan

## G. Consultation With Tribes

Page 43 of the Application Guidance

Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it is to engage in regular and meaningful consultation and collaboration with tribal officials in the development of Federal policies that have Tribal implications.

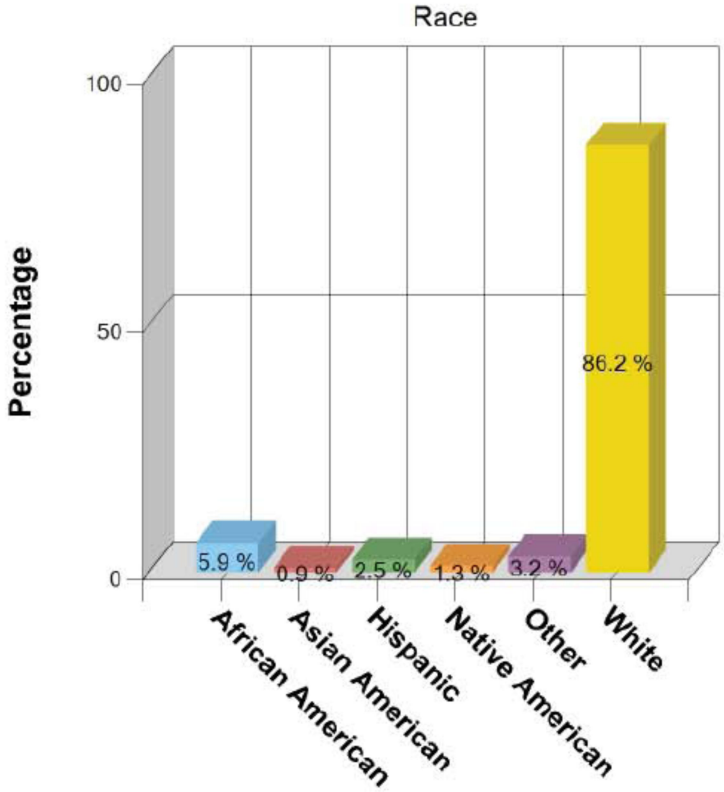
Consultation is an enhanced form of communication, which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues. For the context of the Block Grants, 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 include elected officials of the Tribe or their designee. SAMHSA is requesting that States provide a description of how they consulted with Tribes in their State. This description should indicate how concerns of the Tribes were addressed in the State Block Grant plan(s). States shall not require any Tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for Tribal members on Tribal lands.

Footnotes:

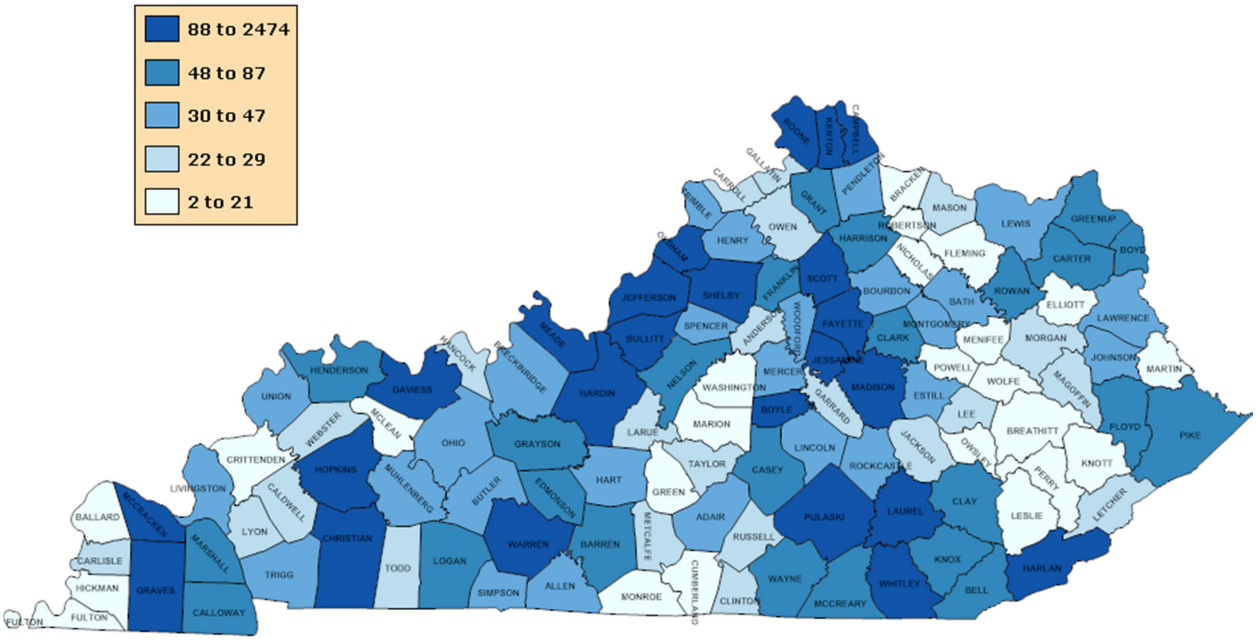
IV: Narrative Plan

G. Consultation with Tribes

No federally recognized Tribes or Tribal lands exist within the Commonwealth of Kentucky. However, the Division of Behavioral Health has opened dialog with the Kentucky Council on Native American Heritage, and is amenable to working with them in the future. Staff within the division has been working with the Kentucky Incentives for Prevention's Survey Statistician to obtain cross tabulations on Native American's past 30 days' consumption of all substances included on the survey. The Synar Program Coordinator used the Native American smokeless tobacco data in a presentation that was given at this year's Synar Conference.



## American Indian and Alaska Native alone population
## 2008




REACH of Louisville

http://quickfacts.census.gov/qfd/states/21000.html

http://sig.REACHofLouisville.com

# IV: Narrative Plan

## H. Service Management Strategies

Page 44 of the Application Guidance

Narrative Question:

SAMHSA, similar to other public and private payers of behavioral health services, seeks to ensure that services purchased under the Block Grants are provided to individuals in the right scope, amount and duration. These payers have employed a variety of methods to assure appropriate utilization of services. These strategies include using data to identify trends in over and underutilization that would benefit from service management strategies. These strategies also include using empirically based clinical criteria and staff for admission, continuing stay and discharge decisions for certain services. While some Block Grant funded services and activities are not amenable (e.g. prevention activities or crisis services), many direct services are managed by other purchasers.

In the space below, please describe:

1. The processes that your State will employ over the next planning period to identify trends in over/underutilization of SABG or MHBG funded services
2. The strategies that your State will deploy to address these utilization issues
3. The intended results of your State's utilization management strategies
4. The resources needed to implement utilization management strategies
5. The proposed timeframes for implementing these strategies

Footnotes:

## IV. Narrative
## H. Service Management Strategies

*SAMHSA, similar to other public and private payers of behavioral health services, seeks to ensure that services purchased under the Block Grants are provided to individuals in the right scope, amount and duration. These payers have employed a variety of methods to assure appropriate utilization of services. These strategies include using data to identify trends in over and underutilization that would benefit from service management strategies. These strategies also include using empirically based clinical criteria and staff for admission, continuing stay and discharge decisions for certain services. While some Block Grant funded services and activities are not amenable (e.g. prevention activities or crisis services), many direct services are managed by other purchasers.*

*In the space below, please describe:*

1. *The processes that your State will employ over the next planning period to identify trends in over/underutilization of SAPTBG or MHSBG funded services*
2. *The strategies that your State will deploy to address these utilization issues*
3. *The intended results of your State's utilization management strategies*
4. *The resources needed to implement utilization management strategies*
5. *The proposed timeframes for implementing these strategies*

To date, planning for implementation of Utilization Management Strategies to ensure that consumers of behavioral health services receive the "right scope, amount and duration of services" has not been completed. The following is offered as a skeleton for this work as it proceeds over SFYs 2012 and 2013.

| Utilization Issues or Trends | Strategies to Address Issue or Trend | Resources Needed to Implement UM Strategies (including staff) | Intended Outcomes/Result of UM Strategies | Proposed Timeframe |
|---|---|---|---|---|
| SMI Served | | | | |
| SED Served | | | | |
| SMI with TCM | | | | |
| SED with TCM | | | | |
| CM for Substance Abuse | | | | |
| | | | | |

## IV. Narrative
## H. Service Management Strategies

*SAMHSA, similar to other public and private payers of behavioral health services, seeks to ensure that services purchased under the Block Grants are provided to individuals in the right scope, amount and duration. These payers have employed a variety of methods to assure appropriate utilization of services. These strategies include using data to identify trends in over and underutilization that would benefit from service management strategies. These strategies also include using empirically based clinical criteria and staff for admission, continuing stay and discharge decisions for certain services. While some Block Grant funded services and activities are not amenable (e.g. prevention activities or crisis services), many direct services are managed by other purchasers.*

*In the space below, please describe:*

1. *The processes that your State will employ over the next planning period to identify trends in over/underutilization of SAPTBG or MHSBG funded services*
2. *The strategies that your State will deploy to address these utilization issues*
3. *The intended results of your State's utilization management strategies*
4. *The resources needed to implement utilization management strategies*
5. *The proposed timeframes for implementing these strategies*

To date, planning for implementation of Utilization Management Strategies to ensure that consumers of behavioral health services receive the "right scope, amount and duration of services" has not been completed. The following is offered as a skeleton for this work as it proceeds over SFYs 2012 and 2013.

| Utilization Issues or Trends | Strategies to Address Issue or Trend | Resources Needed to Implement UM Strategies (including staff) | Intended Outcomes/Result of UM Strategies | Proposed Timeframe<br><br>*Establish baseline for trend data analysis and review available data monthly for up to six months and review quarterly thereafter.* |
|---|---|---|---|---|
| Ensure that adults with SMI are served as a priority and that they receive effective services within a Recovery Oriented continuum of care. | -Review the data available to determine service levels/ type for the priority populations. Data at the county and regional level is needed to compare and contrast. Additional economic and health data from various sources may also be used to enrich planning and implementation strategies.<br>-Collaborative meetings with providers and partner agencies where the data is shared and discussed is also indicated. | -Regularly scheduled meetings with contracted data collection/analysis entities (University of KY, REACH)<br>-Two additional staff within the Division of Behavioral Health are needed to ensure that data reports are shared with staff and providers and that data is fully utilized for program planning and implementation. | -As a part of the goal of moving to a fully Recovery Oriented system, individuals will move from "maintenance" type services to more appropriate and time limited services, including IMR, Supported Housing, Supported Employment, Integrated Services (MH and SA), etc.<br>-Additional funding sources will be sought to fund services and supports not currently reimbursed by Medicaid and | Quarterly |

# IV: Narrative Plan

## I. State Dashboards (Table 10)

Page 45 of the Application Guidance

Narrative Question:

An important change to the administration of the MHBG and SABG is the creation of State dashboards on key performance indicators. SAMHSA is considering developing an incentive program for States/Territories based on a set of state-specific and national dashboard indicators. National dashboard indicators will be based on outcome and performance measures that will be developed by SAMHSA in FY 2011. For FY 2012, States should identify a set of state-specific performance measures for this incentive program. These state-specific performance indicators proposed by a State for their dashboard must be from the planning section on page 26. These performance indicators were developed by the State to determine if the goals for each priority area. For instance, a state may propose to increase the number of youth that receive addiction treatment in 2013 by X%. The state could use this indicator for their dashboard.

In addition, SAMHSA will identify several national indicators to supplement the state specific measures for the incentive program. The State, in consultation with SAMHSA, will establish a baseline in the first year of the planning cycle and identify the thresholds for performance in the subsequent year. The State will also propose the instrument used to measure the change in performance for the subsequent year. The State dashboards will be used to determine if States receive an incentive based on performance. SAMHSA is considering a variety of incentive options for this dashboard program.

Plan Year: 2012

| Priority | Performance Indicator | Selected |
|---|---|---|
| Access | Total number of individuals served annually, by the Regional Boards in mental health and substance abuse programs. | ê |
| Quality Services | Number of Peer Specialists trained. Baseline Number: Number of Peer Specialists who successfully complete the core training module (40 hours) plus at least one of the available secondary modules. | b |
| Integrated Health Services | Number of forums and planning meetings attended by DBH staff. | ê |
| Reduce Premature Death | Number of flyers delivered, number of distribution points Increase in RPC time of spent on environmental strategies relating to Rx drugs in selected counties , number of contest winners, Number of youth who see the media messages | ê |
| Reduce Premature Death | Number of training events conducted annually. | ê |
| Reduce Premature Death | Percentage of schools in which personnel receive training and percentage of schools in which middle and high school students receive suicide prevention information. | ê |
| Reduce Premature Death | Number of new questions added to KIP concerning prescription drug abuse and misuse | ê |
| Reduce Premature Death | Establish baseline data on the number of Medicaid eligible individuals who have filled prescriptions for nicotine replacement pharmaceuticals. | ê |
| Reduce Premature Death | Reduce 10th grade, 30 day binge drinking by at least 1% annually, in targeted counties. | ê |
| Priority Populations | Numerator: Total unduplicated number served in each service category, by the 14 Regional Boards and their affiliates. | ê |
| Promotion and Prevention Services | Baseline data will be collected. Number of trainings provided and the number of Central office staff and Regional Prevention Center staff. | ê |
| Criminal Justice Interface | The number of adults with SMI who are released from prison programs (CPTU and PCU) and who receive services (in the community), from the Regional Boards. | ê |
| | Establish accurate baseline by collecting the number of | |

| | | |
|---|---|---|
| Services for Military | individuals served by the Regional Boards who are active duty service members or veterans, or the family member of active duty service members or veterans. | |
| Anti-Stigma | Develop data base to track the number of Mental Health First Aid trainings provided to targeted individuals and groups that interface with individuals with behavioral health disorders. | |

Footnotes:

## IV: Narrative Plan I. State Dashboards (Table 10)

*Narrative Question:*
*An important change to the administration of the MHSBG and SAPTBG is the creation of State dashboards on key performance indicators. SAMHSA is considering developing an incentive program for States/Territories based on a set of state-specific and national dashboard indicators. National dashboard indicators will be based on outcome and performance measures that will be developed by SAMHSA in FY 2011. For FY 2012, States should identify a set of state-specific performance measures for this incentive program. These state-specific performance indicators proposed by a State for their dashboard must be from the planning section on page 26. These performance indicators were developed by the State to determine if the goals for each priority area. For instance, a state may propose to increase the number of youth that receive addiction treatment in 2013 by X%. The state could use this indicator for their dashboard. In addition, SAMHSA will identify several national indicators to supplement the state specific measures for the incentive program. The State, in consultation with SAMHSA, will establish a baseline in the first year of the planning cycle and identify the thresholds for performance in the subsequent year. The State will also propose the instrument used to measure the change in performance for the subsequent year. The State dashboards will be used to determine if States receive an incentive based on performance. SAMHSA is considering a variety of incentive options for this dashboard program.*

Kentucky has chosen to use one of their Performance Indicators from the Planning Step 4/ Table 3 for a Dashboard for this submission and plans to work to develop additional Dashboard Indicators in subsequent planning cycles.

Dashboard for SFYs 2012 and 2013:

| |
|---|
| **Priority Area #2:** Ensure availability of high quality (science-based) services and supports for all consumers of the publicly funded behavioral healthcare system. |
| **Goal:** Promote Peer Services as a necessary component of Recovery-Oriented Systems of Care for Individuals with Substance Abuse Disorders, Adults with SMI, Children with SED and individuals with co-Occurring Disorders. |
| **Strategy:** Combine core competency training for all Recovery Coaches and Peer Specialists (across populations) and develop population specific modules to address peer services for:<br>• Individuals with substance abuse disorders;<br>• Adults with SMI;<br>• Individuals with co-occurring mental health and substance abuse; or<br>• Individuals with co-occurring behavioral health and physical health concerns. |
| **Performance Indicator:** Number of Peer Specialists trained.<br>**Baseline Number:** Number of Peer Specialists who successfully complete the core training module (40 hours) plus at least one of the available secondary modules. |
| **Description of Collecting and Measuring Changes in Performance Indicators:** Division of Behavioral Health maintains data base(s) of all individuals who participate in Peer Support trainings and certifies those who adequately complete and graduate from the core and secondary trainings. |

# IV: Narrative Plan

## J. Suicide Prevention

Page 46 of the Application Guidance

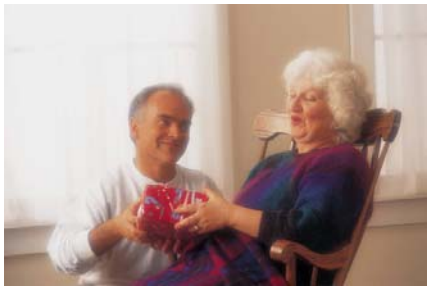
Narrative Question:

In September of 2010, U.S. Health and Human Services Secretary Kathleen Sebelius and Defense Secretary Robert Gates launched the National Action Alliance for Suicide Prevention. Among the initial priority considerations for the newly formed Action Alliance is updating and advancing the National Strategy for Suicide Prevention, developing approaches to constructively engage and educate the public, and examining ways to target high-risk populations. SAMHSA is encouraged by the number of States that have developed and implemented plans and strategies that address suicide. However, many States have either not developed this plan or have not updated their plan to reflect populations that may be most at risk of suicide including America's service men and women -- Active Duty, National Guard, Reserve, Veterans -- and their families. As an attachment to the Block Grant application(s), please provide the most recent copy of your State's suicide prevention plan. If your State does not have a suicide prevention plan or if it has not been updated in the past three years please describe when your State will create or update your plan.

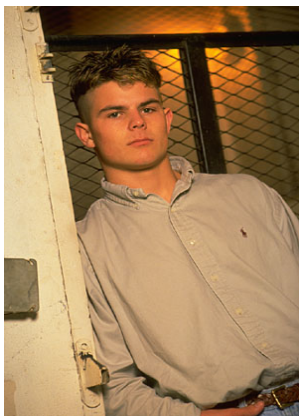
### Footnotes:

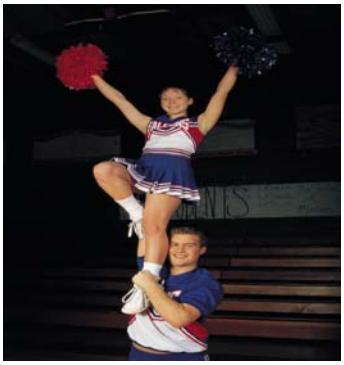
Plan was created in 2007 and a progress report completed in 2008 is also attached. Subsequent year progress reports were not readily available.

“… a life’s too much to lose…”



# Preventing Suicide: Kentucky’s Plan





Prepared by the Kentucky Division of Mental Health and Substance Abuse in collaboration with the Kentucky Suicide Prevention Group (KSPG), a work group of the Kentucky Commission on Services and Support for Individuals with Mental Illness, Alcohol & Other Drug Abuse Disorders, and Dual Diagnosis (HB 843 Commission).

Kentucky UNBRIDLED SPIRIT™

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GOVERNOR

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SECRETARY

Secretary James W. Holsingser, MD
Representative Mary Lou Marzian
Members of the Kentucky Commission on Services and Supports for Individuals with Mental Illness, Alcohol, and Other Drug Abuse Disorders, and Dual Diagnosis (HB 843 Commission)
Citizens of the Commonwealth:

Dear Members and Citizens of the Commonwealth :

With Kentucky's suicide rate exceeding the national suicide rate and the need for a state plan to address this issue, we present you with "Preventing Suicide: Kentucky's Plan" as prepared by the Kentucky Suicide Prevention Group (KSPG), a workgroup of the Commission.

This plan highlights the activities of the KSPG since its inception in March 2002. In particular, the plan illustrates the commitment to the collaborative nature of its work and continued efforts to raise awareness about suicide and its prevention so that fewer Kentuckians experience the pain and grief resulting from the suicide death of a loved one.

We would like to take this opportunity to thank the many volunteers who have shared in the efforts of the KSPG ranging from those who have lost loved ones to suicide, community action groups, government employees, educators, mental health advocacy and support groups, and staff of the regional mental health centers.

Additionally, we are appreciative of the support provided by the administration, the Commission, and the General Assembly in addressing the issue of suicide. On behalf of the KY Suicide Prevention Group, the citizens of the Commonwealth, and especially those affected by the death of a loved one by suicide, we ask for your continued support of this important work.

For additional information about the KSPG or any activities described within this plan, please do not hesitate to contact us or the lead staff at DMHMRS for this initiative.

Sincerely,

Connie Milligan
Steering Committee Chair

Denis Walsh
Steering Committee Vice-Chair

# Table of Contents


| | |
|---|---|
| Introduction | 1 |
| The Impact of Suicide | 2 |
| Vision, Mission & History | 3 |
| Support & Collaboration | 5 |
| Strategy | 6 |
| Goals & Objectives | 7 |
| Structure | 9 |
| Acknowledgements | 10 |
| Reference Web Sites | 11 |
| Contact Information | 12 |

# Introduction

*"even one death by suicide is one death too many"*

**Former HHS Secretary,**
**Tommy G. Thompson**

**Department of Health**
**& Human Services**

**An average of 502 Kentucky citizens die by suicide each year**.

Kentucky loses twice as many citizens to suicide as to homicide.

Kentucky's suicide death rate is the 19th highest in the nation.

Suicide is the 2nd leading cause of death for Kentuckians 15 to 34 years old.

Suicide is the 4th leading cause of death for 35 to 54 year olds.

73 percent of suicide deaths in Kentucky were caused by firearms.

2920 self-inflicted injuries[1] resulted in an in-patient hospital admission in Kentucky during calendar year - 2003.

[1] Self-inflicted injuries from the ICD-9 coding range of 9--- to 9--- are included here. This is the code range identifying suicide attempts.

Suicide is permanent.

However, potential suicide victims usually exhibit warning signs before attempting to end their lives. Therefore, suicide, like other forms of violence, is preventable. It is a preventable public health problem.

With growing concern for the problem of suicide in Kentucky and the knowledge that such devastating acts of violence are preventable, in 2002 the Kentucky Department for Mental Health and Mental Retardation Services invited various community leaders to establish the Kentucky Suicide Prevention Group. In October 2004, a staff person was hired to focus upon suicide prevention efforts in the Commonwealth.

The group's collaborative work continues to provide the framework for Kentucky's response to the problem of suicide. This report provides an overview of the activities over the past fiscal year and incorporates the state suicide prevention plan for the future. The June 2004 Progress Report, which covers the history of the group's efforts from its inception, is also available on-line at the following web-page:
http://mhmr.ky.gov/mhsas/suicidepreventiongroup.asp

# The Impact of Suicide

**Below are quotes from those who have been impacted by the suicide death of a loved one. The efforts of the Kentucky Suicide Prevention Group are dedicated to reducing the rate at which others experience their pain.**

*I am so tired of secrets. Being depressed is not something to be ashamed of. It's about brain chemistry, not some personal weakness. If I had known more about the risk factors, maybe there's something we could have done to help. I knew my son was sad but what I didn't know was that you can die from being too sad."*

*"My son was a basketball player who died by suicide. After an injury basically sidelined him, we all missed the signs of depression that followed. As his mother, I am convinced that if the coaching staff, his team members, his girlfriend, his family or even he had been able to recognize the symptoms of depression, and sought treatment, he would be alive today. That's why the work of the Kentucky Suicide Prevention Group is so important to me - to prevent other families from experiencing the grief and pain that we live with every day."*

# The Vision, Mission & History

## Vision

The vision of the Kentucky Suicide Prevention Group is to lead the Commonwealth in providing and promoting opportunities for all Kentuckians to become active in the reduction of suicide deaths and attempts.

## Mission

The mission of the Kentucky Suicide Prevention Group is to decrease suicide deaths and attempts in the Commonwealth through advocacy, education, training, and evaluation.

## History

As the basis for a collaborative development of a state suicide prevention plan, Kentucky's Division of Mental Health recruited stakeholders from a number of interest areas and from all over the state. At the first meeting in March 2002, approximately 25 people were in attendance who subsequently formed the Kentucky Suicide Prevention Planning Group.

In July 2002, eight of the group members attended the national conference of Suicide Prevention and Advocacy Network (SPAN-USA)[2] in Washington, D.C. There they were given information and tools to assist them in writing a suicide prevention plan. Upon their return, they immediately began working intensively to prioritize goals and action steps. With leadership from this core group, the Kentucky Suicide Prevention Planning Group recommended that the outline proposed by Surgeon General Satcher (US Public Health Service, 1999) and the National Strategy for Suicide Prevention (US Department for Health & Human Services, 2001) be followed in Kentucky. This model recognizes suicide as a preventable public health problem.

In December 2003, several members, including state legislators Senator Tom Buford and Representative Mary Lou Marzian, attended a conference on suicide prevention planning sponsored by the national Suicide Prevention Resource Center (SPRC). At this time further development of efforts in Kentucky occurred through structured facilitation provided by SPRC staff.

In June 2004, a progress report of the efforts of this group and its initial goals was published and presented to the Kentucky Commission on Services and Support for Individuals with Mental Illness, Alcohol & Other Drug Abuse Disorders, and Dual Diagnosis (HB 843 Commission). Some additional highlights of progress from March 2002 through June 2004 included training over 35 trainers of QPR as well as teaching over 500 individuals the basic QPR gatekeeper skills, distributing over 2000 information packets at conferences and events, and utilizing the expertise of several experienced professionals in the field of suicidology and prevention planning.

[2] SPAN-USA is now the acronym for the Suicide Prevention Action Network.

In October 2004, a suicide prevention coordinator was hired to address the issue of suicide via collaborative funding from the Department for Public Health and the Department for Mental Health & Mental Retardation Services. In December 2004, the KY Suicide Prevention Planning Group held a strategic planning retreat. It was determined that the group had moved past the planning stage, thus that word – planning – was removed from its name. Thus the group has since been known as the KY Suicide Prevention Group (KSPG). The strategic planning process was continued in February 2005. As a result of these sessions, a state suicide prevention plan emerged. Additionally, the three main work groups of the planning period which focused upon Awareness, Education, and Evaluation/Research were closed and new task specific groups became the focal point of the efforts of the KSPG.

The group expresses three primary messages:

- **A Life is Too Much to Lose**
- **Suicide is a Preventable Public Health Problem**
- **Suicide Prevention: It's Everybody's Business**

# Support and Collaboration

Since that first meeting in 2002 when a group of devoted and concerned people formed the Kentucky Suicide Prevention Group, over 150 individuals have joined the effort. These people represent much of the Commonwealth's diversity in many areas such as age, geographic location, professions, personal experience and agency affiliation. Some of the involved entities include:

- Survivor Support Groups
- Local School Boards
- Private Psychiatric Hospitals
- Community Mental Health Centers
- Law Enforcement
- Private Businesses
- Citizen Advocacy Groups
- KY School Boards Association
- Local Public Health
- Louisville Youth Group
- Mental Health Association of KY
- Suicide Prevention Training Programs for KY
- Stop Youth Suicide Campaign
- Morehead State University
- State Interagency Council
- Protection and Advocacy
- Kentucky Center for School Safety
- Western Kentucky University
- Hospice of the Bluegrass
- University of Kentucky
- Mental Health Association of Northern KY
- National Alliance of the Mentally Ill - Kentucky

The Division of Mental Health and Substance Abuse sponsors the Kentucky Suicide Prevention Group, in partnership with the Department for Public Health. Each Department has several staff involved in these efforts which are coordinated by the state suicide prevention coordinator.

# Strategy

The invested and active stakeholders propose a strategy to reduce the rate of suicide within the Commonwealth. The strategy is based upon the eleven goals and corresponding objectives from the National Strategy for Suicide Prevention (NSSP), published by the U.S. Department of Health and Human Services in May of 2001, with leadership from the Surgeon General.

NSSP is the result of advocates, clinicians, and researchers and survivors working together to respond to the Surgeon General's challenge. It lays out a framework for action to prevent suicide. It is designed as a catalyst for social change using the public health approach with focus upon the areas of *awareness, intervention, and methodology*.

Based upon the needs in Kentucky, the goals created were focused on the areas of advocacy, education, marketing/public relations, community mobilization, and securing funding which can be tied directly to the national goals of awareness, intervention, and methodology.

The Commonwealth of Kentucky's Suicide Prevention Plan focuses upon the importance of a plan which has a life-span approach. This is important because data shows that persons of all ages are affected by self-inflicted injuries and suicide deaths.

# Goals & Objectives

## Advocate: To advocate for suicide prevention efforts.

### Objectives:

- Promote awareness that suicide is a public health problem that is preventable.
- Develop broad-based support for suicide prevention.
- Identify the need for increased access to and community linkages with mental health and substance abuse services.
- Pursue affiliation with the Suicide Prevention Action Network – USA.
- Prepare an informational packet for various audiences to distribute as needed.
- Make formal recommendations to the HB 843 Commission and the Commissioners of the Department for Mental Health & Mental Retardation Services and the Department for Public Health regarding suicide prevention efforts.
- Utilize survivors to tell their story to legislators, administrators, community leaders, and citizens of the Commonwealth.

## Educate: To develop and implement educational strategies.

### Objectives:

- Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse, and suicide prevention services.
- Identify and maximize existing anti-stigma events (walks, conference, etc.).
- Promote efforts to reduce access to lethal means and methods of self-harm.
- Implement training for recognition of at-risk behavior and delivery of effective treatment.
- Identify and promote effective clinical and professional practices.
- Promote and support research on suicide and suicide prevention.
- Develop, improve, and expand surveillance systems.
- Communicate the availability of gatekeeper training and screening tools.
- Educate public and medical practitioners about appropriate treatment options.

## Marketing and Public Relations: To develop and implement marketing and public relations strategies.

### Objectives:

- Market suicide prevention as a means to lower costs of mental and physical health care costs.
- Develop a public awareness media campaign.
- Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment and news media.
- Enlist the support of media partners.

## Mobilize Communities: To develop and expand community suicide prevention.

### Objectives:

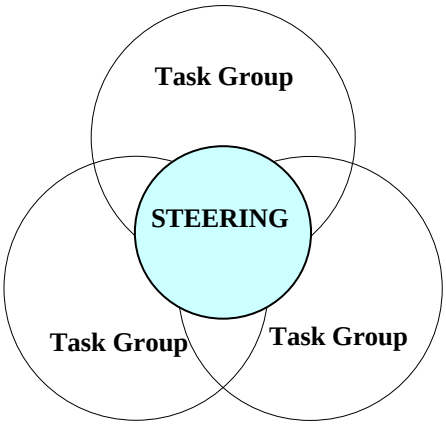
- Research, identify, and encourage implementation of community-based suicide prevention programs.
- Identify the need for increased access to and community linkages with mental health and substance abuse services.
- Mobilize geographic as well as organizational communities to expand suicide prevention efforts.
- Develop and train communities in the usage of a community suicide prevention toolkit.

## Secure Funding: To secure funding for suicide prevention efforts.

### Objectives:

- Identify grant funding options and grant preparation resources.
- Identify foundations and organizations to support the efforts of the KY Suicide Prevention Group (KSPG).
- Utilize public-private partnerships to secure funding and maintain leadership of the KSPG.

# Structure




Task Groups are led by a volunteer from KSPG. Each task group may request technical assistance from the Steering Committee and the suicide prevention coordinator.

The Steering Committee consists of five individuals representing the full KSPG. They serve as the leadership component for the group and are responsible to report annually to the HB 843 Commission.

To accomplish the strategy set forth, there is a steering committee of five individuals which directs the efforts of the KY Suicide Prevention Group. Working task groups are formed to focus upon specific task areas as they arise. These are supported and coordinated through the suicide prevention coordinator.

Each fiscal year a 2-page document will be published to report updates and achievements.

# Acknowledgements

Many thanks are due to the more than 150 Kentuckians who have joined the suicide prevention effort. Without each and every one of them, the group's work would not have progressed as it has.

**The most heartfelt thanks go to the survivors of suicide. They are the essence of this movement. Without the spirit and dedication of those dramatically impacted by the suicide death of their loved ones, the reason for the efforts of this might would be lost. Thanks to their ability to communicate and advocate, we focus on practical and effective ways to prevent others from experiencing the grief they endure daily.**

Special thanks are also given to the following individuals for their consistent support and encouragement, listed in alphabetical order.

| | |
|---|---|
| Mark Birdwhistell | Undersecretary for Health, Cabinet for Health & Family Services |
| Tom Buford | Senator, Kentucky General Assembly |
| Steve Davis, MD | Deputy Commissioner, Department for Public Health |
| Sue Eastgard | Director, Youth Suicide Prevention Program - Washington State |
| Sarah Gilbert | EKU Facilitation Center, Training Assistant |
| William Hacker, MD | Commissioner, Department for Public Health |
| Linda Harney | Deputy Commissioner, Dept. for Mental Health and Mental Retardation Services |
| James Holsinger, MD | Secretary, Cabinet for Health & Family Services & Co-Chair, HB 843 Commission |
| Rice Leach | Former Commissioner, Department for Public Health |
| David Litts, OD | Suicide Prevention Resource Center, Air Force Suicide Prevention Plan |
| Mary Lou Marzian | Representative, Kentucky General Assembly & Co-Chair, HB 843 Commission |
| Margaret Pennington | Former Commissioner, Dept. for Mental Health and Mental Retardation Services |
| Lloyd Potter | Director, Suicide Prevention Resource Center |
| Paul Quinnett, PhD | President and CEO, QPR Institute |
| Bob Robey | Suicide Prevention Training Programs for KY |
| Karen Russell | EKU Facilitation Center, Facilitation Services Specialist |
| Bruce W. Scott | Former Director, Division of Mental Health |
| Steve Shannon | Director, Division of Mental Health and Substance Abuse |
| Pat Wear, II | Commissioner, Department for Mental Health and Mental Retardation Services |
| Sarah Wilding | Chief Nurse, Department for Public Health |
| Linda Whittle | Ohio Coalition for Suicide Prevention |

# Reference Web Sites

## National Resources

| | |
|---|---|
| American Association of Suicidology | http://www.suicidology.org/ |
| American Foundation for Suicide Prevention | http://www.afsp.org/ |
| Jason Foundation | http://www.jasonfoundation.com/ |
| Jed Foundation | http://www.jedfoundation.org/ |
| Kristin Brooks Hope Center / National Hopeline Network | http://www.hopeline.com/ |
| National Center for Suicide Prevention Training | http://www.ncspt.org/courses/orientation/ |
| National Strategy for Suicide Prevention | http://www.mentalhealth.org/suicideprevention/strategy.asp |
| National Suicide Prevention Lifeline | http://www.suicidepreventionlifeline.org |
| National Youth Violence Prevention Resource Center | http://www.safeyouth.org/scripts/index.asp |
| NMHA sponsored Depression Screening | http://www.depression-screening.org/ |
| Organization for Attempters & Survivors of Suicide in Interfaith Services | http://www.oassis.org/ |
| QPR Institute - Gatekeeper Prevention Training | http://www.qprinstitute.com/ |
| Samaritans Suicide Prevention | http://www.samaritansnyc.org/ |
| Stop a Suicide, Today! | http://www.stopasuicide.com/ |
| Suicide Awareness/Voices of Education | http://www.save.org/ |
| Suicide Prevention Action Network (SPAN USA) | http://www.spanusa.org/ |
| Suicide Prevention Resource Center | http://www.sprc.org/ |
| Suicide Reference Library: Suicide Awareness, Support & Education | http://www.suicidereferencelibrary.com/ |
| Surgeon General's 1999 Call to Action | http://www.surgeongeneral.gov/library/calltoaction/default.htm |
| Web-based Injury Statistics Query and Reporting System | http://www.cdc.gov/ncipc/wisqars/default.htm |
| Yellow Ribbon Suicide Prevention Program | http://www.yellowribbon.org/ |

## State and Local Resources

| | |
|---|---|
| Hospice of the Bluegrass | http://www.hospicebg.com/ |
| KY Department for Mental Health & Mental Retardation Services | http://mhmr.ky.gov/KDMHMRS/ |
| – Suicide Prevention Pages | http://mhmr.ky.gov/mhsas/suicidepreventiongroup.asp |
| KY Department for Public Health – Data Resources | http://chfs.ky.gov/dph/surv.htm |
| Mental Health Association of Northern Kentucky | http://www.mhanky.org/index.htm |
| SPAN Kentucky | http://www.span-ky.com/ |
| Stop Youth Suicide Campaign | http://www.stopyouthsuicide.com/ |
| Suicide Prevention Programs for Kentucky (QPR) | http://www.kysuicideprevention.com/index.html |

# Contact Information

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Kentucky Suicide Prevention Group – Steering Committee
Connie Milligan, Chair
Denis Walsh, Vice-Chair
Mary Bolin-Reece, Member
Linda Lancaster, Member
Jan Ulrich, Member

Hatim Omar, Former Chair
Richard Greer, Former Member
Bruce Hey, Former Member

Kentucky
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**Preventing Suicide: Kentucky's Plan**
**Kentucky Department for Mental Health & Mental Retardation Services**
**100 Fair Oaks Lane, 4E-D**
**Frankfort, KY 40621**

Paid for with federal and state funds.

Printed June 2005

# Kentucky Suicide Prevention Group

## Progress Report, October 2007-December 2008

Michael McFarland, LMFT

**Current Steering Committee**

- **Todd Cheever, M.D., Chair**
  U.K. Department of Psychiatry
- **Barbara Kaminer, Vice-Chair**
  Suicide Prevention Coordinator,
  Louisville Veteran's Administration
- Steve Ulrich, *Survivor*
- Jenny Jones, *Survivor*,
  previous Chair (08)
- Julie Cerel, Ph.D.,
  *Assistant Professor,*
  College of Social Work,
  University of Kentucky
- Donna McBee, RN,
  *Community Health*
  *Clinical Nurse Specialist*
- Paula Rymer, *Survivor*

# Progress Report: October 2007-December 2008

## *Context and Cause for Concern*

As of 2005, based on the most recent official data released from the Centers for Disease Control (CDC), Kentucky has the 17th highest rate of death by suicide among its general population. In 2002, its ranking was 19th highest in the nation. The most recent data from the Kentucky Violent Death Reporting System reveals a large single year increase in the number of suicide deaths, from 557 in 2005 to 605 for 2006 (table 1). With suicide deaths representing the largest portion of violent deaths—67% (figure 1), a disturbing trend continues for the state with suicide being the second leading cause of death for those 15 to 34 years of age. There are three suicides for every homicide.

**Figure 1**

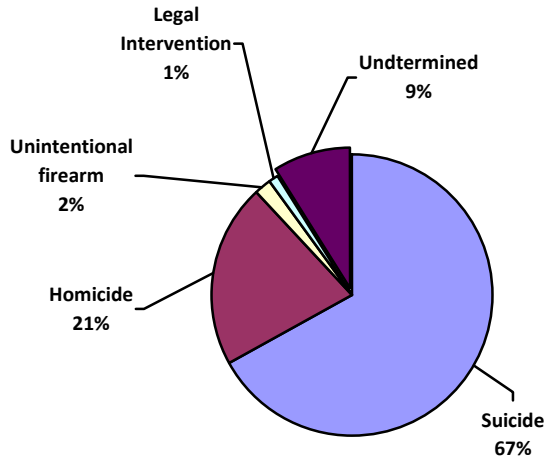



**Table 1**

| Manner of Death | 2005 Count (%) | 2006 Count (%) |
|---|---|---|
| Suicide | 557 (69%) | 605 (67%) |
| Homicide | 191 (24%) | 190 (21%) |
| Legal Intervention | 9 (1%) | 5 (1%) |
| Unintentional Firearm | 14 (2%) | 21 (2%) |
| Undetermined | 38 (5%) | 86 (9%) |
| Total | 809 | 907 |

**Data from chart 1 and table 1 provided by KVDRS, Kentucky Violent Death Reporting System, 2008**

As noted in figure2, the deaths by suicide show a consistent upward trend. The sharp slop from 2005 to 2006 represents a significant one year increase.

## *Youth Suicide Mortality and Morbidity*

At the time of the initial SAMHSA grant application, Kentucky had a reported youth suicide rate of 8.38 per 100,000 and a reported intentional self-inflicted injury rate of 78.83 per 100,000. The youth suicide death rate in Kentucky is higher than the national average of 6.96 per 100,000.

Additionally, nine of 14 Community Mental Health Center (CMHC) regions within Kentucky also exceed the state suicide death rates.

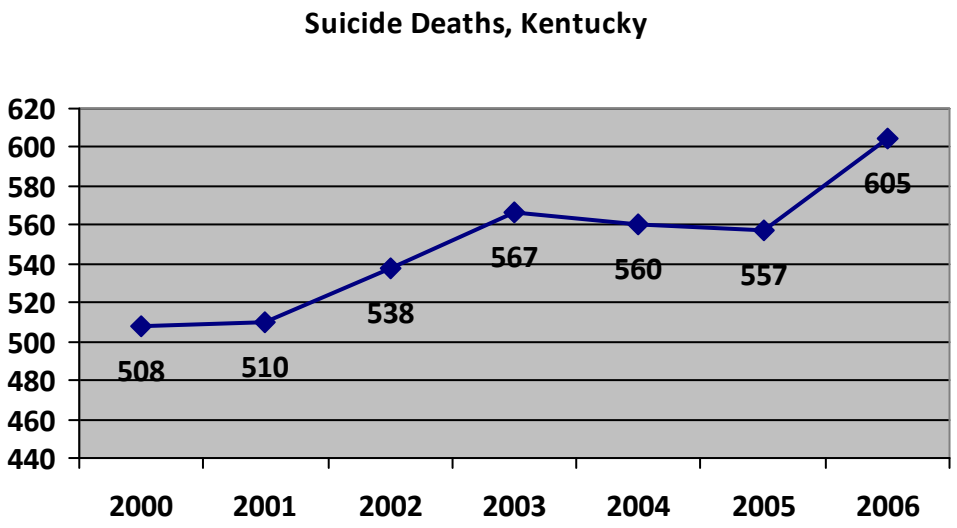



Figure 2

**Data from WISQARS, 2008 and KVDRS**

Based on recent data from KVDRS, 2006 Suicide Prevention Group Draft Report: KVDRS Youth Suicide Data Summary Prepared by Sabrina Walsh, Dr. PH (Submitted 12-23-08), adolescent deaths (ages 10-24) by suicide have increased from 62 in 2005 to 72 in 2006. All but nine of these are males. This is a rate of 8.5 with the national average being 6.96 per 100,000. Overall violent death cases in 2006 separated by manner of death are shown in Table 2. Suicide was the leading cause of death in youth aged 10 to 24 (50%). Circumstantial information was available in 49 (74%) of the 66 cases of suicide.

Table 2. Manner of Death by Age Group

| | **Age Group** | | | | |
|---|---|---|---|---|---|
| **Manner of Death** | <1 (N=5) | 1-3 (N=3) | 4-9 (N=2) | 10-24 (N=131) | Total (N=141) |
| Suicide | 0 | 0 | 0 | 66 (50.4%) | 66 |
| Homicide | 4 (80%) | 3 (100%) | 1 (50%) | 57 (43.5%) | 65 |
| Accident | 0 | 0 | 1 (50%) | 3 (2.3%) | 4 |
| Undetermined | 1 (20%) | 0 | 0 | 5 (3.8%) | 6 |

In 2006, there were 13 KVDRS suicide cases (10-17 age group) and precipitating circumstances known in 12 (92%) of those cases. Table 3 is a list of precipitating suicide circumstances and the frequency distribution by sex.

Table 3. Top Ten Suicide Circumstances (10-17 years old)

| | All (N=13) | Male (N=10) | Female (N=3) |
|---|---|---|---|
| Crisis in the past two weeks | 4 (31%) | 4 (40%) | 0 |
| Ever treated for mental illness | 3 (23%) | 2 (20%) | 1 (33%) |
| Current mental health problem | 4 (31%) | 3 (30%) | 1 (33%) |
| Current treatment for mental health problem | 3 (23%) | 2 (20%) | 1 (33%) |
| Current depressed mood | 2 (15%) | 1 (10%) | 1 (33%) |
| Substance abuse problem | 2 (15%) | 0 | 2 (67%) |
| Intimate partner problem | 4 (31%) | 4 (40%) | 0 |
| Other relationship problem | 3 (23%) | 2 (20%) | 1 (33%) |
| School problem | 2 (15%) | 2 (20%) | 0 |
| Suicide of family or friend in past 5 years | 1 (8%) | 0 | 1 (33%) |
| | | | |
| History of suicide attempts | 1 (8%) | 0 | 1 (33%) |
| Disclosed intent to commit suicide | 5 (38%) | 4 (40%) | 1 (33%) |
| Left suicide note | 3 (23%) | 1 (10%) | 2 (67%) |

*More than one circumstance can apply

The most common reasons for a male youth (10-17 year old age group) to die by suicide in 2006 were problems with a girlfriend, current mental health problems and a recent crisis, where in girls the most common reason was a substance abuse problem. Boys were more apt to disclose their intent to commit suicide while girls were more apt to leave a note and have a history of previous suicide attempts.

In youth who died by suicide in 2006, all were white and the most commonly used mechanism was hanging. Surprisingly, females more often used a firearm where males more often died from strangulation/suffocation (Table 4).

Table 4. Mechanism of Suicide Death (10-17 years old)

| | All (N=13) | Male (N=10) | | Female (N=3) | |
|---|---|---|---|---|---|
| | | White | Black | White | Black |
| Hanging | 7 (54%) | 6 | 0 | 1 | 0 |
| Firearm | 5 (38%) | 3 | 0 | 2 | 0 |
| Other | 1 (8%)* | 1 | 0 | 0 | 0 |

* Intentional Fire Death

In the young adult age group (18-24) 52 people died by suicide and circumstantial information was available in 38 (73%) cases. Table 5 is a list of precipitating suicide circumstances and the frequency distribution by sex.

Table 5. Top Ten Suicide Circumstances (18-24 years old)

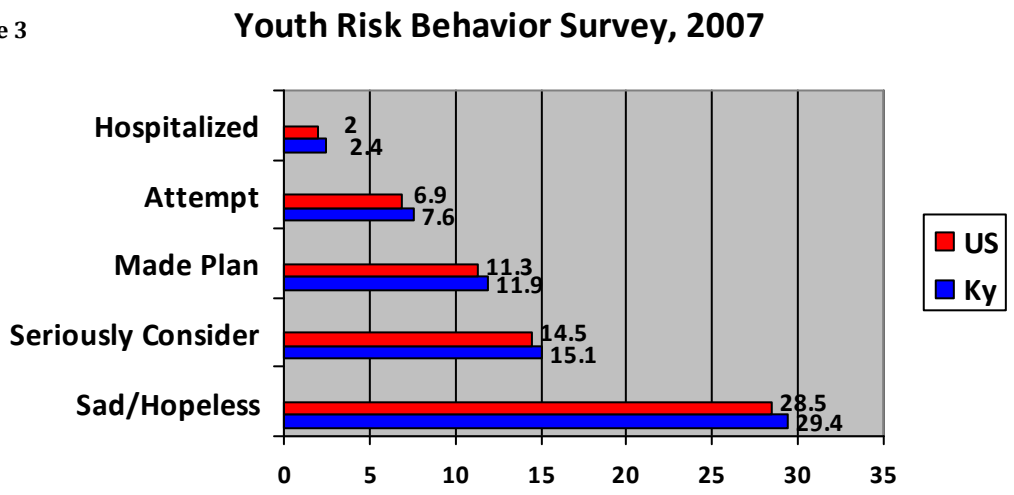
| | All (N=38) | Male (N=29) | Female (N=9) |
|---|---|---|---|
| Current depressed mood | 23 (61%) | 17 (59%) | 6 (67%) |
| Current mental health problem | 22 (58%) | 15 (52%) | 7 (78%) |
| Current treatment for mental health problem | 22 (58%) | 15 (52%) | 7 (78%) |
| Ever treated for mental illness | 21 (55%) | 14 (48%) | 7 (78%) |
| Crisis in the past two weeks | 10 (26%) | 9 (31%) | 1 (11%) |
| Intimate partner problem | 10 (26%) | 8 (28%) | 2 (22%) |
| Substance abuse problem | 8 (21%) | 6 (21%) | 2 (22%) |
| Alcohol problem | 7 (18%) | 5 (17%) | 2 (22%) |
| Recent criminal legal problem | 5 (13%) | 5 (17%) | 0 |
| Job problem | 4 (11%) | 4 (14%) | 0 |
| | | | |
| History of suicide attempts | 8 (21%) | 4 (14%) | 4 (44%) |
| Disclosed intent to commit suicide | 11 (29%) | 9 (31%) | 2 (22%) |
| Left suicide note | 8 (21%) | 5 (17%) | 3 (33%) |

Information regarding mechanism of suicide death in young adults was available for 51 of the 52 cases (98%). Of all young adults who died by suicide in 2006, and the mechanism of death was known, 45% were white males and the most commonly used mechanism was a firearm (Table 5).

Data being provided by the KVDRS is proving to be invaluable for better decisions about target areas, planning for future interventions and seeing patterns develop across the state. The KVDRS is also proving to an important resource partner as we attempt to develop a more collaborative association with the coroners in Kentucky that will lead to a quicker response to community suicide deaths

The nature of the mental health status for Kentucky youth is further reflected by the 2007, Youth Risk Behavior Surveillance Survey (YRBSS). This is a survey conducted every 2 years by the CDC and explores various high risk factors associated with youth in grades 9-12 for the previous 12 months. Figure 3 shows 29% of Kentucky youth grades 9-12 indicated feeling so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months; 15% having seriously considered suicide; 11% had made a plan within the previous 12 months; and 7% having made an attempt.

**Figure 3**




Data from: Youth Risk Behavior Surveillance Survey, Online, 2008

Behind all these statistics is an often hidden tragedy that broadens the impact of suicidality even further across the state—survivors of suicide. A survivor is anyone who has lost a relative, friend, coworker, etc. to suicide. It is estimated that for every death by suicide at least 6 other people are impacted. For 2006 that would mean an estimated 3,600 Kentuckians became survivors of suicide in that one year alone. Over the course of the past two decades, over 60,000 citizens of the Commonwealth have been forced to embark on this painful journey of being a survivor of suicide. As part of the grant effort, the Kentucky Awareness of Suicide (KASS) Phone survey was conducted in August, 2007. A significant revelation from this survey was the extent to which fellow Kentuckian's had been touched by suicide.

- 64% (197) knew at least one person who had attempted or died by suicide (average number = 5).
- 40% knew at least 1 person who had died by suicide
- 33.8% (n=104) considered themselves to be a "suicide survivor."

## *Changes and Adjustments*

Since the last progress report in June of 2006 and prior to October 1, 2007 there have been several changes and adjustments for both KSPG (Kentucky Suicide Prevention Group) and the Department for Mental Health.

- In 2006 the Department for Mental Health, Developmental Disabilities and Addiction Services was awarded a three year SAMHSHA grant for adolescent suicide prevention and intervention.
- The State Suicide Prevention Coordinator position experienced multiple changes in personnel, with the resignation of Jason Padgett in order to pursue a national level position with SPAN (Suicide Prevention Action Network). It was not until October 1, 2007 that the present coordinator was hired.
- The hire of Technical Marketing Specialist, Jan Ulrich, as a grant dedicated position whose responsibilities greatly exceed beyond marketing and help to address school-based prevention and postvention concerns. This position will terminate with the end of the grant in September, 2009.

## *SAMHSA Grant Synopsis--Suicide Prevention in Youth: A Collaborative Effort (SPYCE)*

The purpose of the KY Suicide Prevention in Youth - a Collaborative Effort (SPYCE) project is to raise awareness, enhance quality interventions, and utilize effective research and data collection methodologies to ultimately reduce the number of suicides completed by the youth in Kentucky. The grant was awarded September, 2006; we are now entering the third and final year.

SPYCE uses a public health model of prevention with universal, selective and indicated approaches to address the following goals:

1. Increase knowledge of suicide warning signs, risk factors, and protective factors;
2. Enhance suicide crisis intervention availability, quality and public awareness of service;
3. Increase local community collaboration in suicide prevention;
4. Establish and increase support for suicide survivors through postvention and prevention;
5. Increase resiliency among youth at risk;
6. Enhance existing emergency department services for youth and their families to increase culturally and linguistically-sensitive training regarding ways to reduce future self-injurious behavior through reduction of lethal means and by reducing stigma to seek treatment; and
7. Provide additional training in clinical suicide risk management to medical/mental health professionals and paraprofessionals across the state.

## ACCOMPLISHMENT HIGHLIGHTS

Despite the adjustment challenges and personal changes, the partnership of KSPG and the Department for Mental Health through the support of the Department of Public Health, the Federal Block grant and the Federal SAMHA grant, has been able to move forward to affect numerous accomplishments in the area of suicide prevention across the State of Kentucky.

### GOAL 1, *INCREASE KNOWLEDGE OF SUICIDE WARNING SIGNS, RISK FACTORS, AND PROTECTIVE FACTORS.*

- Social Marketing Campaign
  - The goal in each year of the grant has been to raise overall public awareness through the use of multiple marketing outlets and the development of sustainable marketing products for use in suicide prevention.
  - In year 1, 2007 the focus was on the use radio, press releases, and the network of the Kentucky Suicide Prevention Group, and QPR gatekeeper trainers to raise awareness of the issue of suicide in Kentucky, promote the National Suicide Prevention Lifeline, and increase the demand for gatekeeper training in the state.
    - The Technical Assistance Marketing Coordinator worked with New West Public Relations, an approved media/public relations vendor for Kentucky state government, to develop a 60-second radio spot that aired September 3rd to 15th, 2007.
    - The radio spot aired in the following markets: Louisville, Lexington, Bowling Green, Owensboro, Ashland, Paducah on a total of 32 Kentucky radio stations, airing a minimum of 3,018 times.
    - Audio News Releases (ANR): Some Northern Kentucky media markets are not covered by Kentucky media. In order to reach those markets, New West Public Relations suggested doing an Audio News Release (a purchased "news" story that would air during radio news segments).
      - The ANR aired on 85 Kentucky News Network (KNN) affiliates.
      - WHAS radio in Louisville, Kentucky's largest media market aired the ANR within its news stories throughout the day on September 10th.
  - In year 2, 2008, the Kentucky Suicide Prevention Group in collaboration with MHDDAS launched the "Let's Talk "campaign. As part of this campaign a Kickoff event was hosted at the Capital Plaza Hotel Ballroom, in Frankfort, KY for the premier showing of the Kentucky made DVD: "Kentuckians Affected by Suicide End the Silence". The event was emceed by WHAS' Francene Cucinello with presentations by Eric Friedlander, Health Policy Advisor to Cabinet Secretary Janie Miller, Senator Julie Denton and Representative Mary Lou Marzian. During the Kickoff event, Community Tool Kits where distributed in an effort to stimulate grassroots prevention efforts.
    - Enclosed is a sample of some of the marketing products: Newsletter, logo sticker, DVD, Brochure.

- Prior to Suicide Prevention Week, KSPG mobilized over 60 volunteers to man the first time ever suicide prevention/awareness booth at the Kentucky State Fair.
- For Suicide Prevention Week, Sept. 7-13th there was an intensive effort to distribute suicide prevention literature. A total of **45,398** pieces of literature were disseminated throughout the State as a result of requests made to the Department, consisting of "Let's Talk" T-shirts, brochures and newsletters, depression and suicide prevention pamphlets, suicide symptom and warning cards, and Lifeline 1-800-273-TALK magnets.
  - A major sustainable marketing and support product has been a new Kentucky Suicide Prevention Group website www.kentuckysuicideprevention.org which continues the "Let's Talk" theme to raise awareness in the general public, provide community calendar and training opportunities, provides clips of the "Let's Talk" video, and provides additional resources for KSPG members and QPR instructors.

- QPR (Question, Persuade and Refer) is a popular community gatekeeper 90 minute training program designed to create increased awareness about the signs and symptoms of a suicidal crisis and provide a network of informed gatekeepers which allows for early detection, intervention and referral in order to avoid advanced crisis.
  - Since May of 2004, almost 10,000 citizens have been trained in QPR.
  - Grant specific Training results:

| | Year 1 | Year 2 | Grand Total |
|---|---|---|---|
| Total people trained | 2080 | 3620 | 5868 |
| Total evaluations returned | 1882 | 2712 | 4657 |
| Total number of sessions | 140 | 225 | 385 |
| Number of counties QPR training conducted (KY has 120 counties) | 21 (18% of counties) | 26 (22% of counties) | 37 (31% of counties) |

| | Pre-Grant | Year 1 | Year 2 | Year 3 | Grand Total |
|---|---|---|---|---|---|
| Number QPR Trainers | 79 | 154 | 206* | 265 | 228 |
| Expired certifications w/o renewal | | | 37(20%) | | |
| Number of trainers conducting trainings | | 52 (43%) | 47 (23%) | | |

*37 trainers were removed from the roles in year 2 due to a lack of response regarding the need for recertification.

- Suicide Prevention efforts are actively being coordinated on major Kentucky college and university campuses: University of Kentucky, University of Louisville, Bellarmine, Moorhead State, Western Kentucky University, and Lindsey Wilson College.
    - Through the SPYCE grant approximately 50 QPR Trainers have been added to Kentucky University Campus'
    - At the University of Kentucky new QPR trainers were added to an existing group.
    - New QPR Trainers were established at the following campus' which did not have an existing QPR program: Western University, Bellarmine and the University of Louisville.
    - Clinical trainings have taken place among staff and students for Lindsey Wilson College and consultation has been provided for the Marriage and Family Therapy Program and counseling center at the Presbyterian Seminary, Louisville.
- Signs of Suicide (SOS) and preparatory QPR Implementation for school faculty
    - SOS is a peer based prevention program designed to provide students with basic knowledge about distress warning signs and encourage a positive adult help seeking environment. This program actively offers a referral option to participants via a response card that every participant must turn end at the end of the first session.
    - Warren County Public Schools have implemented the SOS program in 3 high schools, 1 middle school and 1 day treatment facility to date to a total of 880 students. 73 students requested follow up, and 32 referrals were made immediately following SOS implementation and follow up.
    - Additional implementation is planned for Spring 2009 at 4 high schools and 1 middle school. QPR training has been delivered at 9 schools throughout 2008, custodians and family/youth resource coordinators throughout district. QPR training is planned for one additional school in March 2009.
    - Owensboro Public Schools are currently implementing (December 2008) SOS at 1 school and will complete that implementation in January 2009 (total number of students participating estimated at 51). Implementation at 1 additional middle school and 1 additional high school is planned for January/February 2009 for a total of 861 students. Approximately 660 staff members have already been trained in QPR. QPR update will be delivered prior to implementation of SOS for each school.
    - Daviess County Public Schools implemented the SOS program in 1 high school to date, to a total of 150 students. Five students request follow up and referrals were made for each of the five. An additional implementation is planned for another Daviess County high school in Spring 2009. QPR training is ongoing.
    - SOS program information has been distributed to approximately 115 school-associated personnel representing at least 100 Kentucky schools, representing 57 Kentucky counties at their request.

## GOAL, 2 *ENHANCE SUICIDE CRISIS INTERVENTION AVAILABILITY, QUALITY AND PUBLIC AWARENESS OF SERVICE*

- This goal has presented unanticipated challenges.

- Each of the 14 mental health districts in Kentucky have 24-hour crisis lines, with at least two having Lifeline accreditation.
- However, the Crisis and Information Service in Louisville is Kentucky's only accredited Lifeline which has staffing and equipment dedicated to actively receiving Lifeline calls.
- In year 2 and year 3 of the grant, supportive grant funds have been allocated to enhance the sustainability of this critical service.
- The ability to enhance other CMHC crisis lines toward accreditation and participation in the Lifeline system is finding difficulty in the wake of Statewide budgetary concerns.
- Despite this unanticipated barrier toward additional Lifelines, progress has been made in dissemination of information about the National Lifeline number during the Kentucky State Fair Booth and the Suicide Prevention week; a large number of the total 45,000 plus pieces distributed included both Lifeline magnets and symptom cards which contain the Lifeline number.

### *Goal 3, Increase local community collaboration in suicide prevention.*

- Kentucky currently has 10 local suicide prevention coalitions. In each of these both KSPG and MHDDAS has played a significant support role: Ashland, Bowling Green, Bullitt County, Lexington, London, Louisville, Nelson County, Northern Kentucky, Owensboro, and Somerset.
- In at least two recent developments, Bullitt Count and Nelson County have grown out of response to local contagion issues.
- Immediate future plans include a Kentucky Suicide Prevention Coalition Summit in April or May of 2009; development of a coalition tool kit and grassroots development guide in cooperation with the SPRC's "Suicide Prevention: Community Core Competencies Course".

### *Goal 4, Establish and increase support for suicide survivors through postvention and prevention.*

- Three local Survivors of Suicide Day Conferences were hosted on November 22: Louisville, Lexington, and Paducah.
- QPR training/survivor resources among funeral directors
  - One trainer recently trained is a funeral director who has taken the initiative to obtain continuing education credit for funeral directors in Kentucky for QPR training,
  - During these trainings funeral directors will also be exposed to postvention resources for survivor families impacted by suicide
  - Because many funeral directors also serve as coroners in Kentucky communities, during QPR trainings coroners will be encouraged to participate in the online death

reporting system being launched by the KVDRS (Kentucky Violent Death Reporting System

- Survivor Guides
  - Bob Robey, a member of the Owensboro suicide prevention coalition has developed a survivor guide, a resource designed to be given to new survivors by first responders and funeral directors
  - This survivor guide provides contact information for a newly forming survivor network with whom survivors can interact either face to face, by phone and through listserv.
  - The guide also provides normalizing and support information
  - Evaluation efforts will monitor the number and location of distribution of the guides; efforts will be devised for obtaining survivor feedback regarding the helpfulness of the guide
  - It is anticipated this effort will help pave the way for more comprehensive efforts in the form of LOSS teams.
- Year 1 of KASS, Kentucky Awareness of Suicide Survey, was conducted in August 2007.
  - Recent Analyses have focused on using KASS data to determine definitional issues around who is a survivor
    - Personal Experience with Suicide
      - 64% (197) knew at least one person who had attempted or died by suicide; average number = 5
      - 40% (123) knew at least 1 person who had died by suicide; average age of person who died=35.3
      - Asked question: "Do you consider yourself to be a survivor of suicide. That is, someone whose life has been personally affected by a suicide?"; 33.8% (n=104) responded affirmatively
    - Relationships to person who died: 9 Most common relationship categories:

| Category | % (n) |
|---|---|
| Friend | 36.3 (45) |
| Cousin | 8.1 (10) |
| Extended Family | 5.6 (7) |
| Friend's Family | 5.6 (7) |
| Uncle | 5.6 (7) |
| Co-Worker | 4.0 (5) |
| Acquaintance | 4.0 (5) |
| Brother-in-law | 3.2 (4) |
| Neighbor | 3.2 (4) |

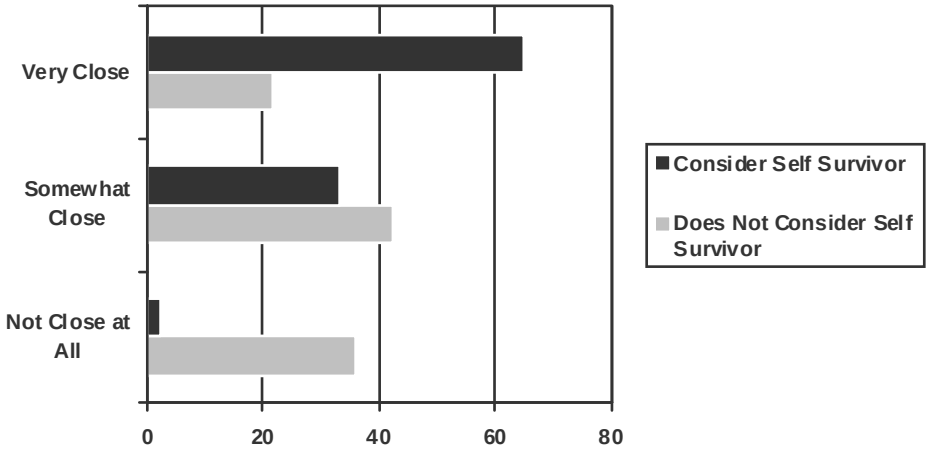
- Relationship Compared to Survivor Status

| Relationship | Percent who experienced death in category who consider self survivor (n=62, 66%) |
|---|---|
| Friend | 51.2 |
| Cousin | 66.7 |
| Extended Family | 57.1 |
| Friend's Family | 28.6 |
| Uncle | 28.6 |
| Co-Worker | 40.0 |
| Acquaintance | 0.0 |
| Brother-in-law | 75.0 |
| Neighbor | 25.0 |

- Relationship to decedent does not appear to predict survivor status
- Relationship of survivor status to demographics

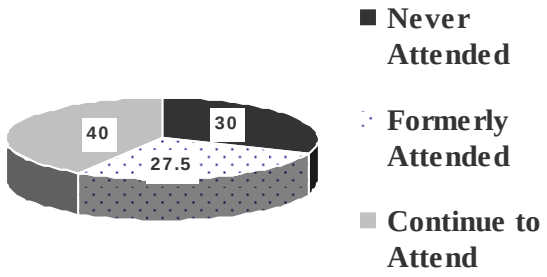
o Survivor status related to:
  - Age of decedent: Survivor x=36.05±15.5 vs. Non x=37.4±19.5, Not Significant (NS)
  - Age of respondent: Survivor x=50.8±16.5 vs. Non x=54.8±14.2, NS
  - Sex of respondent: NS
  - Race of respondent: NS
  - Educational Level of respondent: NS
  - Demographics do not seem to predict survivor status

o Comparison of Survivor Identification & Closeness with Decedent

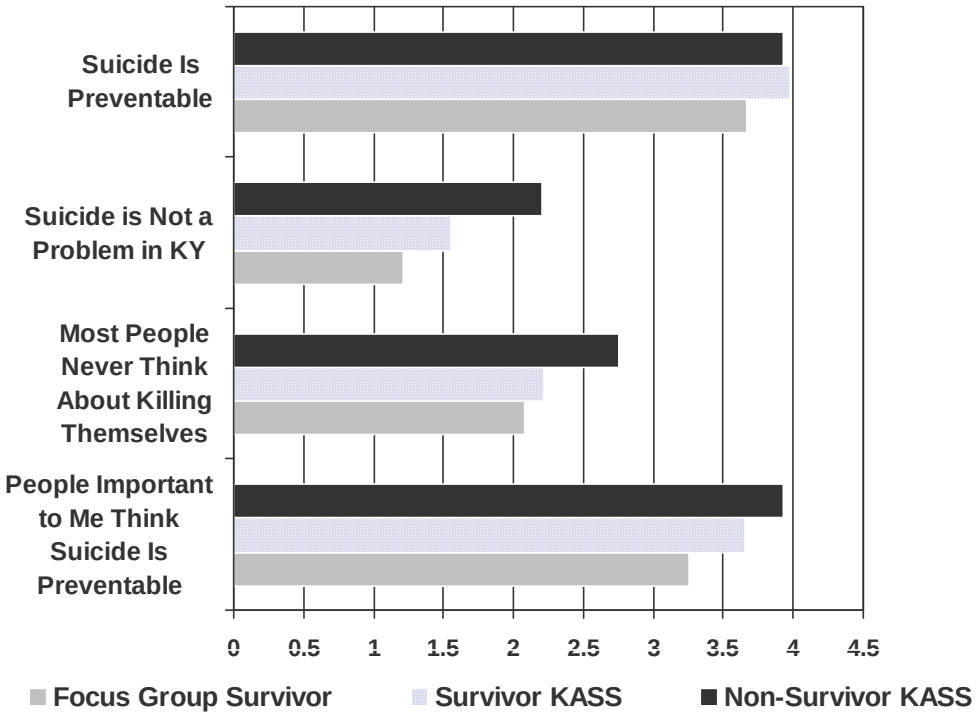



$\chi^2$ (2)=50.3, p<.001

    - Essential feature of who is survivor appears to be more related to closeness and not type of relationship
- How do survivors compare to general public?
    - Age: 50.05 vs. 54.18 , t(298)=2.15, p<05: slightly younger
    - Sex: 74% female vs. 68.2% female NS
    - Race: 87.5% white vs. 91.1% white NS
    - Live in rural county: 42.3% vs 45.5% NS
    - Education: 52.9% high school or less vs. 44.4% NS
    - Income: 69.2% under 50,000 vs. 54.0%, ⍰2=5.46, p<.05; slightly lower income
- Focus Groups with Survivors and Professionals
    - Purpose is to find out more about survivor's needs in Kentucky
    - Also conducting focus groups of professionals who work with survivors
    - Recruited via word of mouth from survivor support groups across state, annual National Survivors of Suicide Day events, and word of mouth from members of Kentucky Suicide Prevention Group
    - Participants
        - 40 survivor participants total completed questionnaires
        - 18 survivor participants completed focus groups sessions
        - 14 professions completed focus group sessions and questionnaires
        - Average age 52.0 (range 19-86, sd=14.5)
        - 62.5% female
        - Participants' participation in SOS groups




Attitudes about Suicide Prevention- KASS Survivors, Non-Survivors and Focus Group Participants




- Next Steps for Focus Groups
  - Continuing to conduct focus groups
  - Analyze qualitative data
  - Hope that findings will inform state activities

## *Goal 5, Increase resiliency among youth at risk.*

- Coping and Support Training (CAST) – training implemented in December 2007 through SPYCE grant
  - Warren County Public Schools has implemented CAST at 2 high schools and is currently implementing at 1 day treatment school, for 22 students in total. In addition to new CAST groups at these 3 schools in 2009, implementation will begin in Spring at 3 additional schools.
  - Owensboro Public Schools has implemented CAST at 2 groups at 1 high school for 12 students in total. Two additional CAST groups are planned to begin in 2009 (beginning January and March) for an estimated total of 16 students.
  - Daviess County Public Schools implemented 4 CAST groups in total at the high school and alternative school for 29 students. Two additional CAST groups are planned to begin in Spring 2009.
- Reconnecting Youth (RY) classes – training implemented in June 2008 through SPYCE grant
  - Warren County Public Schools are currently implementing RY at 3 high schools and 1 day treatment school for 64 students in total. Additional classes are planned upon completion of the current RY classes.

- Owensboro Public Schools are implementing RY classes at an alternative school and a middle school (to be completed in December 2008) for a total of 67 students. Implementation for an additional class is planned for Spring 2009 for an estimated 8 students.
- Daviess County Public Schools - RY data is not available at this time.
- Lion's Quest Skills for Adolescence (an evidence-based life skills program similar Other to RY; on SAMHSA registry) – training implemented in 2008 through Owensboro Public Schools
- Owensboro Middle School found this program to be a better fit for their middle school students and has implemented with 3 targeted groups of 7th and 8th graders in daily classes during 3 separate six-week sessions.

### *Goal 6, Enhance existing emergency department services for youth and their families to increase culturally and linguistically-sensitive training regarding ways to reduce future self-injurious behavior through reduction of lethal means and by reducing stigma to seek treatment.*

- Based on an extensive summary of suicide prevention strategies, Mann, et al. (2005) cited means restriction specifically as one of the strategies which had demonstrated efficacy support in the literature.
- After discussions with the Kentucky Hospital Association, staff members at several area hospitals, current efforts are underway to advance a means restriction strategy.
    - A 90 minute general training has been developed for Healthcare providers and general public around practical steps anyone can take to increase the environmental safety of someone who may be in a vulnerable mental health state.
    - MHDDAS is attempting to develop relationships with local healthcare facilities to disseminate the NAMI brochure series: "After an Attempt". The series contains brochure specific information for: the attempt survivor, family members of the attempt survivor and the healthcare provided.
    - Development of a professionally made brochure which provides practical steps for family members in creating a safer environment during mental health treatment.
    - IRB proposal has been written and pending approval for a study involving Kosair Children's Hospital and Baptist Northeast Hospital Emergency Departments around survey results on staff knowledge and attitudes toward adolescent suicides and the existing means restriction protocols in these locations. Further, focus group discussions will take place with staff to better understand potential training needs and barriers in order to design a training format to better support emergency department staff.

### *Goal 7, Provide additional training in clinical suicide risk management to medical/mental health professionals and paraprofessionals across the state.*

- Increased awareness and early intervention creates an anticipated increase demand for services. Multiple research findings, as well as antidotal personal reports, indicate an overall deficiency in training for clinicians around assessing, management and treatment of suicidal clients.
- The average clinician receives very little pre-licensure academic training around suicidality, typically about two hours of didactic training so it is not skilled based. Most training comes in post-licensure continuing education formats.
- One of the main efforts since October 1, 2007, with the new suicide prevention coordinator has been to address this issue through the provision of evidenced based training for clinicians.
- Training results:
    - Clinical training workshops have been conducted by the prevention coordinator for over 700 licensed mental health professionals, school counselors, case workers, etc. in the area of suicide assessment, management, treatment and means restriction.

| **Title of training** | **Total Attended** |
|---|---|
| Adolescent Suicide | 175 |
| Evidence Based Care for a client at-risk for suicide | 160 |
| Identifying Clients at-risk for suicide | 25 |
| Safety Talks | 230 |
| Working with the Suicidal Client | 188 |
| Total Sum of # attended | 778 |

    - MHDDAS staff and the grant Technical Marketing Specialist have also made presentations at numerous professional conferences across the state.

## 2009 Goals and Objectives

1. Promote awareness that suicide is a public health problem that is preventable.
    a. Continue an ongoing public awareness campaign.
    b. Continue statewide public awareness media events utilizing our partners annually, including suicide prevention week
    c. Develop and distribute resources on developing and maintaining community coalitions.

    d. Continue to provide QPR training, assist trainers and promote opportunities for QPR training
2. Develop a broad-based support for suicide prevention
    a. Increase membership base for KSPG; mentor leaders
    b. Provide welcoming atmosphere, newcomers packet, orientation
    c. Plan for long-term plan for independent sustainability
3. Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention suicides
    a. Increase collaboration with existing events in which suicide prevention can play a role.
    b. Host statewide events.
    c. Awareness week event
    d. State Fair
4. Develop and implement suicide prevention program
    a. Indentify gaps in suicide prevention efforts for targeted population
    b. Outreach to targeted communities/counties with highest suicide rates and/or communities in crisis
    c. Identify and examine ways to increase services and outreach for survivors
    d. Continue exploration of active postvention for KY communities
5. Promote efforts to reduce access to lethal means and methods of self-harm
6. Implement training for recognition of at-risk behavior
    a. Develop and promote effective clinical and professional practices
    b. Create web link to SPRC best-practice registry and other national organizations
    c. Identify and promote training opportunities
7. Increase access to and community linkages with mental health and substance abuse services
    a. Encourage Community Mental Health Center to participate in local suicide prevention efforts.
    b. Encourage the establishment of a suicide prevention specialist in each CMHC
    c. Assist and support established or new non-profit prevention partners
    d. Identify funding resources for local coalitions
8. Improved reporting and portrayals of suicide behavior, mental illness, and substance abuse in the entertainment and news media
    a. Continuing to grow marketing efforts
9. Promote and support research on suicide and suicide prevention
    a. Establish and maintain an evaluation system for all KSPG objectives
    b. Create and maintain a registry of intervention and postvention activities in the state.
10. Improve and expand surveillance systems
    a. Collaborate with KVDRS through its developing Web-Based system to identify more quickly areas in need of prevention and postvention supports due to recent suicide deaths.
    b. Advocate for KVDRS' strategic roll in suicide prevention efforts

# IV: Narrative Plan

## K. Technical Assistance Needs

Page 46 of the Application Guidance

Narrative Question:

Please describe the data and technical assistance needs identified by the State during the process of developing this plan that will be needed or helpful to implement the proposed plan. The technical assistance needs identified may include the needs of State, providers, other systems, persons receiving services, persons in recovery, or their families. The State should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

Footnotes:

**IV: Narrative Plan**
**K. Technical Assistance Needs**

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**Creating a Behavioral Health Planning and Advisory Council**
Kentucky has a strong Mental Health Planning and Advisory Council that has been active for many years. This Council includes representation from statewide stakeholders, including providers, consumers, family members and other vested state and advocacy organizations.

Prior to the current year changes in the Federal Block Grant "strongly encouraging" a Behavioral Health Planning and Advisory Council, DBHDID had already begun to communicate about this idea. The current Council has identified individuals with Co-occurring disorders to be a priority population and agreed that the Council needed to represent all behavioral health populations.

However, assistance is needed to guide the Council and the Department in the best way to incorporate all of these populations and their needs into a Behavioral Health Planning and Advisory Council, while at the same time being mindful of our financial, geographical and spatial limitations.

**Behavioral Health Managed Care**
Kentucky's behavioral health public service arena has not experienced Managed Care before, except in the small region in Central Kentucky being managed by Passport Health Care. DBHDID has already received some technical assistance in this area, regarding contract language with CMHCs, Medicaid and Managed Care companies. However, more work will be necessary to ensure indigent consumers with behavioral health issues receive timely, quality behavioral health services.

**Substance Abuse Treatment**
Kentucky has been in communication with SAMHSA staff to increase the Department's understanding of the requirements and appropriate steps to take in order to comply with Tuberculosis expenditure methodology for substance abuse clients. Additional technical assistance is needed to ensure that Kentucky is in compliance.
Subsequent to the discussions with SAMHSA staff, the Division currently has plans to add the following to our process for determining the percentage of TB expenditures spent on individuals in substance use disorder treatment:

- Enter into a Memorandum of Understanding with the Department for Public Health (DPH) to obtain individual-level DPH tuberculosis client data.
- Request from DPH on an annual basis a list using unique identifiers of the individuals receiving TB treatment in Kentucky.
- Match the individuals receiving TB treatment with the individuals receiving SA treatment in our state data set.

- Calculate the percentage of the overall TB expenditures which were spent on individuals also receiving SA treatment.

# IV: Narrative Plan

## L. Involvement of Individuals and Families

Page 46 of the Application Guidance

Narrative Question:

The State must support and help strengthen existing consumer and family networks, recovery organizations and community peer advocacy organizations in expanding self advocacy, self-help programs, support networks, and recovery-oriented services. There are many activities that State SMHAs and SSAs can undertake to engage these individuals and families. In the space below, States should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the State mental health and substance abuse treatment system. In completing this response, State should consider the following questions:

- •How are individuals in recovery and family members utilized in the development and implementation of recovery oriented services (including therapeutic mentors, recovery coachers and or peer specialists)?
- •Does the State conduct ongoing training and technical assistance for child, adult and family mentors; ensure that curricula are culturally competent and sensitive to the needs of individuals in recovery and their families; and help develop the skills necessary to match goals with services and to advocate for individual and family needs?
- •Does the State sponsor meetings that specifically identify individual and family members? issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
- •How are individuals and family members presented with opportunities to proactively engage and participate in treatment planning, shared decision making, and the behavioral health service delivery system?
- • How does the State support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Footnotes:

## IV: Narrative Plan
## L. Involvement of Individuals and Families

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*•Does the State sponsor meetings that specifically identify individual and family members, issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?*
*•How are individuals and family members presented with opportunities to proactively engage and participate in treatment planning, shared decision making, and the behavioral health service delivery system?*
*• How does the State support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?*

Kentucky's Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) staff feels strongly about supporting and strengthening consumer and family networks, recovery organizations and community peer advocacy organizations to promote self advocacy, self-help programs, support networks, and Recovery-Oriented Systems of Care across all services and in all areas of the Commonwealth. While there is a desire to enhance integration and collaboration across specific populations served, there are some distinct activities best described by populations. To this end, the following provides information about the current activities and future plans.

**Adults with SMI**
Since the mid-1980s, DBHDID has been committed to consumer and family involvement in program development and service delivery as a strategy for strengthening informal community supports. This focus has empowered consumers and family members to become more active in assisting Department staff in developing policies, monitoring and providing technical assistance to local programs, and evaluating requests for funding. The Division of Behavioral Health was directed by leadership to convene a workgroup in SFY 2009 with the goal of redesigning the consumer affairs function within the Division. A framework for a redesign of the consumer affairs office was developed.

During SFY 2010, the Division of Behavioral Health began working to implement recommendations. Department leadership agreed to hire a full time "Recovery Services Coordinator," who is a self-identified consumer of behavioral health services and who is a part of the Division's management team. Department staff as well as consumers gave input on the job description for this individual. In February 2011, a Recovery Services Coordinator was hired. The Recovery Services Coordinator is responsible for introducing and supporting recovery-oriented initiatives throughout Kentucky. He collaborates with the entire Division of Behavioral Health, including the Adult Mental Health Services Branch, the Children, Youth and Family Services Branch, the Substance Abuse Treatment Branch and the Prevention Branch. DBHDID partners with private/public organizations to foster recovery-oriented treatment as a normal expectation for providers, consumers and family members.

One of the first things done during the reorganization of recovery services was to redefine "Recovery" in a way to encompass multiple population groups. DBHDID now defines Recovery as the following: ***Recovery begins with the positive expectation that all individuals can successfully overcome emotional distress, mental health disorders and/or substance abuse disorders, and move forward in a meaningful way toward a purposeful, independent life of their own choosing. Recovery asserts that early engagement can prevent or ameliorate negative consequences. When consumers are provided resources in a manner unique to their personal circumstances, they will ultimately make healthy choices. Recovery requires a shift in focus from a maintenance model to a model built around expectations of functional independence. Furthermore, recovery-oriented treatment operates from the fundamental assumption that people can have occasional setbacks in their recovery journey, but that their overall movement is toward health and productive, engaged independence. Five key elements of recovery are hope, self-direction, strength based treatment, community engagement and meaningful activity.***

The Department currently provides funds for a variety of statewide and local consumer and family support initiatives. These initiatives are focused on goals related to discrimination reduction, wellness and recovery programs, peer support, education and training, and consumer advocacy. During SFY 2010, Division staff used consumer recommendations to create revised Requests for Proposals (RFPs) to solicit more targeted "deliverables" than in previous contract cycles. Two contracts were awarded for: 1) Recovery-Oriented Training and Technical Assistance and 2) Recovery-Oriented Family Support Services. Both are supported with CMHS Block Grant funds.

The Recovery-Oriented Family Support Services contract was awarded to NAMI Kentucky and includes requirements for providing quality family support groups across the state. NAMI Kentucky is contracted to provide at least one instructor training per year for the "family to family" support training. This contract also required the provision of leadership in advocacy activities including collaboration with other organizations in supporting improved and evidence-based practices such as Supported Employment, stigma reduction and mental health recovery. New to this contract was the provision of regional educational symposiums, based on the assessed needs and requests of local populations. During SFY 2011, a statewide instructor training for "Family to Family" was held. NAMI Kentucky partnered with DBHDID to host "Community Conversations" across the state, to assist with a Supported Employment pilot project in four (4) regions of the state, and to provide seven (7) regional educational symposiums. In addition, NAMI Kentucky created a listserv for statewide providers, consumers and family members, to promote recovery and community integration.

The Recovery-Oriented Training and Technical Assistance contract required the development of a Technical Assistance Center and the provision of recovery oriented trainings across the state. Contractors gathered stakeholders from across the state, including consumers, family members and providers, and developed consensus for the formation of Kentucky System Transformation, Advocacy, Recovery and Support (KY STARS), a training and technical assistance center focusing on recovery-oriented mental health services. During SFY 2011, KY STARS provided education to consumers in state psychiatric hospitals, consumers in treatment at local CMHCs, staff of two state psychiatric hospitals and the fourteen CMHCs, and to Leadership Academy graduates, and credentialed Kentucky Peer Specialists. KY STARS provides technical assistance for consumers of peer run programs and for the staffs of the CMHCs and the state psychiatric hospitals. In addition, KY STARS worked to expand the number of peer to peer

support groups available across the state and worked to train peers as facilitators of activities that are considered best practices.

The Recovery-Oriented Training and Technical Assistance is contracted to provide a three-day Leadership Academy, a three-day educational program for persons with a mental illness who have a desire and interest in developing and improving their leadership and advocacy skills. The Leadership Academy consists of two training levels; Level I offers general skills training and practice and Level II is a Train-the-Trainers format, teaching the skills of leading local groups. Graduates of the Leadership Academy (I and II) are able to:

- Enhance their communication skills;
- Identify and assess community issues and needs;
- Create, develop and participate in group action plans;
- Organize local advocacy groups into a respected and effective voice on mental health issues; and
- Participate on boards, councils and commissions as consumer representatives.

During SFY 2011, two (2) Leadership Academy trainings were held, one in Louisville and one in Bowling Green, Kentucky. Instructors for these trainings are Kentucky Peer Specialists. The goal for SFYs 2012 and 2013 is to continue to provide at least two (2) Leadership Academy trainings per year. Many behavioral health consumers have reported that this specific training has been the start of their journey to recovery.

During SFY 2011, KY STARS met with staff at Western State Hospital to assist with implementation of a “Recovery Mall” as part of the services offered to inpatient mental health consumers. This program was modeled after the Recovery Mall at Eastern State Hospital and Appalachian Regional Hospital. Thus, to date, three of the four state psychiatric hospitals have Recovery Malls, which are designed to improve patient self-direction and functional life skills.

Since April 2007, Leadership Academy graduates have attended meetings and participated on Eastern State Hospital’s Recovery Mall Leadership Council. These graduates assist the attendees at the Council meetings in learning recovery skills and in learning how to conduct effective meetings, benefitting both the residents at Eastern State Hospital who are working on their own recovery, as well as the Leadership Academy graduates who are utilizing their newly learned skills.

Eastern State Hospital has recently initiated a service delivery transformation process designed to foster recovery throughout the facility. Appalachian Regional Hospital hired a Kentucky Peer Specialist approximately three (3) years ago. This is the first peer support service offered by this hospital, and the Peer Specialist has received rave reviews. During SFYs 2012 and 2013, KY Peer Specialists and Leadership Academy graduates will make efforts to further support Western State Hospital and Recovery Mall programming.

Kentucky Peer Specialist Training is an intensive training program for persons with a mental illness who have a desire to learn more about the recovery process and how to help others move forward in their own recovery process. The training program was modeled after the Georgia and South Carolina models of Peer Support.

While Kentucky peer to peer services are not currently Medicaid reimbursed, DBHDID continues to train consumers and work with KY Medicaid to change this. In November 2010, Larry Fricks and Ike Powell facilitated a one-day training event, focusing on the "whole health" aspect of peer support. The event was co-sponsored by Seven Counties Services, Inc. (the CMHC the Louisville area and 15 surrounding counties) and DBHDID and twenty (20) Kentucky Peer Specialists attended. In April 2011, eighteen (18) "new" participants attended Level I Peer Support Training at Blue Licks State Park. The goal for SFYs 2012 and 2013 is to reorganize the Peer Specialist Training curriculum and continue to provide credentialing for peers in Kentucky.

Part of the reorganization has begun, with training expanding to a minimum of a two week program, with one core module and additional module offerings. After completing an extensive application process, candidates will be required to successfully complete a one week (40 hours) core module. This core module will include an introduction to Recovery concepts, ethics, listening skills, Wellness Recovery Action Plan (WRAP) services, a brief introduction to Motivational Interviewing, how to navigate the social services network, the five stages of recovery and an introduction to whole health. Candidates who successfully complete this module will be offered the opportunity to complete modules around Mental Health and/or Substance Abuse. This module will be approximately one week (30-40 hours) in length. The Substance Abuse module will be approximately one week (30-40 hours) as well. At the completion of these modules (the core module plus either Mental Health, Substance Abuse, or both) individuals will be awarded a provisional certificate. When individuals complete an internship consisting of one hundred, twenty (120) hours of supervised peer support services, a full certification will be provided. To maintain this certification, Kentucky Peer Specialists will be required to complete a minimum of two (2) continuing education units per year. DBHDID will assist with offering continuing education opportunities.

The DBHDID and the CMHCs encourage consumer and family member participation in planning, monitoring, and service delivery. Consumers participate in treatment planning processes and sign their treatment plans. To build on existing strengths and improve existing weaknesses, plans are to:

- Continue to involve consumers and family members in the Behavioral Health Block Grant planning process;
- Design programs, trainings, and outcome measures that incorporate recovery principles;
- Implement Supported Employment training to encourage hiring of consumers;
- Encourage the growth of consumer run services;
- Continue to encourage statewide consumer participation at all planning events; and
- Make Recovery Model training available in all CMHC regions.

During SFY 2011, DBHDID collaborated with Mental Health America – Kentucky in providing a one-day workshop regarding Evidence Based Practices utilization and fidelity. This event was well attended by providers all over the state. Another workshop is scheduled, again with the support of Mental Health America – Kentucky for SFY 2012. DBHDID is also working on a statewide training initiative involving Mental Health First Aid, a training designed to sensitize individuals to mental health symptomontology and support, particularly to stigma. The goal for

SFYs 2012 and 2013 is to more clearly define this initiative and the target audience(s) and to provide this training statewide.

While the DBHDID and the CMHCs have come a long way in fostering consumer and family member participation in planning, monitoring, and service delivery, many challenges remain, including:

- Lack of dedicated funding for consumer run services;
- Few programs that fully incorporate recovery principles;
- Limited number of consumer run services that can serve as "mentor" programs; and
- Persistent transportation barriers for individuals to attend meetings and other events.

In keeping with SAMHSA's long standing principle that "Recovery from mental illness is the expectation, not the exception," DBHDID will continue to enlist state government entities, consumers, family members, friends, providers, community leaders including faith based initiators, educators and emergency service personnel to recognize mental illness and substance abuse as diseases from which people can and do recover.

**Substance Abuse Treatment**

A cornerstone in effective recovery from substance use disorder is a strong sponsor. Someone who's "been there" and can provide the support necessary. The Department collaborates with various organizations committed to peer-based recovery and contracts with one statewide entity, People Advocating Recovery, to promote recovery principles and provide education and consultation to a wide variety of stakeholders. PAR is guided by a volunteer board of directors.

People Advocating Recovery (PAR) operates a Recovery-Oriented Training and Technical Assistance Center that has been instrumental in providing services and supports to individuals in all stages of recovery; their family members and friends; along with staff, programs, public, quasi-public and private organizations and other entities that influence recovery services within Kentucky. Training is based on nationally recognized recovery principles and best practices, and technical assistance focuses on incorporating recovery-oriented principles into existing programming and staff training within Kentucky. The Center has developed informational materials (e.g., pamphlets, brochures, website) outlining available substance abuse prevention and recovery services.

Opportunities available through PAR include trainings and support activities, utilizing established training modalities and curricula that represent best practices in the area of recovery-oriented services. Participants generally include people in recovery, providers of services for people in recovery, policymakers, and others who could benefit in learning more about recovery. Training topics include:

- Orientation to recovery principles and practices;
- Communicating recovery (Recovery Messaging);
- Co-occurring disorders and integrated services;
- Client rights (as set forth by the Legal Action Center);
- Effective advocacy; and
- Recovery coaches' training and certification.
-

In addition to the training opportunities, PAR offers support groups and contributes to the website **www.carebetter.org**. The Executive Director of PAR is a founding member of the

Association of Recovery Community Organizations. He is also a board member of Faces and Voices of Recovery.

The Sobriety Treatment and Recovery Team (START) program, in which DBHDID partners with the Department for Community Based Services (child welfare), employs people in recovery from addiction as Family Mentors who use their life experience to engage families, involved with child protective services and are engaged in or in need of substance abuse treatment. Family Mentors provide recovery coaching, aid in navigating the child welfare system, and support sober parenting for parents with substance use disorders and have open child maltreatment cases. The START program also collaborates with People in Recovery, community groups, and community partners to develop and support community/based, recovery supports. START has helped get 12-Step and faith-based recovery support groups going in the community, has organized town hall meetings to educate the community about addiction and recovery, and has set up recovery celebrations to raise awareness in the community about the power of recovery. START has also fostered the development of two recovery advocacy group chapters in small communities in Appalachian regions of the Commonwealth.

**Substance Abuse Prevention**

The Prevention Branch is making a concerted effort to expand its reach beyond needs in substance abuse prevention and tobacco use cessation. Adopting “Whole Health” and recovery orientations, the Prevention Branch is identifying areas of engagement and commonality with the Adult Behavioral Health Services Branch and the Children and Families Behavioral Health Services Branch. During SFY 2012, the Recovery Services Coordinator will be presenting at Prevention’s conference on the “Convergence of Mental Health and Substance Abuse Treatment.”

**Children with SED**

It is the belief of DBHDID that parents’ voices should help shape not only individual treatment decisions, but also program development and policy determinations at the local, regional, and state levels. This principle is strengthened by the advocacy efforts of parents at various points in the system of care. In support of this vision, significant portions of state general funds and approximately 20 percent of the children's portion of CMHS Block Grant funds are allocated to youth consumer and parent initiatives at each level.

Across all regions of Kentucky, parents’ voices are most consistently heard through their membership on Local and Regional Interagency Councils. These Councils are responsible for the identification of children with SED and for coordination of the services that they receive. These representatives also make up the State Family Advisory Council (SFAC), which serves in an advisory capacity to the State Interagency Council to Children with an Emotional Disability (SIAC).

The majority of regional IMPACT programs, which serve children with SED and their families, also have staff positions of “Family Liaison.” These individuals provide peer-to-peer mentoring, facilitate the creation and maintenance of local parent support groups/family network activities, provide education and offer technical assistance on a variety of topics to families and service providers.

A review of the information from the SFY 2012 Annual Plan and Budget applications submitted by Regional Boards reveals that there are ongoing efforts to maintain and increase consumer/family involvement at all levels of the service system, including:

- Parents participating on Regional Planning Councils in all fourteen regions and serving on various regional and state level policy and program development committees;
- A growing number of “grandparents raising grandchildren” support efforts;
- Regions creatively building their consumer networks and providing for parent input into programming and future planning for children’s programming;
- At least one parent support group is active in thirteen regions and there are eight support groups across the state for transition age youth;
- A parent newsletter is regularly published in eight regions;
- A resource library either dedicated for use by parents or available to parents and staff in ten regions;
- Parents acting as evaluators for several initiatives and participating in focus groups to analyze gathered data; and
- Provision of parenting skills training for parents/family members, and sponsored “family fun events” for children and families, in most regions.

Opportunities for Family Leadership (OFL) is a unit within DBHDID which offers a resource line for parents and caregivers. The resource line connects families with the OFL program, which is a first step for accessing education, resources and support. The toll free number for the resource line is (800) 374-9146. OFL provides numerous services for families and the systems that serve them, including:

- Training in advocacy, communication, cultural competency, collaboration and legal rights in schools;
- Awarding mini-grants for parent support groups to develop local training events and provide community resource libraries. Over 250 training events were funded in SFY 2011 and the same is expected for SFY 2012;
- Providing technical assistance to ensure Standards of Practice for Family Liaisons and Kentucky Family Peer Support Specialists across the state are met and approving required trainings per the Standards of Practice;
- Awarding mini-grants for parent support groups to develop local training (over 200 training events were funded in SFY 2011 and the same is expected for SFYs 2012 and 2013);
- Providing technical assistance to ensure Standards of Practice for Family Liaisons across the state are met and approving required trainings per the Standards of Practice;
- Distributing reader friendly versions of Client Rights and Grievance Procedures, and supporting documents to parents and others to ensure that these policies and procedures are understood by everyone; and
- Providing technical assistance to organizations and individuals with regard to children’s mental health, intellectual disabilities and substance abuse services and supports. Resource information and training opportunities are among the many items provided on OFL’s web site at **http://mhmr.ky.gov/mhsas/OFL.asp**.

The Kentucky Partnership for Families and Children (KPFC) is a statewide organization dedicated to improving services for children with emotional, behavioral and/or mental health disabilities by providing support, education and advocacy to youth and families. There are over 1,500 members statewide. Their Board of Directors is comprised of 30 members, with 60% being parent representatives. Activities of the KPFC include:

- Dissemination of printed information and a quarterly newsletter;
- Participation on numerous interdisciplinary committees;
- Operation of a web site (www:kypartnership.net) and a toll-free phone number (800-369-0533) for parents to access information about KPFC and resource information statewide;

- Distribution of scholarships for parents and youth to attend conferences and other advocacy events;
- Formation of a statewide Youth Council comprised of 14-25 year olds who have an emotional disability/mental illness;
- Creation and Facilitation of Family Leadership Academy and Family Peer Support Specialist Training; and
- Formation of Regional Youth Councils in partnership with Regional Boards to replicate the statewide council.

# IV: Narrative Plan

## M. Use of Technology

Page 47 of the Application Guidance

Narrative Question:

Interactive Communication Technologies (ICTs) are being more frequently used to deliver various health care services. ICTs are also being used by individuals to report health information and outcomes. ICT include but are not limited to: text messaging, etherapy, remote monitoring of location, outreach, recovery tools, emotional support, prompts, case manager support and guidance, telemedicine. In the space below, please describe:

a. What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?
b. What specific applications of ICTs does the State plan to promote over the next two years?
c. What incentives is the State planning to put in place to encourage their use?
d. What support systems does the State plan to provide to encourage their use?
e. Are there barriers to implementing these strategies? Are there barriers to wide-scale adoption of these technologies and how does the State plan to address them?
f. How does the State plan to work with organizations such as FQHCs, hospitals, community-based organizations and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine?
g. Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?
h. What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs?

Footnotes:

**IV: Narrative Plan**
**M. Use of Technology**

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a. *What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?*
b. *What specific applications of ICTs does the State plan to promote over the next two years?*
c. *What incentives is the State planning to put in place to encourage their use?*
d. *What support systems does the State plan to provide to encourage their use?*
e. *Are there barriers to implementing these strategies? Are there barriers to wide-scale adoption of these technologies and how does the State plan to address them?*
f. *How does the State plan to work with organizations such as FQHCs, hospitals, community-based organizations and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine?*
g. *Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?*
h. *What measures and data collection will the State promote for promoting and judging use and effectiveness* of *such ICTs?*

Interactive Communication Technologies (ICTs) are used in many ways, in Kentucky's public behavioral health system, to affect both the service delivery and information processes.

On December 1, 2003, **907 KAR 3:170E Telehealth Services and Reimbursement** became effective as a state regulation. This regulation allowed CMHCs to provide some services (diagnostic interview examination, medication management, outpatient collateral, individual psychotherapy, outpatient family therapy) by telehealth technology. However, these services had to be provided by either a psychiatrist or an advanced registered nurse practitioner (ARNP).

On March 10, 2011, **907 KAR 3:170** was amended to include many more professionals as reimbursable providers, including registered nurses, licensed marriage and family therapists, licensed professional counselors, licensed clinical social workers, psychologists, and psychiatric medical residents. Several CMHCs have begun to use this technology in their service array.

Many CMHCs are interested in this technology but barriers are the cost of equipment and some reluctance from individual professionals to embrace the technology. The four (4) westernmost regions in the state were able to purchase video technology equipment by funding made available through DIVERTS (Direct Intervention: Very Early Treatment System) resources. DIVERTS was specifically designed to decrease state psychiatric hospitalization rates in the Western Kentucky Hospital region. Because of DIVERTS these four (4) regions are farther along in using this technology.

Through a technology sharing agreement with the Department for Public Health (DPH), DBHDID has been able to provide video conferencing for meetings with Regional Boards, training events, and webinars. DPH has many video conferencing sites across the state and

Regional Board staff have been able to share those sites and communicate with the Department and other Regional Boards.

Videoconferencing equipment has been used to provide the Leadership Academy (recovery program for adult consumers) simultaneously at several sites in western Kentucky. It has also been used to provide Continuing Education Units (CEUs) for Regional Board staff and Department staff. Plan for SFY 2012/2013 are to include CEUs for Kentucky Peer Specialists and Leadership Academy graduates, through webinars and other video conferencing, on a regular basis.

DBHDID also has partnered with the Department for Public Health in providing training events in an online forum. Training Real-time Affiliate Integrated Network (TRAIN) is an online program provided by DPH. The Department utilizes TRAIN for several ongoing training events, including case management and service coordinator mandatory training. Manuals and training modules are available for providers to view at any time through this program and TRAIN is also utilized to register and organize participants. Adult case management training was able to be reduced from three (3) days to one (1) day of face to face training with the help of TRAIN.

DBHDID realizes that ICTs are important in providing critical information for treatment, outcomes and education. Goals are to continue to expand utilization and efficiency in technology resources.

# IV: Narrative Plan

## N. Support of State Partners

Page 48 of the Application Guidance

Narrative Question:

The success of a State's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, education and other State and local governmental entities. States should identify these partners in the space below and describe the roles they will play in assisting the State to implement the priorities identified in the plan. In addition, the State should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the State education authority(ies); the State Medicaid agency; the State entity(ies) responsible for health insurance and health information exchanges (if applicable); the State adult and juvenile correctional authority(ies); the State public health authority, (including the maternal and child health agency); and the State child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan. This could include, but is not limited to:

- The State Medicaid Agency 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 the expanded Medicaid population.
- The State Department of Justice that will work with the State and local judicial system to develop policies and programs that address the needs of individuals with mental and substance use disorders that come into contact with the criminal and juvenile justice systems; promote strategies for appropriate diversion and alternatives to incarceration; provide screening and treatment; and implement transition services for those individuals reentering the community.
- The State Education Agency examining current regulations, policies, programs, and key data-points in local school districts to ensure that children are safe; supported in their social-emotional development; exposed to initiatives that target risk and protective actors for mental and substance use disorders; and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
- The State Child Welfare/Human Services Department, in response to State Child and Family Services Reviews, working with local child welfare agencies to address the trauma, and mental and substance use disorders in these families that often put their children at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system.

Footnotes:

**IV: Narrative Plan**
**N. Support of State Partners**

*The success of a State's MHSBG and SAPTBG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, education and other State and local governmental entities. States should identify these partners in the space below and describe the roles they will play in assisting the State to implement the priorities identified in the plan. In addition, the State should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the State education authority(ies); the State Medicaid agency; the State entity(ies) responsible for health insurance and health information exchanges (if applicable); the State adult and juvenile correctional authority(ies); the State public health authority, (including the maternal and child health agency); and the State child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan. This could include, but is not limited to:*

- *The State Medicaid Agency 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 the expanded Medicaid population.*
- *The State Department of Justice that will work with the State and local judicial system to develop policies and programs that address the needs of individuals with mental and substance use disorders that come into contact with the criminal and juvenile justice systems; promote strategies for appropriate diversion and alternatives to incarceration; provide screening and treatment; and implement transition services for those individuals reentering the community.*
- *The State Education Agency examining current regulations, policies, programs, and key data-points in local school districts to ensure that children are safe; supported in their social-emotional development; exposed to initiatives that target risk and protective actors for mental and substance use disorders; and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.*
- *The State Child Welfare/Human Services Department, in response to State Child and Family Services Reviews, working with local child welfare agencies to address the trauma, and mental and substance use disorders in these families that often put their children at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system.*

The KY Mental Health Planning and Advisory Council reviewed a draft of the plan and signed a letter acknowledging this at their August 2011 meeting.

The State Interagency Council for Children with an Emotional Disability signed a Memorandum of Agreement annually.

The Department also has numerous Memoranda of Understanding and Agreements with other state agencies to designate specific agreements for data sharing, service delivery and oversight as well as policy statements.

Department of Juvenile Justice, Cabinet for Health and Family Services, and

Administrative Office of the Courts

With the State Interagency Council (SIAC)

Memorandum of Understanding

In a spirit of cooperation between the Department of Juvenile Justice (DJJ) and the Cabinet for Health and Family Services (CHFS), Department of Mental Health and Mental Retardation, State Interagency Council and Administrative Office of the Courts (AOC) in an effort to provide services to serve the best interests, as well as community safety, of the children of the Commonwealth of Kentucky and their families, the following guidelines are adopted to assist the personnel of each agency in providing the most appropriate services and treatment to children and their families;

All agencies agree that the best interest of the child is the governing factor in interpreting this memorandum of understanding;

Each agency shall not initiate any court action or generate courtroom conflict in violation of the spirit of this agreement;

Each agency shall not act in violation of any statutes, regulations or policies pertaining to the operations or activities of that agency;

The format of the Regional Interagency Councils (RIAC) or the Local Interagency Council (LIAC), when applicable, shall be utilized to review the youth and family's current risk and needs to assist in making the recommendations regarding services for the youth and family. The consultation from the RIAC will be requested by the DCBS or DJJ Case Manager by completing the "RIAC Consultation Request Form" (Attachment A) and sending it to the Local Resource Coordinator (LRC)(see Attachment B). In addition, the RIAC/LIAC shall be available for ongoing case consultation as requested by the DJJ or DCBS Case Manager.
.
The RIAC is made up of representatives of Department of Community Based Services (DCBS), Public Health, Department of Mental Health and Mental Retardation (MHMR), DJJ, AOC, Department of Education and parent representatives. Reference KRS 200.509;

DCBS shall provide DJJ with information related to the youth's and his/her family's active involvement with DCBS. Staff of both agencies shall provide the most current information, required for the referral to RIAC, in the best interest of the child and family to present to the RIAC.

If the DCBS and DJJ representatives involved in the RIAC meetings are not able to resolve internal processes, individual case issues to come to agreed recommendations regarding services for the youth and family, the information from both agencies involving the respective recommendations shall be forwarded through the regional supervisory chain of each agency. If an agreement is not reached at the regional level, then it shall be forwarded to each agency's Central Office to designated individuals within each agency.

For youth with an open DCBS case involving dependency abuse or neglect and pending or adjudicated public offense charges, excluding youth with pending or adjudicated sexual offenses as defined in KRS 635.505 and KRS 17.165, the processes outlined below shall be followed to assist the staff of each agency to resolve issues of care and treatment.

1. The youth's case shall be referred to the RIAC by the DJJ worker within two working days of adjudication. The DCBS worker, if appropriate, shall cooperate in this process by providing the youth and family's historical information regarding the youth and family's current circumstances.

2. The RIAC shall meet to review the youth's case within 30 days of receipt of the referral or sooner if the disposition hearing is scheduled by the court. If the RIAC does not meet prior to the disposition hearing, due the scheduling of such, the youth's case shall be presented at the first available opportunity.

3. The RIAC shall review the information provided and make a recommendation to the DJJ case manager and the DCBS case manager regarding the available services for the youth and family. These recommendations for services shall be incorporated into the dispositional recommendations to the court. The recommendation regarding the services for the youth and family may also include, but not be limited to:

a. Education

b. Vocational

c. Mental health

d. Physical health

e. IMPACT services, if appropriate and available

f. Family interventions

g. Individual youth interventions

4. The dispositional recommendation as to the public offense charges shall be consistent with the assessment and classification process promulgated by DJJ regarding classification of the youth. The classification process shall take into consideration all factors that shall mitigate or aggravate the classification of the youth.

5. Once the recommendations are agreed upon, the DJJ case manager shall prepare the dispositional report for the court following processes outlined in policy. The DCBS case manager may also attend the dispositional hearing to support the recommendation to the court.

6. If the court orders the youth to remain under the supervision of DCBS, the DCBS case manager shall assume case responsibility and shall implement the plan taking into consideration the recommendations of the RIAC. The DJJ case manager shall be available for consultation to assist in the implementation of the youth's ongoing treatment plan. The DCBS case manager shall be responsible for all reports and progress reviews provided to the RIAC.

7. If the court orders the youth is to be probated to DJJ, the DJJ case manager shall assume responsibility for coordinating services and the monitoring of the youth's compliance with the Conditions of Probation. They shall also take into consideration the recommendations of the RIAC. The DCBS case manager shall continue to maintain case responsibility as the primary case manager. The DJJ worker and the DCBS Case Manager shall request a RIAC consultation as needed to assist with the planning of the youth's release/discharge from DJJ probation.

8. If the court orders the youth to be committed to DJJ, the DJJ case manager shall assume case responsibility and shall implement the plan taking into consideration the recommendations of the RIAC. The DCBS case manager shall continue to actively participate in the progress reviews of the specific youth and family. The DJJ/DCBS Case Manager shall request a RIAC consultation as needed to assist with the planning of the youth's release/discharge from DJJ commitment.

9. If DJJ has case management responsibility, the information for the RIAC shall be gathered and presented by the DJJ case manager with other information being presented by other service providers as appropriate. Written progress reports shall also be forwarded to the DCBS case manager.

10. Meetings shall be held with the IMPACT Service Team, if appropriate, or the LIAC to review the progress of the youth and family. The review will encompass the youth and family involvement and compliance with recommended services, as well as, the partner agencies referral, provision and monitoring of the recommended services.

11. Once the DJJ case manager determines that a youth probated to or committed to DJJ has completed the treatment/service plan, the RIAC shall be consulted, in conjunction with the DJJ and DCBS case managers, to assist in developing recommendations for continued services for the youth and family upon the youths' release from probation or commitment.

12. These recommendations shall include, but not be limited to, whether continued involvement with DCBS is necessary due to abuse, neglect or dependency issues, make recommendations to the court regarding continued commitment as a public offender or dependent child, and recommendations regarding integration and transition back to the family and community.

13. The DJJ case manager shall prepare and provide the recommendation for the youth's release from probation or commitment to the court. The DCBS case manager shall assist as needed and may attend the court hearing, if held, to support the recommendation.

14. Once the youth is released from probation to DJJ, the DCBS case manager shall continue case responsibility provided that issues of abuse, neglect or dependency still exist. In addition, if the youth is released from commitment to DJJ, the DCBS case manager shall assume case responsibility provided that issues of abuse, neglect or

dependency still exist. The involvement with the RIAC may continue while the youth is active with DCBS.

In circumstances where a youth is probated or committed to DJJ without previous notice to DJJ, DCBS shall share all appropriate information and the youth's case shall be referred to the RIAC by the DJJ case manager to review the youth's case and assist in establishing the plan for the youth and family.

CHFS will accept all reports of abuse, neglect or dependency on a child committed or probated to *DJJ* (who is not placed in a Department of Juvenile Justice state operated facility) and investigate them according to the law. This memorandum of understanding is to be read in conjunction with the Memorandum of Understanding between the Justice and Public Safety Cabinet and Cabinet for Health and Family Services entered into on October 14, 1998, and shall not impact that agreement. When issues of abuse, neglect or dependency have arisen after a DJJ committed child has been placed at home on supervised placement, DJJ will cooperate with CHFS in the investigation. *DJJ* will not place a child at home on supervised placement where abuse, neglect or dependency is likely without first consulting with local staff of CHFS to determine that no safety concerns exist.

Both DJJ and CHFS will utilize KRS 610.160, any time it is appropriate, to ask for the court's assistance in compelling the parents, guardians or legal custodians of a child to participate in the child's treatment and care, particularly where such efforts might result in avoiding a commitment of the child to either agency.

A commitment of a child to DJJ as a public offender will be cause to terminate a status commitment. However, a commitment to DJJ as a public offender will not be cause to terminate an abuse, neglect or dependency commitment.

For any other circumstances involving a status offender or a dependency, neglect or abuse, a referral for consultation with the RIAC shall be made in instances where there is an open case of abuse, neglect, and dependency for joint assessment, planning, and case management. A referral may also be made in instances where the assessment of the youth's circumstances indicates that the matter may be more appropriately handled in the Family Court system. In these situations, both agencies will work together in the best interest of the child. However, for the duration of the public offender commitment, DJJ will take primary responsibility for the care and treatment of the child.

DJJ will assume responsibility for any status conduct committed by a child either probated or committed to DJJ.

*6/07* 4

In those situations where issues of dependency arise during the DJJ commitment (for example, either parents are incarcerated or deceased or all other siblings have subsequently been removed from the home) the DJJ worker shall notify DCBS and initiate the process to refer the youth to the RIAC for review and case planning. If a recommendation to file a petition of dependency is being considered the RIAC may be consulted.

In matters of referrals for abuse, neglect or dependency, DJJ agrees to provide any and all records in its possession and control to DCBS regarding that child, to the extent permitted by law. Likewise, DCBS will share any and all records in its possession and control, regarding a child who is has been adjudicated on a public offense to the extent permitted by law.
DCBS and DJJ mutually agree to cooperatively provide the number of children under the care of DCBS who are transferred into the custody DJJ on an annual basis. It is understood that this data is required for the annual federal reporting requirements of each agency.

The parties agree to meet at the request of either party to consider in good faith any future modifications or additions to the guidelines set forth in this Memorandum of Understanding. The parties to this agreement agree to abide 1;Jy the "HIPAA Privacy Rule," 45 CFR Parts 160 and 164, established under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (42 USC I320d) to protect the security, confidentiality, and integrity of health information.

It is understood that these are merely guidelines, and that facts and circumstances of a particular case may require a different result than the guidelines direct in order to serve the best interest of a child. As such, this memorandum of understanding is to assist DJJ and DCBS workers in serving their clients and is not binding on the courts. In the event the community workers from each agency cannot agree on the best course of action to take regarding a given child, after having consulted with their respective supervisors and these guidelines, the specific case information should be forwarded to each agency's designated contact persons to arbitrate a resolution to the matter.

Inasmuch as the purpose of this Memorandum is to foster a spirit of cooperation between agencies and to serve the best interests of the child, and not an attempt to reduce caseloads, it is understood that neither agency will initiate petitions in an attempt to transfer youth to the other agency in violation of the spirit of this Memorandum of Understanding.

# Kentucky Mental Health Planning & Advisory Council

Steve Liles, Chair • Rebecca Garrett, Vice Chair • Mary Sue Klusman, Secretary
100 Fair Oaks Lane, 4E-D, Frankfort, Kentucky 40601


August 18, 2011

Barbara Orlando
Division of Grants Management
OPS/SAMHSA
1 Choke Cherry Road, Room7-1091
Rockville, MD 20857

Dear Ms. Orlando:

I am writing on behalf of Kentucky's Mental Health Planning & Advisory Council to confirm that Council members have reviewed Kentucky's FFY 2012-2013 application Unified Community Mental Health and Substance Abuse Prevention and Treatment Block Grant application. Time was allocated at today's Council meeting to discuss the state plan and solicit comments before the September 1st due date. The Department for Behavioral Health, Developmental and Intellectual Disabilities will continue to accept comments until the end of August. The Department has also advised members about citizens' opportunity to review the application and provide comment online at the WebBGAS site.

Our Council has met quarterly over the past year. Our committees have met often and members have been diligent as we continue to build a solid Council that will guide the development of Kentucky's mental health system of care. Recent activities of the Council include the following:

- The Membership Committee began working on a new orientation curriculum for members;
- The Council has stayed abreast of SAMHSA's development of the new Unified Block Grant application and reporting requirements;
- The Finance Committee provided a comprehensive review of the SFY 2012 plan and budget applications submitted by Kentucky's 14 regional mental health boards; and
- The Finance Committee reviewed the CMHCs' financial allocations for evidence-based and promising practices and provided comments.

Thank you for the continued support of community-based services for adults with SMI and children with SED. Our Council membership is honored to serve as advisors for planning in Kentucky.

Sincerely,

Steve Liles

Steve Liles
Chair, Kentucky Mental Health Planning & Advisory Council

Cc: Stephen Hall, Commissioner
Lou Kurtz, Acting Director
Michele Blevins, State Planner - Children
Melissa Runyon, State Planner - Adults

Gina Sparks, KENTUCKY HOUSING CORP. 8/18/11
Carol H Estes KY office of Vocational Rehabilitation 8/18/2011
Betty Jo Moss Adult Consumer, Mental Health Advocate
Steve Lepon Consumer.
Robert Ray Hicks, Family member
Lynn Haney, Family Member
Gayla Hayes Family Member - Adult
Mary Singleton - Consumer & advocate
John L Flaherty - Family Member - Adult
Matthew T. Smith - Family Member - Adult
Rebecca Hewitt - Family Member - Adult
Mary Sue Klusman - Family Member Adult

# IV: Narrative Plan

## O. State Behavioral Health Advisory Council

Page 49 of the Application Guidance

Narrative Question:

Each State is required to establish and maintain a State advisory council for services for individuals with a mental disorder. SAMHSA strongly encourages States to expand and use the same council to advise and consult regarding issues and services for persons with or at risk of substance abuse and substance use disorders as well. In addition to the duties specified under the MHBG, a primary duty of this newly formed behavioral health advisory council would be to advise, consult with and make recommendations to SMHAs and SSAs regarding their activities. The council must participate in the development of the Mental Health Block Grant State plan and is encouraged to participate in monitoring, reviewing and evaluating the adequacy of services for individuals with substance abuse disorders as well as individuals with mental disorders within the State.

Please complete the following forms regarding the membership of your State's advisory council. The first form is a list of the Advisory Council for your State. The second form is a description of each member of the behavioral health advisory council.

Footnotes:

**IV: Narrative Plan**

**O. State Behavioral Health Advisory Council** *Page 45 of the Application Guidance*

*Narrative Question:*

*Each State is required to establish and maintain a State advisory council for services for individuals with a mental disorder. SAMHSA strongly encourages States to expand and use the same council to advise and consult regarding issues and services for persons with or at risk of substance abuse and substance use disorders as well. In addition to the duties specified under the MHSBG, a primary duty of this newly formed behavioral health advisory council would be to advise, consult with and make recommendations to SMHAs and SSAs regarding their activities. The council must participate in the development of the Mental Health Block Grant State plan and is encouraged to participate in monitoring, reviewing and evaluating the adequacy of services for individuals with substance abuse disorders as well as individuals with mental disorders within the State. Please complete the following forms regarding the membership of your State's advisory council. The first form is a list of the Advisory Council for your State. The second form is a description of each member of the behavioral health advisory council.*

## Kentucky Mental Health Planning & Advisory Council

**Vision**

The members of the Kentucky Mental Health Planning & Advisory Council believe that all children, adolescents, and adults in the Commonwealth have the right to excellent, recovery-oriented mental health services that are affordable and consumer-driven, values their individuality, assists them to achieve their fullest potential, and enables them to live in their community.

**Mission**

The Council seeks to be an active voice for all Kentuckians affected by mental illness by forming a broad partnership of consumers, family members, providers and state agencies that assures through a comprehensive plan that all individuals with mental illness have awareness of and access to effective, affordable services in their own communities which promote ongoing recovery.

**Meetings**

The Kentucky Mental Health Planning & Advisory Council meets at least four times per year. Historically and this year, the Council uses its August meeting to review and comment on the state's Plan. At its November meeting, it reviews and comments on the state's Implementation Report, including the URS tables. All comments are included in the final documents. Additionally, meeting time is spent discussing mental health issues or learning more about Kentucky's implementation of national initiatives related to the block grant. For example, this year the Council heard several presentations and participated in discussions around:

- Kentucky's continuing development of recovery services and supports and transformation to a recovery-oriented system of care
- Alignment of SAMHSA's Eight Strategic Initiatives and the Council's Priorities
- Changes to the Mental Health and Substance Abuse Prevention and Treatment Block Grants
- Potential changes to the structure and mission of the Council
- Multiple initiatives around Olmstead compliance and Kentucky's Olmstead Coalition grant.
- Cultural Awareness
- Expansion of Managed Care in Kentucky
- Services for Youth Transitioning to Adulthood
- Kentucky Crisis Intervention Team

- Evidence-based and Promising Practices
- Affordable Care Act and how it is affecting Kentuckians
- Client-level Reporting Update – Kentucky Data Infrastructure Grant
- Kentucky's System to Enhance Early Development (KY SEED)
- WebBGAS
- National Olmstead Initiatives
- Application for Garrett Lee Smith Suicide Prevention Grant
- Johnson & Johnson – Dartmouth Supported Employment Grant
- Kentucky's system of care for children and adolescents
- Access to transportation
- Reports from advocacy organizations
- Training opportunities and public awareness events

These presentations allow all Council members to gain knowledge about programs and activities and also provide a forum for discussion around important issues, which often results in action taken by members and others. The Council also tries to keep abreast of the efforts of the Kentucky Commission on Services and Supports for Individuals with Mental Retardation and Other Developmental Disabilities (HB 144 Commission), the State Interagency Council for Services to Children with an Emotional Disability (SIAC), and the Kentucky Suicide Prevention Group (KSPG). Ongoing communication between the Council and these groups remains a goal.

**Members**

The Council currently has 34 members. Nineteen of those members are parents, consumers, and family members. Three are representatives of statewide advocacy organizations. One is a provider representative, and 11 members represent state agencies. The Council is fortunate to have broad representation and involvement from other state agencies beyond those members mandated by federal law (e.g., Department for Aging and Independent Living, Protection and Advocacy, Department of Juvenile Justice and Department for Public Health).

During this past year, two new members joined the Council, an adult consumer and a young adult consumer. The young adult slot required multiple attempts to recruit applicants. Both members are proud to bring diverse viewpoints to the Council. This upcoming year could bring many new faces and perspectives to the Council; nine of nineteen elected members' terms will expire January 2012.

**Officers**

The Council has the following offices:

- Chair Steve Liles;
- Vice Chair Rebecca Garrett
- Secretary Mary Sue Klusman

Per Kentucky's Council Bylaws, officers of the Planning Council must be consumers and family members. They serve two-year terms, with a limit of two consecutive terms. Officer terms ended in May and a new Chair was appointed to the Council.

**Website**

Department staff are committed to maintaining a useful, current Council web site that serves to share information and highlight important events and training opportunities for members. The web site contains a membership list, membership application, Council and committee meeting summaries, copies of the Block Grant Applications and Implementation Reports for the past four

years, Council Bylaws and a calendar of events. You may access the site at the following address: http://www.mhmr.ky.gov/mhsas/kmhpac.asp.

**Committees**

The Council currently has an active Executive Committee, Membership Committee, Bylaws Committee, Finance Committee and an ad hoc Nominating Committee.

The committees are led by the following officers:

- Bylaws Committee – Steve Shannon, Chair
- Executive Committee – Steve Liles, Chair
- Finance Committee – Betty Jo Moss, Chair
- Membership and Nominating Committees – Mary Singleton, Chair

**Accomplishments during FY 2011**

The members of the Kentucky Mental Health Planning & Advisory Council were extremely active over the past year. They convened ten council and committee meetings and accomplished numerous tasks. Their voice remains a strong asset to the Department.

Activities of the Committees include:

- **Executive Committee** prioritized the agenda for the Council and committee meetings and resolved issues as they arose;
- **Membership Committee** began working on a new orientation curriculum for members. Members identified topics that need to be included in the new training. The training will be lead by members. There was very little transition in elected membership this year; only two vacancies developed during the year. Nine elected members' terms expire in January 2012.
- **Finance Committee** met three times in SFY 2011. The members did their annual review of the CMHC's applications for funds, specifically reviewing the child system of care plans, adult system of care plans, and their financial plans. Members provided comments to the department. The committee also reviewed the CMHCs' financial designation/allotments for evidence-based and promising practices, discussed Kentucky's Maintenance of Effort recalculation, reviewed WebBGAS, heard updates on the state general fund and block grant allocations to the Department, and learned about improvements being implemented for client-level reporting.
- **Nominating Committee** did not meet this year because officers were in the middle of their two-year terms.
- **Bylaws Committee** reviewed the state and federal definitions of severe emotional disability and severe mental illness as they relate to membership.

**Review of SFY 2011 Plans**

1. The Executive Committee will determine the Council agenda, with the following topics as a priority:
    - Mental health needs of active military personnel, veterans and their families – *Ongoing.*
    - Services for youth transitioning to adulthood – *Ongoing.*
2. The Membership Committee will prepare a new, member-led orientation for April 2012. *Ongoing: A core team of presenters were established and work began on the new curriculum. The orientation had to be cancelled, however, due to low demand (a small number of new members this year) and poor weather. Nine elected members' terms expire in January 2012, so it is anticipated the Orientation will occur next year.*

3. The Finance Committee will review programming and financial reports from the Regional Boards and provide comments. *Goal met.*
4. The Finance Committee will continue to use data to review the systems of care for adults with SMI and children with SED and make recommendations. *Ongoing.*
5. The Council will schedule presentations and reports from block grant funded entities. *Goal met.*

**Plans for SFYs 2012 and 2013**

1. The Executive Committee will determine the Council agenda, with the following topics as priority:
    - Explore transitioning the Council to a Behavioral Health Advisory Council;
    - Services and supports for active military personnel, veterans and their families; and
    - Services and supports for youth transitioning to adulthood.
2. The Membership Committee will create a curriculum and present a member-led orientation in April 2012.
3. The Finance Committee will review programming and financial reports from the Regional Boards and provide comments.
4. The Finance Committee will expand their knowledge of available data and further utilize data to make recommendations.
5. The Council will schedule formal presentations from at least three (3) block grant funded entities.

**Transformation Activities**

The Planning Council plays a role in the planning for and the implementation of Kentucky's efforts to transform our mental health system of care. On the planning side, they have participated in lengthy discussions about ways in which to move fully towards a recovery-oriented system of care. The Finance Committee is actively engaged in their initiative to educate and advocate for integrated treatment.

Council members are involved with current activities to make peer support services readily available in state psychiatric hospitals and community settings by training a competent workforce and ensuring reimbursement for such services. They are involved in creating brochures and a video to improve awareness and understanding of mental illness and the path to recovery.

*Attached to this document are the Council Bylaws adopted November 13, 2008 which further outline the policies and procedures of operation. Note: The Department name change is not reflected in the Bylaws and thus KDBHDID is synonymous with KDMHDDAS.*

# Bylaws of the
# Kentucky Mental Health Planning and Advisory Council

## ARTICLE I: PURPOSE

***Section 1 - Name:*** The name of this unincorporated entity shall be the Kentucky Mental Health Planning and Advisory Council and is herein after referred to as the Council.

***Section 2 - Authority:*** The Kentucky Mental Health Planning and Advisory Council was established pursuant to Administrative Order 89-43, dated September 12, 1989, and amended by Administrative Order 93-225, dated August 26, 1993. The Council was established to conform to Public Law 102:321 that requires formation of such a Council and specifies its composition.

***Section 3 - Mission:*** The Council seeks to be an active voice for all Kentuckians affected by mental illness by forming a broad partnership of consumers, family members, providers, and state agencies that assures through a comprehensive plan that all individuals with mental illness have awareness of and access to effective, affordable services in their own communities which promote ongoing recovery.

***Section 4 - Vision:*** The members of the Kentucky Mental Health Planning and Advisory Council believe that all children, adolescents, and adults in the Commonwealth have the right to excellent, recovery-oriented mental health services that are affordable and consumer driven, values their individuality, assists them to achieve their fullest potential, and enables them to live in their community.

## ARTICLE II: DUTIES

***Section 1 - Duties:*** The Council shall do all of the following:

- Report directly to the Commissioner of the Kentucky Department for Mental Health, Developmental Disabilities and Addiction Services (KDMHDDAS).
- Assist KDMHDDAS in designing a comprehensive, recovery-oriented system of care.
- Advise KDMHDDAS on the use of Mental Health Block Grant resources and on the quality of statewide, recovery-oriented mental health services.
- Review the annual Community Mental Health Services Block Grant Application and Implementation Report pursuant to Public Law 102-321, Section 1915 (a) and to submit recommendations to KDMHDDAS, prior to the September 1 and December 1 due dates, respectively.
- Advocate for adults with serious mental illnesses, children with severe emotional disabilities, individuals with co-occurring mental health and substance abuse disorders, and other individuals with mental illness or emotional issues.
- Monitor, review, and evaluate, no less than once a year, the allocation and quality of statewide, recovery-oriented mental health services.

## ARTICLE III: MEMBERSHIP

***Section 1 - Council Membership:*** Members shall be appointed in accordance with federal laws and regulation by Mental Health Order from the Commissioner of KDMHDDAS.

***Section 2 - Anti-Discrimination:*** The Council shall not discriminate in any regard with respect to age, race, creed, color, sex, sexual orientation, marital status, religion, national origin, ancestry, pregnancy, parenthood, custody of a minor child, or physical or mental disability.

***Section 3 - Membership Seats:*** Seats on the Council shall be allotted as follows:

A. Eleven seats are allotted to state agency representatives. State agency representatives are designated by their respective agency heads by virtue of the positions they hold.
B. Three seats are allotted to advocacy organizations, including: One for adult consumers; One for family members of adult consumers; and One for youth and family members of youth consumers. Advocacy organization representatives shall be the Board Chair or designee.
C. One seat is allotted to a community mental health center provider representative. The community mental health center provider representative is the Executive Director or designee of the Kentucky Association of Regional Programs.
D. Six seats are allotted to adult consumers of mental health services.
E. Six seats are allotted to parents/guardians/foster parents of children with a severe emotional disability.
F. Six seats are allotted to family members of an adult with severe mental illness.
G. One seat is allotted to a young adult consumer of mental health services (age 18-25).

***Section 4 - Terms of Membership:*** The terms of membership shall be as follows:

A. State agency representatives do not have membership terms, nor is there a limit to their years of service.
B. Representatives of mental health consumer and family advocacy organizations do not have membership terms, nor is there a limit to their years of service.
C. The community mental health center provider representative does not have a membership term, nor is there a limit to his or her years of service.
D. Adult consumers of mental health services, parents/guardians/foster parents of children with a severe emotional disability, family members of an adult with severe mental illness, and the young adult consumer of mental health services shall serve a term of membership of two years from his or her date of appointment. There is no limit to the number of terms these members may serve.

***Section 5 - Qualifications:*** For the purposes of Council membership, a state employee or provider of mental health services is considered any individual who is a full-time, permanent employee of the aforementioned organizations.

***Section 6 - Designees:*** State employees and members of advocacy organizations who are designated as members by virtue of their office or advocacy organization representation may appoint, in writing or by email, a designated alternate to attend meetings in their stead, and such alternate shall have full Council member privileges.

***Section 7 - Appointment of Members:*** The Council shall recommend, to the Commissioner of KDMHDDAS, persons to fill Council vacancies, once voted upon by the Council.

***Section 8 - Attendance:*** Minutes of Council meetings shall reflect the names of those members in attendance, absent and those serving as representatives or alternates.

***Section 9 - Absences:*** Members who miss three consecutive meetings without a substantial reason submitted and approved by the Chair shall be recommended for removal from membership unless the Council acknowledges special circumstances and acts to continue the membership.

***Section 10 - Conflict of Interest:*** Members shall abstain from voting upon such matters in which they have a direct financial interest.

***Section 11 - Removal:*** The Chair or any member of the Council may be removed with just cause with a two-thirds vote of the membership of the Council, at any time, at a properly called meeting of the Council.

***Section 12 - Reimbursement of Expenses:*** Consumer and family Council members shall be reimbursed for necessary expenses incurred with the performance of duties related to approved Council business consistent with the policies of the Cabinet for Health and Family Services. The members who are representing state agencies, providers, and consumer or family member organizations will not be reimbursed with Council funds but may be reimbursed by the organization which they are representing. This includes stipends, travel, lodging and per diem expenses.

## ARTICLE IV: OFFICERS

***Section 1 - Officers and Duties:*** The officers shall include a Chair, Vice Chair, and ~~a~~ Secretary.

A. The **Chair** shall be the principal officer of the Council. The Chair shall preside over all meetings of the Council, call special meetings as needed, appoint committees, and generally supervise and direct all actions of the Council with assistance from staff liaison(s) from KDMHDDAS.
B. The **Vice Chair** shall assist the Chair in all duties assigned to that office and preside over the meeting in the Chair's absence.
C. The **Secretary** shall oversee recording and distribution of the minutes and other written announcements of all meetings with support from KDMHDDAS staff.

***Section 2 - Terms:*** Officers shall serve a two-year term and be limited to two consecutive terms in the same office (i.e., serve no more than four consecutive years as Chair, Vice Chair or Secretary).

***Section 3 - Qualifications of Officers:*** Nominations for officer positions shall be limited to individuals who have served on the Council for at least one year.

***Section 4 - Nomination and Approval Process for Officers:*** Nominations for Officers of the Council shall be made at a duly called meeting of the Council and shall be from:

A. The Nominating Committee; and
B. The attending Council members (including those joining by telephone).

***Section 5 - Nominating Committee:*** The Nominating Committee shall recommend a slate of candidates, one for each office, to the Council for approval. Upon approval, the Council shall then forward its recommendation to the Commissioner of KDMHDDAS.

***Section 6 - Appointment of Officers:*** Officers of the Council shall be appointed by the Commissioner of KDMHDDAS. In the event that the Commissioner does not make the recommended appointment, the nomination process shall be repeated to create new recommendations.

***Section 7 - Vacancies:*** If an Officer is unable to complete their term in an appointed office for any reason, the nomination process shall be repeated to create new recommendation(s).

## ARTICLE V: MEETINGS

***Section 1 - Quorum:*** One-third of the membership of the Council present, consisting of one-half plus one of the assembled members being consumer or family member representatives shall constitute a quorum. Agency and organizational representatives who may be consumers and/or family members shall not be considered consumer and family member representatives.

***Section 2 - Regular Meetings:*** The Council shall meet a minimum of four times per calendar year. Members shall be notified in writing of the date, time, and place of the meeting at least 10 days in advance.

***Section 3 - Special Meetings:*** The Chair may call special meetings of the Council as is necessary to fulfill the purpose and mission of the Council.

***Section 4 - Public Participation:*** Members of the public are entitled to attend meetings, but shall not have the right to participate under Kentucky's Open Meetings Act. They may propose new business for the next meeting; however, the Council encourages all new business or comments to be submitted in writing for consideration by the Executive Committee.

## ARTICLE VI: COMMITTEES

***Section 1 - Standing and Ad Hoc Committees:*** The Council shall have such standing and ad hoc committees as the Council shall deem necessary for the proper conduct of its business. Such committees shall be appointed by the Chair and shall report directly to the Council, unless otherwise requested by the Council.

***Section 2 - Executive Committee:*** The Council shall have an Executive Committee to include the Chair, the Vice Chair, and the Secretary, the Manager of the Adult Services Branch (KDMHDDAS) or designee, the Manager of the Children, Youth and Families Services Branch (KDMHDDAS) or designee, and the Commissioner of KDMHDDAS or designee. The Executive Committee shall be responsible for the formulation of the meeting agenda for the full Council and for conduct of such Council business as may arise and require attention at times other than during regular meetings of the full Council.

***Section 3 - Nominating Committee:*** The Nominating Committee shall be comprised of Council members who are appointed to the Council because they are consumers, family members of an adult with SMI, or parent of a child with SED. This shall not include individuals who may be a consumer or family member but who are appointed to the Council by virtue of their being a representative of an agency or organization.

## ARTICLE VII: COMPLAINTS AND RESOLUTION

***Section 1 - Complaints by Council Members or Meeting Guests*:** Any formal complaint from a Council member or meeting guest shall be submitted in writing to the Chair stating the specific issues, documentation to support the complaint, and a potential resolution. The Chair shall present the complaint to the Executive Committee for resolution. If the complaint lies with the Chair, the complaint shall be handled by another Executive Committee member.

## ARTICLE VIII: RULES OF ORDER

***Section 1 - Rules of Order:*** In all procedural matters not governed by these bylaws, the Council shall be bound by the policy and procedures of the KDMHDDAS or by the provisions of Robert's Rules of Order (latest edition). However, the Council may, by the vote of two-thirds of a quorum of the Council present at a meeting of the Council, suspend any provision of these bylaws or of Robert's Rules at any time.

***Section 2 - Open Meetings and Open Records:*** All meetings of the Council shall be open to the public and adhere to the provisions for open meetings as set forth in KRS 61.870 to KRS 61.884. The Council shall refer to the most recent edition of *"Protecting Your Right to Know: The Kentucky Open Records and Open Meetings Acts"* published by the Office of the Attorney General, should further procedural clarification be needed.

***Section 3 - Amendments to the Bylaws:*** The Council Bylaws may be amended by a majority vote of a quorum at any meeting of the full Council, provided that the proposed amendment shall have been submitted in writing to the entire membership at least ten days prior to such meeting.

**Adopted and approved by the Council at its meeting on November 13, 2008.**

_____ _____

**Rebecca Garrett, Chair** **Date**

# IV: Narrative Plan

## Table 11 List of Advisory Council Members

Page 51 of the Application Guidance

Start Year: 2012

End Year: 2013

| Name | Type of Membership | Agency or Organization Represented | Address, Phone, and Fax | Email (if available) |
|---|---|---|---|---|
| Gayla Hayes | Individuals in Recovery (from Mental Illness and Addictions) | | 401 Pebbles Avenue<br>Franklin, KY 42134<br>PH: 270-586-3367 | ghayes@accessky.net |
| Steven Lyons | Individuals in Recovery (from Mental Illness and Addictions) | | 96 9th Street<br>Shelbyville, KY 40065<br>PH: 502-633-4178 | lyonssadsack@aol.com |
| Betty Jo Moss | Individuals in Recovery (from Mental Illness and Addictions) | | 4029 Briar Creek Drive<br>Lawrenceburg, KY 40342<br>PH: 502-839-6413 | mss_bttyi@yahoo.com |
| Carmilla Ratliff | Individuals in Recovery (from Mental Illness and Addictions) | | 107 Northwood Road, Apt. 2<br>Frankfort , KY 40601<br>PH: 606-329-2883 | |
| Mary Singleton | Individuals in Recovery (from Mental Illness and Addictions) | | 3565 W. Hwy 221<br>Bledsoe, KY 40810<br>PH: 606-558-5076 | Angels2830@netscape.com |
| Brad Williams | Individuals in Recovery (from Mental Illness and Addictions) | | 13 Sassafrass Lane<br>Florence , KY 41042<br>PH: 859-371-4146 | Bradwilliams19873@hotmail.com |
| John Flickinger | Family Members of Individuals in Recovery (from Mental Illness and Addictions) | | PO Box 651<br>Winchester , KY 40392<br>PH: 859-745-7784 | Jlf234@aol.com |

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| Rebecca Garrett | Family Members of Individuals in Recovery (from Mental Illness and Addictions) | 461 Jack Arnett Br.<br>Prestonsburg , KY 41653<br>PH: 606-889-0258 | Becky.garrett@hotmail.com |
| Lynn Haney | Family Members of Individuals in Recovery (from Mental Illness and Addictions) | 9773 Windsor Way<br>Florence , KY 41042<br>PH: 859-282-9166 | |
| Robert Hicks | Family Members of Individuals in Recovery (from Mental Illness and Addictions) | 631 Timothy Drive<br>Frankfort , KY 40601<br>PH: 502-223-3034 | bettybobhicks631@aol.com |
| Mary Sue Klusman | Family Members of Individuals in Recovery (from Mental Illness and Addictions) | 3004 Piedmont Drive<br>Louisville , KY 40205<br>PH: 502-459-0581 | |
| Matthew Smith | Family Members of Individuals in Recovery (from Mental Illness and Addictions) | 2905 Woodbrook Court<br>Lexington , KY 40511<br>PH: 859-296-0714 | smithski126@aol.com |
| Yolonda Clay | Family Members of Individuals in Recovery (from Mental Illness and Addictions) | 124 Homestead Drive<br>Nicholasville , KY 40356<br>PH: 859-305-6436 | |
| Balinda Hudson | Family Members of Individuals in Recovery (from Mental Illness and Addictions) | 1305 Old Rosebower Church Road<br>Paducah , KY 42003<br>PH: 270-898-8279 | |
| Angela Isaacs | Family Members of Individuals in Recovery (from Mental Illness and Addictions) | 1592 State Hwy 1654<br>Rush , KY 41168<br>PH: 606-474-6546 | chloteanstone@yahoo.com |
| Steve Liles | Family Members of Individuals in Recovery (from Mental Illness and Addictions) | 149 Wheaton Drive<br>Lawrenceburg , KY 40342<br>PH: 502-839-3180 | |
| Jim Reed | Family Members of Individuals in Recovery (from Mental Illness and Addictions) | 439 College Street<br>Somerset , KY 42501<br>PH: 606-802-2588 | Eagle2719501@aol.com |
| Anna Winchell | Family Members of Individuals in Recovery (from Mental Illness and Addictions) | 1129 Johnstown Road, Apt. 1C<br>Elizabethtown , KY 42701<br>PH: 270-982-3582 | annajo@bbtel.com |

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| Joy Varney | Others (Not State employees or providers) | Kentucky Partnership for Families and Children | 207 Holmes Street<br>Frankfort , KY 40601<br>PH: 502-875-1320 | |
| Cathy Epperson | Others (Not State employees or providers) | NAMI Kentucky | 808 Monticello Street<br>Somerset , KY 42501<br>PH: 606-451-6935 | |
| Kelly Gunning | Others (Not State employees or providers) | | 869 Sparta Court<br>Lexington , KY 40504<br>PH: 859-309-2856 | |
| Donna Collins | State Employees | KY Department for Aging & Independent Living | 275 E Main Street 3W-F<br>Frankfort , KY 40621<br>PH: 502-564-6930 | DonnaM.Collins@ky.gov |
| Steve Hartwig | State Employees | KY Department for Community Based Services | 275 E Main Street, 3E-B<br>Frankfort , KY 40621<br>PH: 502-564-2136 | Steve.Hartwig@ky.gov |
| Deborah Coleman | State Employees | KY Department of Corrections | 3000 Ash Avenue<br>Pewee Valley, KY 40056<br>PH: 502-241-8454 | Deborah.Coleman@ky.gov |
| Artye Dulaney | State Employees | KY Department of Education | 500 Mero Street 8th Floor<br>Frankfort , KY 40601<br>PH: 502-564-4970 | Artye.Dulaney@education.ky.gov |
| Bill Heffron | State Employees | Department for Juvenile Justice | 1025 Capital Center Drive, Bldg 3 Third Floor<br>Frankfort , KY 40601<br>PH: 502-573-2738 | BillM.Heffron@ky.gov |
| Lou Kurtz | State Employees | Department for Behavioral Health, Developmental and Intellectual Disabilities | 100 Fair Oaks Lane 4E-D<br>Frankfort , KY 40621<br>PH: 502-564-4456 | Louis.Kurtz@ky.gov |
| Sheila Davis | State Employees | Department for Medicaid Services | 275 E Main Street, 6W-B<br>Frankfort , KY 40621<br>PH: 502-564-5560 | Sheila.Davis@ky.gov |
| Jim Sparks | State Employees | Kentucky Housing Corporation | 1231 Louisville Road<br>Frankfort , KY 40601 | JSparks@kyhousing.org |

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| | | | PH: 502-564-7630 | |
| Jan Powe | State Employees | Kentucky Protection & Advocacy | 100 Fair Oaks Lane, 3rd Floor<br>Frankfort , KY 40601<br>PH: 502-564-2967 | Jan.Powe@ky.gov |
| Carol Estes | State Employees | Office of Vocational Rehabilitation | PO Box 457<br>Carrollton , KY 41008<br>PH: 502-732-6103 | CarolH.Estes@ky.gov |
| Steve Shannon | Providers | Kentucky Association of Regional MH/MR Programs | 152 W. Zandale Drive, Suite 201<br>Lexington , KY 40503<br>PH: 859-272-6700 | SShannon.KARP@iglou.com |

Footnotes:

# IV: Narrative Plan

## Table 12 Behavioral Health Advisory Council Composition by Type of Member

Page 52 of the Application Guidance

Start Year: 2012

End Year: 2013

| Type of Membership | Number | Percentage |
|---|---|---|
| Total Membership | 32 | |
| Individuals in Recovery (from Mental Illness and Addictions) | 6 | |
| Family Members of Individuals in Recovery (from Mental Illness and Addictions) | 12 | |
| Vacancies (Individuals and Family Members) | 0 | |
| Others (Not State employees or providers) | 3 | |
| Total Individuals in Recovery, Family Members & Others | 21 | 65.63% |
| State Employees | 10 | |
| Providers | 1 | |
| Leading State Experts | 0 | |
| Federally Recognized Tribe Representatives | 0 | |
| Vacancies | 0 | |
| Total State Employees & Providers | 11 | 34.38% |

Footnotes:

# IV: Narrative Plan

## P. Comment On The State Plan

Page 50 of the Application Guidance

Narrative Question:

SAMHSA statute requires that, as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State plan. States should make the plan public in such a manner as to facilitate comment from any person (including Federal or other public agencies) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary. In the section below, States should describe their efforts and procedures to obtain public comment on the plan in this section.

Footnotes:

**IV: Narrative Plan**
**P. Comments on the State Plan**

*Narrative Question:*
*SAMHSA statute requires that, as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State plan. States should make the plan public in such a manner as to facilitate comment from any person (including Federal or other public agencies) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary. In the section below, States should describe their efforts and procedures to obtain public comment on the plan in this section.*

The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities values the input of stakeholders during the development of its application. Multiple opportunities are provided for the public to view the plan and provide comments, such as the following:

- A Public Forum was held on August 11, 2011. Notice of this event was shared widely using electronic distribution lists available to the department.
- A memorandum soliciting public comment was posted to the department's web home page under "Hot Topics." The memorandum offers to provide hard copy upon request.
- Per KRS 45.351, the Department provided a draft of the application to the Kentucky Legislative Research Commission for their review.
- The Interim Joint Committee on Health and Welfare of the Kentucky General Assembly holds a public hearing prior to the federal due date (generally in August). There is broad public notice of these Committee meetings.
- A time for public comment was set aside at the August 18th meeting of the Kentucky Mental Health Planning & Advisory Council.
- The Department accepts comments via email, fax, or mail until the submission date.

**Comments on Kentucky's FFY 2012-2013 application for the Unified Community Mental Health and Substance Abuse Prevention and Treatment Block Grant**

1. I would like to see more clarification of expectations/context for the funds allocated to the CMHCs to support evidence-based and promising practices.
2. The "choking game" has received media attention in Kentucky due to a recent death. As the Department expands mental health prevention and promotion efforts, it would be a good idea to include information about the choking game.
3. Kentucky's system of care needs to increase long-term substance abuse treatment capacity. Individuals who need treatment are becoming involved with the criminal justice system at increasingly high rates due to lack of access. Once individuals have a criminal record, then they no longer qualify for many of the jobs that have a living wage.

4. Facebook and Twitter should be incorporated into Kentucky's behavioral health system of care. I am not certain how we could use them, but I think we should explore that option.
5. I would like to see "parents" be included as a Behavioral Health Advisory Council membership category, as it has been in previous applications.
6. There can never be enough suicide prevention and treatment services for children.
7. The wait to get into services is a problem. Individuals often have to wait one or two months for services. People may commit suicide before they get their first appointment or evaluation.
8. Despite all the challenges that the community mental health centers experience due to lack of resources, they do a great job.
9. In my area of the state, a licensed therapist makes less than half of what a coal miner makes.

The public was made aware of the Public Hearing, held on August 5, 2011, through the Department and Cabinet web site where all public meetings are announced. Also, an email notice was sent to all known providers (MH and SAPT) and to several statewide advocacy (consumer and family) organizations with a request to forward to their membership, include in newsletter or post on web sites, etc. These organizations include; Kentucky Partnership for Families and Children, People Advocating Recovery (SA), NAMI-KY, MHA-KY, and KY-System Transformation, Advocacy, Recovery & Support (KY-STARS).

# I: State Information

## Assurances - Non-Construction Programs

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Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

**PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.**

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**Note:** Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

| | |
|---|---|
| Name | Janie Miller |
| Title | Cabinet Secretary |
| Organization | Cabinet for Health and Family Services |

Signature Janie Miller

Date 8/19/11

**Footnotes:**

# I: State Information

## 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 45 CFR Part 76, and its principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

**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 45 CFR Part 76 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), ?, (d), ?, and (f).

For purposes of paragraph ? regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

**3. Certifications Regarding Lobbying**

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

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)**

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.

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| Name | Janie Miller |
| Title | Cabinet Secretary |
| Organization | Cabinet for Health and Family Services |

Signature Janie Miller

Date 8/19/11

**Footnotes:**

# I: State Information

## Chief Executive Officer's Funding Agreements/Certifications [CMHS]

**Community Mental Health Services Block Grant Funding Agreements**
FISCAL YEAR 2012

I hereby certify that Kentucky agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

I. Section 1911:

Subject to Section 1916, the State will expend the grant only for the purpose of:
i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:
ii. Evaluating programs and services carried out under the plan; and
iii. Planning, administration, and educational activities related to providing services under the plan.

II. Section 1912:

(c)(1)&(2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms "adults with a serious mental illness" and "children with a severe emotional disturbance" and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

III. Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2011, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a "service area")
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

IV. Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:
(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:
(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and
(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

V. Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.
(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

VI. Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;
(2) to make cash payments to intended recipients of health services;
(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or
(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

VII. Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

VIII. Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]
(c) The State will:
(1) make copies of the reports and audits described in this section available for public inspection within the State; and
(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

IX. Section 1943:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

Notice: Should the President's FY 2008 Budget be enacted, the following statement applies only to States that received the Mental Health Transformation State Infrastructure Grants:

This Agreement certifies that States that received the Mental Health Transformation State Infrastructure Grants shall not use FY 2008 Mental Health Block Grant transformation funding to supplant activities funded by the Mental Health Transformation Infrastructure Grants.

| | |
|---|---|
| Name | Janie Miller |
| Title | Cabinet Secretary |
| Organization | Cabinet for Health and Family Services |

Signature Janie Miller

Date 8/19/11

**Footnotes:**

COMMONWEALTH OF KENTUCKY
OFFICE OF THE GOVERNOR

STEVEN L. BESHEAR
GOVERNOR

700 CAPITOL AVENUE
SUITE 100
FRANKFORT, KY 40601
(502) 564-2611
FAX: (502) 564-2517

March 2, 2010

Ms. Barbara Orlando
Grants Management Officer
Office of Program Services
Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1091
Rockville, Maryland 20857

Dear Ms. Orlando:

I hereby delegate authority to the Secretary of the Cabinet for Health and Family Services, or in his/her absence, the Deputy Secretary of the Cabinet for Health and Family Services, to sign funding agreements and certifications, provide assurances of compliance to the Secretary of the United States Department of Health and Human Services and to perform similar acts relevant to the administration of the Substance Abuse Prevention and Treatment Block Grant until such time as this delegation of authority is rescinded.

Sincerely,

Steven L. Beshear

COMMONWEALTH OF KENTUCKY
OFFICE OF THE GOVERNOR

STEVEN L. BESHEAR
GOVERNOR

700 CAPITOL AVENUE
SUITE 100
FRANKFORT, KY 40601
(502) 564-2611
FAX: (502) 564-2517

August 30, 2010

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

Dear Ms. Orlando:

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

Sincerely,

Steven L. Beshear

# EXECUTIVE SUMMARY
## Unified Community Mental Health and Substance Abuse Prevention and Treatment Block Grant Application for FFY 2012-2013 Funds

This document contains Kentucky's plan for State Fiscal Years 2012-13 to strengthen the publicly funded behavioral health systems of care for adults and youth across the Commonwealth. It is submitted by the state's designated authority for both mental health and for substance abuse, the Department for Behavioral Health, Intellectual and Developmental Disabilities (DBHDID) in compliance with Public Law 102-321, and applies for funds that will become available in Federal Fiscal Years 2012 and 2013.

Historically, the federal Center for Mental Health Services and the Center for Substance Abuse Prevention and Treatment, within the Substance Abuse and Mental Health Services Administration (SAMHSA) have had markedly different planning and application processes, as well as different reporting requirements. This marks the first year that states have been encouraged to submit a "unified" application with a significantly changed format. While the funds will continue to be awarded separately, states are strongly encouraged to participate in joint planning in an effort to transform their behavioral health system into one that is fully integrated.

In addition to the new planning and reporting processes, the Block Grants are transitioning to funding cycles more aligned to the state fiscal years used in the majority of states and this application allows the Commonwealth to submit a bi-annual plan. A detailed timetable for this is included at the end of this summary.

Looking to the future, SAMHSA envisions that Block Grant funds should be directed toward four purposes: (1) To fund priority treatment and support services for individuals without insurance or who cycle in and out of health insurance coverage; (2) To fund those priority treatment and support services not covered by Medicaid, Medicare or private insurance and that demonstrate success in improving outcomes; (3) To fund universal, selective and targeted prevention activities and services; and (4) To collect performance and outcome data to determine effectiveness and to plan the implementation of new services. States are instructed to begin planning now for 2014 when more individuals will be insured and to allow SAMHSA to work with states during 2012 and 2013 to plan for and transition the Block Grants to these four purposes.

Block Grant funds will only be used to carry out the activities identified in the state's approved plan; to evaluate programs under the plan; and to plan, administer and educate stakeholders regarding services and supports under the plan. The majority of the Block Grant funds are allocated to Kentucky's fourteen Regional Mental Health and Mental Retardation Boards (Community Mental Health Centers) that provide a full array of mental health and substance abuse prevention and treatment services. Federal limitations on administrative costs and maintenance of effort requirements will be met. A certain percentage of the state's mental health funding must be set aside for children's services, and a certain percentage of substance abuse funding must be set aside for prevention activities. Kentucky generally exceeds these minimum requirements.

The plans required by the block grant must address all activities and funding that build systems of care for individuals with behavioral health care needs, not just those supported by Block Grant funds. Therefore, this application for federal funds generally drives the development of stronger services and supports using all funding sources, including Medicaid, other federal grants, local funds, and appropriations from the Kentucky General Assembly.

The planning process required by the federal agency also provides an opportunity to present it for formal review by a panel of stakeholders, the Kentucky Mental Health Planning & Advisory Council. Parents, family members, and consumers are well represented on the Council, and we believe that the state's plan is stronger because of their involvement, ideas, and comments. It is anticipated that additional members will be appointed to the Council to more fully represent consumers and family members affected by substance abuse disorders. In addition to the Council meetings, a Public Forum is scheduled for August 11, 2011. This forum will be advertised and allow all stakeholders to provide comments regarding the Commonwealth's proposed application for these federal funds.

As a result of the required planning process for this funding application, the table below represents the *State Priorities* for Kentucky's publicly funded behavioral healthcare system.

| STATE PRIORITIES | |
|---|---|
| 1 | Ensure access to behavioral health services and supports across the Commonwealth. |
| 2 | Ensure availability of high quality (science based) services and supports for all consumers of the publicly funded behavioral healthcare system. |
| 3 | Promote holistic, integrated physical and behavioral health services/supports, utilizing bi-directional models, across Kentucky's publicly funded healthcare system. |
| 4 | Reduce health disparities and premature death among individuals with behavioral health disorders. |
| 5 | Maintain focus on addressing the behavioral healthcare needs of targeted populations, including:<br>• Persons who have mental health or substance abuse disorders and are:<br>➢ Pregnant;<br>➢ Diagnosed with HIV/AIDS;<br>➢ Intravenous drug users;<br>➢ Diagnosed with tuberculosis;<br>➢ Adolescents; or<br>➢ Parents with dependent children.<br>• Adults with Severe Mental Illness<br>• Children/youth with Severe Emotional Disturbance; or<br>• Individuals with co-occurring mental health and substance use disorders. |

| | |
|---|---|
| 6 | Further develop evidence-based substance abuse prevention and mental health promotion and prevention activities across the Commonwealth. |
| 7 | Further develop behavioral health services and supports for adults with SMI and children/youth with SED who are involved with the juvenile and criminal justice systems. |
| 8 | Expand behavioral health (mental health and substance abuse) prevention and treatment services to military personnel and their families. |
| 9 | Enhance the knowledge and skills of behavioral health providers and others that could/do lend support to citizens with behavioral health disorders (first responders, correctional officers, courts, employers, human service agencies, etc.). |

States are required to develop Goals, Strategies and Performance Indicators to address each of these priorities and these are detailed in Section II of this document. Additionally, states are required to provide detailed planned and expended financial tables in Section III, followed by multiple narrative reports in Section IV.

**A Note on the Changes in Application and Reporting Due Dates and Fiscal Years**

While the statutory deadlines remain unchanged, SAMHSA has made changes to the timeframe in which states are asked to submit its application and report their implementation progress to better coincide with the state fiscal year calendar (July 1-June 30). The FFY 2012 block grant application must be submitted by September 1, 2011 and will be for a 21-month period (10/1/11-6/30/13). The subsequent Block grant application will be submitted to SAMHSA on 4/1/13 for a two year period (July1 2013-June 30, 2015). The table below shows the full timelines with which states must comply.

| Application for FFY | Plan Due | Plan is for the Period of | Reports and Assurance Due | Reporting Period |
|---|---|---|---|---|
| 2012 | 9/1/2011 | 10/1/11-6/30/13 | 12/1/11 | 10/1/10-9/30/11 |
| 2013 | | | 12/1/12 | 7/1/11-6/30/12 |
| 2014 | 4/1/13 | 7/1/13-6/30/15 | 12/1/13 | 7/1/12-6/30/13 |
| 2015 | | | 12/1/14 | 7/1/13-6/30/14 |
| 2016 | 4/1/15 | 7/1/15-6/30/17 | 12/1/15 | 7/1/14-6/30/15 |
| 2017 | | | 12/1/16 | 7/1/15-6/30/16 |

*Note: Reporting timeframes for SYNAR will remain on the current schedule.*

# I: State Information

## Chief Executive Officer's Funding Agreements/Certifications (Form 3) [SAPT]

**FY 2012 Substance Abuse Prevention and Treatment Block Grant Funding Agreements/Certifications as required by Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act**

Title XIX, Part B, Subpart II and Subpart III of the PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute.

SAMHSA will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached.

I. FORMULA GRANTS TO STATES, SECTION 1921

II. Certain Allocations (Prevention Programs utilizing IOM populations ; Pregnant women and women with dependent children) Section 1922

III. INTRAVENOUS DRUG ABUSE, SECTION 1923

IV. REQUIREMENTS REGARDING TUBERCULOSIS AND HUMAN IMMUNODEFICIENCY VIRUS, SECTION 1924

V. Group Homes for Recovering Substance Abusers, Section 1925

VI. State Law Regarding Sale of Tobacco Products to Individuals Under Age of 18, Section 1926

VII. TREATMENT SERVICES FOR PREGNANT WOMEN, SECTION 1927

VIII. ADDITIONAL AGREEMENTS(IMPROVED REFERRAL PROCESS, CONTINUING EDUCATION, COORDINATION OF ACTIVITIES AND SERVICES), SECTION 1928

IX. IX SUBMISSION TO SECRETARY OF STATEWIDE ASSESSMENT OF NEEDS, SECTION 1929

X. MAINTENANCE OF EFFORT REGARDING STATE EXPENDITURES, SECTION 1930

XI. Restrictions on Expenditure of Grant, Section 1931

XII. APPLICATION FOR GRANT; APPROVAL OF STATE PLAN, SECTION 1932

XIII. Opportunity for Public Comment on State Plans, Section 1941

XIV. Requirement of Reports and Audits by States, Section 1942

XV. ADDITIONAL REQUIREMENTS, SECTION 1943

XVI. Prohibitions Regarding Receipt of Funds, Section 1946

XVII. Nondiscrimination, Section 1947

XVIII. Continuation of Certain Programs, Section 1953

XIX. Services Provided By Nongovernmental Organizations, Section 1955

XX. Services for Individuals with Co-Occurring Disorders, Section 1956

I hereby certify that Kentucky will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, as 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.

| | |
|---|---|
| Name | Janie Miller |
| Title | Cabinet Secretary |
| Organization | Kentucky Cabinet for Health and Family Services |

Signature: Janie Miller Date: 10/11/11

**Footnotes:**

The Attachments section of the 2012 Combined Behavioral Health Assessment and Plan contains the signed .pdf version of the Chief Executive Officer's Funding Agreements/Certifications (Form 3) [SAPT].