Behavioral Health

(Mental Health & Substance Abuse)

Block Grant

Draft Application

for FFY 2016-2017

Please Note:

- Due September 1, 2015
- Feedback and Comments received through Friday, August 28, 2015 –Submit to Michele.Blevins@ky.gov
- The application is submitted electronically and is formatted according to federal instructions requiring responses to specific questions, thus the information presented is not always sequential and at times, may appear redundant

Thank you for your interest in reviewing the application!

EXECUTIVE SUMMARY
Unified Community Mental Health and Substance Abuse Prevention and Treatment Block Grant Application for FFY 2016-2017 Funds

Please note that no Executive Summary is required/able to be loaded into the electronic web application but is provided by KDBHDID for informational purposes.

This document contains Kentucky's plan for State Fiscal Years 2016-17 to strengthen the publicly-funded behavioral health systems of care for adults and youth across the Commonwealth. It is submitted by the Department for Behavioral Health, Intellectual and Developmental Disabilities (DBHDID), the state's designated authority for both mental health and for substance abuse prevention and treatment, in compliance with Public Law 102-321, and applies to funds that will become available in Federal Fiscal Years 2016 and 2017.

Historically, the federal Center for Mental Health Services and the Centers 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 and timeframes. In recent years, SAMHSA has encouraged states to submit a "unified" application with a significantly changed format. While the funds will continue to be awarded separately, states are strongly encouraged to participate in joint planning in an effort to transform their behavioral health system into one that is fully integrated. This is the third grant cycle in which Kentucky has submitted a "unified" application.

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, along with an annual abbreviated "funding" application. 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 include in their plan the efforts made toward the transition of block grants for 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 Behavioral Health Boards (the Community Mental Health Centers) that provide a full array of mental health and substance abuse prevention and treatment services. Federal limitations on administrative costs and maintenance of effort requirements will be met. A certain percentage of the state's mental health funding must be set aside for children's services and for first episode psychosis, and a certain percentage of substance abuse funding must be set aside for prevention activities and for treatment services

for pregnant/postpartum women and women with dependent children. 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 helps drive the development of stronger services and supports using all funding sources, including Medicaid, other federal grants, locally obtained funds, and State General Fund 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 Behavioral 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. There are currently new members being added to the Council to more fully represent substance abuse prevention and consumers and family members affected by substance use disorders. In addition to the Council meetings, a drafted application will be posted on the DBHDID website and comments are received through Friday August 28, 2015.

The application is comprised of four sections, including State Information, Planning Steps (2), Planning Tables (10), and Environmental Factors (22). Within the Planning Steps, states are required to address the five (5) federally designated Criterion for SMI and SED. In the first Planning Table, states are required to develop *Performance Indicators* with *Goals* and *Strategies* to address a number of federally prescribed priority areas/populations. States also are required to provide detailed planned and expended financial tables for mental health, substance use primary prevention, and substance use treatment.

As a result of the required planning process for this funding application, the table below represents *Performance Indicators* chosen for Kentucky for each of the prescribed priority areas/populations, including:

- Adults with Serious Mental Illness (SMI)
- Children/youth with Severe Emotional Disabilities (SED)
- Primary Prevention for Substance Use
- Persons who have Substance Use Disorders (SUD) and are:
    - Pregnant
    - Parents with dependent children
    - Intravenous drug users
    - Diagnosed with tuberculosis
    - Adolescents
- Other (as chosen by the state) Kentucky has chosen Service Members, Veterans and their Families and Individuals in Recovery from Substance Use Disorders.

STATE PERFORMANCE INDICATORS	
1	Increase the Number of Adults with SMI who receive Peer Support Services
2	Increase the Number of Adults with SMI who receive Assertive Community Treatment Services
3	Increase the Number of Children/Youth with SMI who receive High Fidelity Wraparound
4	Increase the Number of Certified Youth Peer Specialists statewide
5	Reduce the Incidence of Underage Drinking (10th graders who used Alcohol in the Past 30 days)
6	Increase the Number of Women with Substance Use Disorders who are Pregnant/Have Dependent Children who receive Case Management services, including Adolescents.
7	Increase Access to Naloxone/NARCAN Kits for IV Drug Users who Risk Death from Overdose
8	Improve Data Collection of Individuals with or at risk of Tuberculosis who are receiving Treatment for Substance Use Disorders
9	Increase Access to Culturally Competent Behavioral Health (Mental Health and Substance Use) Prevention and Treatment Services to Service Members, Veterans and their Families
10	Increase the Number of Oxford Houses for Individuals in Recovery from Substance Use Disorders

Detail about measurement and strategies to achieve the goals above are provided in detail in Section III, Table 1 of the application.

A Note Application and Reporting Due Dates and Fiscal Years

The FFY 2016-17 block grant application must be submitted by September 1, 2015 for the two year period of October 1 2015-September 30, 2017. States, also, are required to submit an abbreviated funding application based on their plan in the interim year (prior to September 1, 2016). The table below shows the timelines with which states must comply.

Application for FFY	Two Year Plan Due	Abbreviated Funding Application	Plan is for the Period of	Implementation Reports Due	Reporting Period
2016	9/1/2015		10/1/15-9/30/16	12/1/15	7/1/14-6/30/15
2017		9/1/2016	10/1/16-9/30/17	12/1/16	7/1/15-6/30/16

Note: Reporting timeframes for SYNAR (sale of tobacco products to minors) will remain on the same schedule and are annually due by December 31.

State Information

State Information

Plan Year

Start Year 2016

End Year 2017

State SAPT DUNS Number

Number 927049767

Expiration Date

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

Agency Name Cabinet for Health and Family Services

Organizational Unit Department for Behavioral Health, Developmental and Intellectual Disabilities

Mailing Address 275 East Main Street 4 W-G

City Frankfort

Zip Code 40601

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

First Name Michele

Last Name Blevins

Agency Name Cabinet for Health and Family Services

Mailing Address 275 East Main Street 4W-G

City Frankfort

Zip Code 40601

Telephone 502-782-6150

Fax 502-564-9010

Email Address Michele.Blevins@ky.gov

State CMHS DUNS Number

Number 927049767

Expiration Date

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

Agency Name Cabinet for Health and Family Services

Organizational Unit Department for Behavioral Health, Developmental and Intellectual Disabilities

Mailing Address 275 East Main Street 4W-G

City Frankfort

Zip Code 40601

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

First Name Michele

Last Name Blevins

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

Mailing Address 275 East Main Street 4W-G

City	Frankfort
Zip Code	40621
Telephone	502-782-6150
Fax	502-564-9010
Email Address	Michele.Blevins@ky.gov

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

From

To

IV. Date Submitted

Submission Date

Revision Date

V. Contact Person Responsible for Application Submission

First Name	Michele
Last Name	Blevins
Telephone	502-782-6150
Fax	5025649010
Email Address	michele.blevins@ky.gov

Footnotes:

State Information

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

Fiscal Year 2016

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

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

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

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

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

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

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

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

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

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

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

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

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

State Information

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

Fiscal Year 2016

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
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Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
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1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
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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.
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14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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

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3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

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

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

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

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

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

State Information

Disclosure of Lobbying Activities

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

Standard Form LLL (click here)

Name	Audrey Tayse Haynes
Title	Secretary
Organization	Kentucky Cabinet for Health & Family Services

Signature: _____ Date: _____

Footnotes:

Quality and Data Collection Readiness

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's ***NBHQF****. The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.*

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at ***http://www.samhsa.gov/data/quality-metrics/block-grant-measures****. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.*

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. *Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).*
2. *Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).*
3. *Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?*
4. *If not, what changes will the state need to make to be able to collect and report on these measures?*

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

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Adults with Serious Mental Illness (SMI)

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Increase the availability of evidence based practices for Adults with SMI

Objective:

Increase the total number of Adults with SMI who receive Assertive Community Treatment (ACT) and Peer Services (PS) by 5% from SFY 2015 to SFY 2017.

Strategies to attain the objective:

CMHCs are required by contract to develop ACT teams and also to employ Peer Support Specialists to serve Adults with SMI. PS are also required as a designated member of ACT teams.
Each of the 14 CMHCs is required by contract to have at least one fully staffed ACT team.
Provide training and technical assistance to ensure that CMHCs understand how to provide and bill for ACT services.
Provide training and Technical Assistance and fidelity monitoring to ensure most effective implementation of ACT services.
Continue to provide awareness activities and training regarding Recovery Principles and the importance of including Peers in the service delivery array.
Provide training for how to most effectively supervise the work of Peer Specialists.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Peer Services for Adults with SMI

Baseline Measurement: The total number of Adults with SMI who recieved Peer Services in SFY 2015.

First-year target/outcome measurement: 2.5% increase

Second-year target/outcome measurement: 2.5% increase

Data Source:

MHSIP data set used by the Department and the 14 CMHCs

Description of Data:

Data report to show number of unduplicated adults with SMI served received the identified service of Peer Services.

Data issues/caveats that affect outcome measures::

Department will also keep track of the number of Peer Specialists employed by the CMHCs to use for comparative analysis.

Indicator #: 2

Indicator: Assertive Community Treatment (ACT) services for Adults with SMI who meet criteria for the service

Baseline Measurement: Total number of Adults with SMI who recieve ACT services from the 14 CMHCs in SFY 2015

First-year target/outcome measurement: 2.5% increase in the total number of Adults with SMI who recieve ACT services from the 14 CMHCs from SFY 2015 to SFY 2016

Second-year target/outcome measurement: 2.5% increase in the total number of Adults with SMI who recieve ACT services from the 14 CMHCs from SFY2016 to SFY 2017in SFY 2015

Data Source:

MHSIP data set used by the Department and the 14 CMHCs

Description of Data:

Data report to show the total number of unduplicated Adults with SMI served by the 14 CMHCs who received the identified service of ACT in the SFY (July 1-June 30)

Data issues/caveats that affect outcome measures::

Department will also track the number of ACT teams in operation through the CMHCs to use for comparative analysis

Priority #: 2

Priority Area: Children and Youth with Severe Emotional Disabilities (SED)

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Increase access to evidence based practices for Children/Youth with SED

Objective:

Track the total number of children/youth who receive High Fidelity Wraparound (HFW) and from the 14 CMHCs and track the total number of certified Youth Peer Specialists from SFY 2015 to SFY 2017

Strategies to attain the objective:

Recruit and train high fidelity wraparound facilitators and their supervisors
Recruit and train youth peer specialists
Ensure there is a formalized process in place to train, certify and track SED Targeted Case Managers and HFW facilitators
Ensure there is a formalized process in place to train, certify and track Youth Peer Specialists

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase in the total number of DBHDID Certified HFW facilitators to serve children/youth with SED from SFY 2015 to SFY 2017

Baseline Measurement: Total number of DBHDID Certified HFW facilitators in SFY 2015 =0

First-year target/outcome measurement: At least 50 unduplicated HFW facilitators shall be trained and certified in SFY 2016

Second-year target/outcome measurement: At least 100 unduplicated HFW facilitators shall be trained and certified in SFY 2017

Data Source:

DBHDID Certification Data base

Description of Data:

Provider entities must obtain approval of training curricula or receive training through DBHDID. DBHDID is in the process of creating an on line data base in AFY 2016 to track the training and certification of non-licensed service providers (TCM, PS, Community Support Associates)

Data issues/caveats that affect outcome measures::

All new tracking system

Indicator #: 2

Indicator: Increase in the total number of DBHDID Certified Youth Peer Specialists to serve children/youth with SED from SFY 2015 to SFY 2017

Baseline Measurement: Total number of DBHDID Certified Youth Peer Specialists in SFY 2015 =0

First-year target/outcome measurement: At least 10 Youth Peer Specialists shall be trained and certified in SFY 2016

Second-year target/outcome measurement: At least 10 additional Youth Peer Specialists shall be trained and certified in SFY 2017

Data Source:

DBHDID Certification Data Base

Description of Data:

DBHDID Certification Data Base
Provider entities must obtain approval of training curricula or receive training through DBHDID. DBHDID is in the process of creating an on-line data base in SFY 2016 to track the training and certification of non-licensed service providers (TCM, PS, Community Support Associates)

Data issues/caveats that affect outcome measures::

All new tracking system

Priority #: 3

Priority Area: Primary Prevention Substance Abuse

Priority Type: SAP

Population(s): PP

Goal of the priority area:

Reduce the incidence of Underage Drinking

Objective:

Decrease in the number of 10th graders who report drinking alcohol

Strategies to attain the objective:

Educate parents about 'host parties"
Improve early screening and assessment of adolescents in school settings

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Numer of 10th graders who report drinking alcohol in the past 30 days

Baseline Measurement: 2014 Survey results indicate 21% of 10th graders that answered at least once they have had an alcoholic beverage in the past 30 days

First-year target/outcome measurement: N/A Survey is only conducted every two years

Second-year target/outcome measurement: Decrease by 2% the number of 10th graders that answered at least once they have had an alcoholic beverage in the past 30 days

Data Source:

Kentucky Incentives for Prevention Survey

Description of Data:

The KIP survey provides information about student self-reported use of substances (e.g., within the last 30 days, last year), student perceptions about substance use (e.g., level of risk, peer and parent disapproval), and perceived accessibility of substances in the community. The 2014 survey includes the addition of several new questions related to heroin use, bullying, dating violence, and suicidal ideation. Once the survey data are gathered and analyzed, each participating school district receives a report outlining district specific results, and depicting comparisons to the region, state and (when available) the rest of country.
The KIP survey is Kentucky's largest source of data related to student use of alcohol, tobacco, and other drugs (ATOD), as well as a number of factors related to potential substance abuse. In 2014, over 124,000 students representing 159 school districts completed the survey, and the information gathered provided an invaluable substance abuse prevention tool for those communities. Districts utilize

their KIP results extensively for grant-writing purposes, prevention activities, and various other needs related to program planning.

Data issues/caveats that affect outcome measures::

Priority #: 4

Priority Area: Pregnant Women/Women with Dependent Children (Adolescents and Adults) with Substance Use Disorders

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Increase access to treatment for Pregnant/Post Partum and Women with Dependent Children who have Substance Use Disorders (SUDs)

Objective:

Increase the total number of Pregnant/Post Partum women and Women with Dependent Children with SUDs who receive Case Management Services

Strategies to attain the objective:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase by 10% the total number of unduplicated PWWDC who recieve Case Management from the 14 CMHCs in the SFY

Baseline Measurement: Total number served in SFY 2015

First-year target/outcome measurement: 5% increase in the Total number served from SFY 2015 to SFY 2016

Second-year target/outcome measurement: 5% increase in the Total number served from SFY 2016 to FY 2017

Data Source:

MHSIP data set used by the Department and the 14 CMHCs

Description of Data:

Data report shows the unduplicated number of individuals served who meet the demographics for PWWDC and received a service for SUD

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Increase by 10% the total number of unduplicated PWWDC who recieve Case Management services

Baseline Measurement: The total number of unduplicated PWWDC who recieved Case Management services from the 14 CMHCs in SFY 2015

First-year target/outcome measurement: Increase by 5% the total number of unduplicated PWWDC who recieved Case Management services from the 14 CMHCs from SFY 2015 to SFY 2016

Second-year target/outcome measurement: Increase by 5% the total number of unduplicated PWWDC who recieved Case Management services from the 14 CMHCs from SFY 2016 to SFY 2017

Data Source:

MHSIP data set used by the Department and the 14 CMHCs and additional Data Analysis provided by the Center for Drug and Alcohol Research

Description of Data:

Data reports show the unduplicated number of PWWDC served who meet the demographics for PWWDC and received case management services from the CMHCs in the SFY

Data issues/caveats that affect outcome measures::

Priority #: 5

Priority Area: Intravenous Drug Users

Priority Type: SAT

Population(s): IVDUs

Goal of the priority area:

Reduce deaths of IV Drug Users

Objective:

Provide, free of charge, Naloxone Rescue kits to hospitals for distribution to every treated and discharged overdose victim at specified hospitals across the state

Strategies to attain the objective:

Distribute NARCAN Kits to additional hospitals in other areas of the state and to first responders and others as funding allows
Educate IV Drug Users, their families and the general public about the availability and effectiveness of Naloxone in the effect of an overdose.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The total number of Narcan (Naloxone) kits distributed to hospitals or elsewhere in the SFY

Baseline Measurement: Two thousand kits were distributed to three hospitals (UK,U of L and St. Elizabeth) in SFY 2015

First-year target/outcome measurement: 200 additional kits will be distributed in SFY 2016

Second-year target/outcome measurement: 200 additional kits will be distributed in SFY 2017

Data Source:

The Substance Abuse Treatment Advisory Committee (SATAC)

Description of Data:

DBHDID has access to the number of kits distributed through the KYKIDS Recovery

Data issues/caveats that affect outcome measures::

Priority #: 6

Priority Area: Individuals who recieve SUD services and have or are risk for TB

Priority Type: SAT

Population(s): TB

Goal of the priority area:

Improve data collection of individuals with or at risk of TB who receive services for SUDs

Objective:

Strategies to attain the objective:

Partner with the KY Department for Public Health and the CMHCs to improve data collection definitions and screening protocol

Priority #: 7

Priority Area: Service Members, Veterans and their Families

Priority Type: SAP, SAT, MHS

Population(s): SMI, SED, PWWDC, PP, IVDUs, TB

Goal of the priority area:

Increase access to culturally competent behavioral health (mental health and substance use) Prevention and Treatment services to Service Members, Veterans and their Families (SMVF).

Objective:

Create SMVF behavioral health designation for providers of prevention activities and services for mental health and substance use disorders

Strategies to attain the objective:

Utilize previously developed and/or endorsed programs and trainings to collaboratively develop a Military Behavioral Health Provider Designation and tracking system to capture applicable programs and activities.
Prior to receiving the designation, providers will participate in Operation Immersion, complete web-based educational sessions, receive 2-day in-depth training in suicide prevention and intervention (non-clinical), or assessment, management, and treatment (clinical).
Following designation, providers will be required to maintain designation through continued education opportunities.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The total number of designated programs and activites statewide

Baseline Measurement: Number of designated programs in SFY 2015 (o)

First-year target/outcome measurement: 5 Designations

Second-year target/outcome measurement: 5 Designations

Data Source:

MHSIP data set used by the Department and the 14 CMHCs
Program staff will monitor and receive reports from the Providers.

Description of Data:

Collection of individuals served, providers designated and prevention and treatment outcomes of individuals served.

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Peer services for SMVF that are culturally competent for population served

Baseline Measurement: Number of Peer Specialists with applicable lived experience who are certified as Peer Specialists by DBHDID

First-year target/outcome measurement: 5

Second-year target/outcome measurement: 10

Data Source:

MHSIP data set used by the Department and the 14 CMHCs
Reports regarding Peer Specialists working in the filed with applicable lived experience
On line tracking system that captures the number of Peer Specialists certified by DBHDID and their required annual continuing education

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 8

Priority Area: Individuals in Recovery from Substance Use Disorders

Priority Type: SAT

Population(s): Other

Goal of the priority area:

Increase the number of Oxford Houses in Kentucky

Objective:

Open at least 2 additional Oxford Houses in KY by the end of SFY 2017

Strategies to attain the objective:

Contract with Oxford House to employ Case Managers and secure housing units

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	$31,870,694		$0	$1,705,800	$3,589,600	$0	$0
a. Pregnant Women and Women with Dependent Children*	$7,000,000		$0	$0	$3,589,600	$0	$0
b. All Other	$24,870,694		$0	$1,705,800	$0	$0	$0
2. Substance Abuse Primary Prevention	$8,503,860		$0	$1,470,000	$0	$0	$0
3. Tuberculosis Services	$0		$0	$0	$0	$0	$0
4. HIV Early Intervention Services	$0		$0	$0	$0	$0	$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention**							
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)							
10. Administration (Excluding Program and Provider Level)	$120,000		$0	$0	$2,245,206	$0	$0
13. Total	**$40,494,554**	**$0**	**$0**	**$3,175,800**	**$5,834,806**	**$0**	**$0**

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

State Pregnant and Women with Dependent Children funding includes agency receipts received from the state Department of Early Childhood Development.

Other Federal Prevention funding includes funds received from SAMHSA to provide Partnerships for Success 2015.

Other Federal Treatment funding includes a small carry-forward from SAMHSA for Adolescent Treatment, and the SA portion of the Cooperative Agreement to Benefit Homeless Individuals - States.

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			$0	$0	$0	$0	$0
6. Other 24 Hour Care		$0	$0	$0	$0	$0	$0
7. Ambulatory/Community Non-24 Hour Care		$0	$0	$0	$0	$0	$0
8. Mental Health Primary Prevention**		$0	$0	$0	$0	$0	$0
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)		$0	$0	$0	$0	$0	$0
10. Administration (Excluding Program and Provider Level)		$0	$0	$0	$0	$0	$0
13. Total	$0	$0	$0	$0	$0	$0	$0

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

Planning Tables

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	SABG Expenditures	MHBG Expenditures
Healthcare Home/Physical Health	$	$
General and specialized outpatient medical services;		
Acute Primary Care;		
General Health Screens, Tests and Immunizations;		
Comprehensive Care Management;		
Care coordination and Health Promotion;		
Comprehensive Transitional Care;		
Individual and Family Support;		
Referral to Community Services;		
Prevention Including Promotion	$	$

Screening, Brief Intervention and Referral to Treatment ;		
Brief Motivational Interviews;		
Screening and Brief Intervention for Tobacco Cessation;		
Parent Training;		
Facilitated Referrals;		
Relapse Prevention/Wellness Recovery Support;		
Warm Line;		
Substance Abuse Primary Prevention	**$**	**$**
Classroom and/or small group sessions (Education);		
Media campaigns (Information Dissemination);		
Systematic Planning/Coalition and Community Team Building(Community Based Process);		
Parenting and family management (Education);		
Education programs for youth groups (Education);		
Community Service Activities (Alternatives);		
Student Assistance Programs (Problem Identification and Referral);		

Employee Assistance programs (Problem Identification and Referral);		
Community Team Building (Community Based Process);		
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental);		
Engagement Services	$	$
Assessment;		
Specialized Evaluations (Psychological and Neurological);		
Service Planning (including crisis planning);		
Consumer/Family Education;		
Outreach;		
Outpatient Services	$	$
Individual evidenced based therapies;		
Group Therapy;		
Family Therapy ;		
Multi-family Therapy;		

Consultation to Caregivers;		
Medication Services	$	$
Medication Management;		
Pharmacotherapy (including MAT);		
Laboratory services;		
Community Support (Rehabilitative)	$	$
Parent/Caregiver Support;		
Skill Building (social, daily living, cognitive);		
Case Management;		
Behavior Management;		
Supported Employment;		
Permanent Supported Housing;		
Recovery Housing;		
Therapeutic Mentoring;		
Traditional Healing Services;		

Recovery Supports	$	$
Peer Support;		
Recovery Support Coaching;		
Recovery Support Center Services;		
Supports for Self-directed Care;		
Other Supports (Habilitative)	$	$
Personal Care;		
Homemaker;		
Respite;		
Supported Education;		
Transportation;		
Assisted Living Services;		
Recreational Services;		
Trained Behavioral Health Interpreters;		

Interactive Communication Technology Devices;		
Intensive Support Services	$	$
Substance Abuse Intensive Outpatient (IOP);		
Partial Hospital;		
Assertive Community Treatment;		
Intensive Home-based Services;		
Multi-systemic Therapy;		
Intensive Case Management ;		
Out-of-Home Residential Services	$	$
Crisis Residential/Stabilization;		
Clinically Managed 24 Hour Care (SA);		
Clinically Managed Medium Intensity Care (SA) ;		
Adult Mental Health Residential ;		
Youth Substance Abuse Residential Services;		
Children's Residential Mental Health Services ;		

Therapeutic Foster Care;		
Acute Intensive Services	$	$
Mobile Crisis;		
Peer-based Crisis Services;		
Urgent Care;		
23-hour Observation Bed;		
Medically Monitored Intensive Inpatient (SA);		
24/7 Crisis Hotline Services;		
Other	$	$
Total	$0	$0

Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Expenditure Category	FY 2016 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	$15,935,347
2 . Substance Abuse Primary Prevention	$4,251,930
3 . Tuberculosis Services	$0
4 . HIV Early Intervention Services**	$0
5 . Administration (SSA Level Only)	$60,000
6. Total	**$20,247,277**

* Prevention other than primary prevention

** 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by CDC, National Center for HIV/AIDS, Hepatitis, STD and TB Prevention. The HIV Surveillance Report, Volume 24, will be used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective FY 2016 SABG allotments to establish one or more projects to provide early intervention services for HIV at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state does not meet the AIDS case rate threshold for the fiscal year involved. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would be allowed to obligate and expend FY 2016 SABG funds for EIS/HIV if they chose to do so.

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Strategy	IOM Target	FY 2016
		SA Block Grant Award
Information Dissemination	Universal	$585,422
	Selective	$7,998
	Indicated	$4,418
	Unspecified	$0
	Total	**$597,838**
Education	Universal	$416,434
	Selective	$9,010
	Indicated	$10,152
	Unspecified	$0
	Total	**$435,596**
Alternatives	Universal	$178,037
	Selective	$494
	Indicated	$0
	Unspecified	$0
	Total	**$178,531**
Problem Identification and Referral	Universal	$162,889
	Selective	$3,475
	Indicated	$725
	Unspecified	$0
	Total	**$167,089**

Community-Based Process	Universal	$1,238,882
	Selective	$3,721
	Indicated	$656
	Unspecified	$0
	Total	**$1,243,259**
Environmental	Universal	$372,869
	Selective	$0
	Indicated	$0
	Unspecified	$0
	Total	**$372,869**
Section 1926 Tobacco	Universal	$0
	Selective	$0
	Indicated	$0
	Unspecified	$85,000
	Total	**$85,000**
Other	Universal	$0
	Selective	$0
	Indicated	$0
	Unspecified	$1,253,618
	Total	**$1,253,618**
Total Prevention Expenditures		$4,333,800
Total SABG Award*		**$20,247,277**
Planned Primary Prevention Percentage		**21.40 %**

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

Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award	
Universal Direct	$2,954,533	
Universal Indirect	$1,338,617	
Selective	$24,698	
Indicated	$15,952	
Column Total	**$4,333,800**	
Total SABG Award*	**$20,247,277**	
Planned Primary Prevention Percentage	**21.40 %**	

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

Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

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

Planning Tables

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award			
	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	$0	$0	$0	**$0**
2. Quality Assurance	$0	$0	$0	**$0**
3. Training (Post-Employment)	$0	$0	$0	**$0**
4. Education (Pre-Employment)	$0	$0	$0	**$0**
5. Program Development	$0	$0	$0	**$0**
6. Research and Evaluation	$0	$0	$0	**$0**
7. Information Systems	$0	$0	$0	**$0**
8. Total	**$0**	**$0**	**$0**	**$0**

Footnotes:

Planning Tables

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	Block Grant
MHA Technical Assistance Activities	
MHA Planning Council Activities	
MHA Administration	
MHA Data Collection/Reporting	
MHA Activities Other Than Those Above	
Total Non-Direct Services	$0
Comments on Data:	

Footnotes:

SUBSTANCE ABUSE BLOCK GRANT ALLOCATIONS FOR STATE FISCAL YEAR 2016

CONTRACTED TO THE REGIONS FOR SERVICES:

Region	Treatment	Preg & Post-Partum	Prevention	TOTAL
1 Four Rivers	471,211	72,896	153,862	697,969
2 Pennyroyal	528,568	75,305	224,516	828,389
3 River Valley	515,115	79,297	226,693	821,105
4 LifeSkills	721,556	233,883	225,137	1,180,576
5 Communicare	533,379	188,746	252,502	974,627
6 Seven Counties	2,136,172	1,145,316	338,274	3,619,762
7 NorthKey	893,695	630,729	217,048	1,741,472
8 Comprehend	189,196	15,010	111,044	315,250
10 Pathways	786,001	195,123	251,536	1,232,660
11 Mountain Comp	332,745	63,172	163,543	559,460
12 Kentucky River	288,221	90,494	192,645	571,360
13 Cumberland River	538,649	178,790	197,635	915,074
14 Adanta	403,817	117,882	232,652	754,351
15 Bluegrass	1,831,667	445,727	473,170	2,750,564
	10,169,992	3,532,370	3,260,257	**$16,962,619**

STATEWIDE PROJECTS:

Region	Program or Service	Amount
4 LifeSkills	NIATx Training Funds	35,000
4 LifeSkills	Prevention	70,222
4 LifeSkills	Treatment	10,000
4 LifeSkills	Kentucky Prevention Network	19,950
5 Communicare	Crisis Intervention	30,000
15 Bluegrass	Statewide Deaf & Hard of Hearing	20,000
15 Bluegrass	Suicide Prevention	15,000
		$200,172

MISCELLANEOUS FUNDED WITH SAPT BLOCK GRANT:

	Treatment	Preg & Post-Partum	Prevention	TOTAL
REACH of Louisville	-	-	365,321	365,321
Recovery Oriented Training (People Advocating Recovery)	96,300	-	-	96,300
Office of Vocational Rehabilitation	100,000	-	-	100,000
Oxford House	180,000	-	-	180,000
KPFC	15,000	-	-	15,000
Kentucky Housing Corp	13,333	-	-	13,333
Louisville Metro Health Dept	500,000	-	-	500,000
Eastern Kentucky University	280,776	-	184,635	465,411
UK - CDAR	614,571	60,000	-	674,571
	1,799,980	60,000	549,956	**$2,409,936**

TOTAL CONTRACTED **$19,572,727**

Audit Reserve	674,558 *	674,558

TOTAL BLOCK GRANT ALLOCATIONS $20,247,285

* Division management staff plan to meet to discuss various proposals received for unallocated funding.

MENTAL HEALTH BLOCK GRANT ALLOCATIONS FOR FISCAL YEAR 2016

Rev. 7.10.15

CONTRACTED TO THE REGIONS FOR SERVICES:

Region	Emergency	DIVERTS	Children	Consumer Operated Programs	SMI/SED Deaf & HoH	TOTAL
Four Rivers	11,936	135,139	80,257	35,000		262,332
Pennyroyal	10,391	169,967	77,492			257,850
River Valley	10,221	186,882	83,988			281,091
LifeSkills	15,697	191,484	91,609	35,000		333,790
Communicare	14,843	163,047	107,963	35,000		320,853
Seven Counties	30,801	441,424	190,488	50,000	38,833	751,546
North Key	12,914	258,649	118,853	50,000		440,416
Comprehend	6,917	35,045	76,963			118,925
Pathways	12,787	212,432	94,444	50,000		369,663
Mountain	12,879	169,467	87,466	35,000		304,812
Kentucky River	9,086	85,096	82,176			176,358
Cumberland River	13,169	243,676	107,350			364,195
Adanta	11,843	135,747	92,674			240,264
Bluegrass	23,908	135,983	152,512		34,482	346,885
TOTAL	**197,392**	**2,564,038**	**1,444,235**	**290,000**	**73,315**	**$4,568,980**

STATEWIDE PROJECTS:

Regional Board	Program or Service	Amount
LifeSkills	Children's Training & Technical Assistance	40,000
LifeSkills	Adult MH Training and Technical Assistance	40,000
LifeSkills	Recovery Initiative	20,000
LifeSkills	Peer Support Training & Technical Assistance	20,000
LifeSkills	MH 5% Sed Aside	15,000
LifeSkills	LOCUS	5,000
LifeSkills	Person Centered Recovery Plans	20,000
LifeSkills	Supported Employment Fidelity Initiative	21,000
Seven Counties	Office of Consumer Advocacy	53,000
Seven Counties	Mental Health and Aging	20,000
Bluegrass	SIAC Support	25,000
Bluegrass	Statewide Deaf & Hard of Hearing	34,787
Communicare	CIT Training	70,000
		$383,787

OTHER:

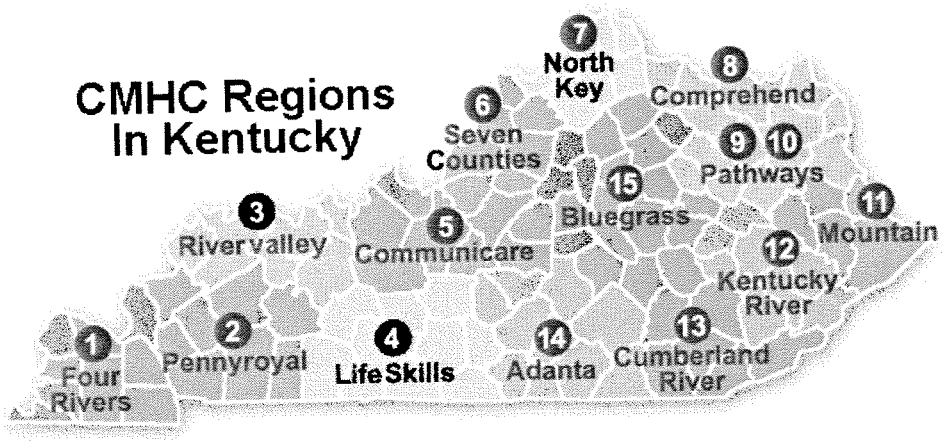
Department of Corrections - Reintegration Specialist	50,000
Office of Vocational Rehabilitation - Supported Employment Services	250,000
Eastern Kentucky University	325,868
Kentucky Housing Corporation - Supported Housing Specialist	13,334
Kentucky Partnership for Families & Children - Family Driven Youth Guided Training & Support	143,000
Behavioral Health Planning Council	20,000
NAMI KY - Recovery Oriented Family Support	142,554
NAMI of Lexington (Participation Station) - Recovery Oriented Training	150,190
University of Kentucky - Institute for Pharmaceutical Outcomes & Policy (IPOP)	100,000
University of Kentucky - Dartmouth Supported Employment	204,097
Audit Reserve	1,455,790
State Travel	20,000
	$2,874,833

TOTAL BLOCK GRANT ALLOCATIONS **$7,827,600**

Step 1: Assess the Strengths and Needs of the Service System to Address the Specific Populations

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; and Developmental and Intellectual Disabilities. The DBHDID receives state general funds allocated for the prevention and treatment of behavioral health (mental health and substance abuse) in a biennial budget and is charged with administering the funds annually to achieve its service and quality goals.

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; that is governed by a volunteer board of directors that broadly represents stakeholders (including consumers and family members) and counties in the region; and is licensed by the Cabinet for Health and Family Services as a "Community Mental Health Center."



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

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; Outpatient Services; Partial Hospitalization or Psychosocial Rehabilitation Services; Emergency Services; Consultation and Education Services; and Services for Individuals with an Intellectual Disability.

Behavioral health services, including mental health services for adults and children, substance abuse services for adults and adolescents, and services for individuals with co-occurring disorders are provided in county level clinics. 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 established to provide technical assistance and training on evidence-based prevention strategies.

With its available resources of state general funds, block grant/other federal funds, and awarded agency funds, DBHDID contracts with the fourteen private, not-for-profit CMHCs to provide services to citizens in all 120 counties of the state. CMHCs are required to specifically describe their current systems of care for adults and children, including crisis care, and are required to report their plans for development regarding key system components, within an annual Plan & Budget process. DBHDID is committed to working collaboratively with CMHCs to continuously enhance continuity of care, service effectiveness and accountability. DBHDID contracts with a small number of other non-profit, community based, providers for additional targeted services.

DBHDID also has authority for inpatient psychiatric care for the indigent and operates or contracts for several adult mental health inpatient facilities, as displayed in the table below. The care in these facilities is provided with state general funds as they are IMD designated facilities.

State Hospital	Location	Operation	SFY 2005 ADC*	SFY 2013 ADC	SFY 2014 ADC
Western State Hospital	Hopkinsville	State operated	144	119	
Central State Hospital	Louisville	State operated	108	59	
Eastern State Hospital	Lexington	Contracted	162	127	
Appalachian Regional Hospital (ARH) -Hazard Psychiatric Center	Hazard	Contracted	82	88	
*ADC= Average Daily Census		TOTAL	496	393	

Census at state hospitals had declined over the past decade as efforts were made to place persons in appropriate community programs. However, fluctuating factors, such as the closing of many psychiatric units within local community primary care hospitals and the implementation of Medicaid managed care in Kentucky has affected state hospital census in recent years.

In August 2013, the Cabinet for Health and Family Services entered into a settlement agreement with Kentucky Protection and Advocacy to develop and implement services to allow 600 individuals with SMI, who are residing in or at risk of entry into Personal Care Homes, to live in the community by October 2016. To operationalize this, DBHDID reallocated funding from state psychiatric facilities to the 14 CMHCs to provide the intensive community services needed. These funds, combined with Mental Health Block Grant funds, provide Assertive Community Treatment (ACT), Supported Housing (SH), Supported Employment (SE), and Peer Support (PS). *For Medicaid recipients, ACT and PS are covered services.*

Kentucky Correctional Psychiatric Center is an inpatient psychiatric hospital, located within a correctional system complex, but operated by DBHDID. It primarily provides court-ordered inpatient evaluation and treatment to restore competency to persons charged with a felony offense. When inpatient evaluation is unnecessary, the Center facilitates outpatient competency evaluations through contracts for professional services with CMHCs. The facility's average daily census in SFY 2014 was approximately 60 people.

Although Kentucky has operated a variety of psychiatric facilities for adults, for over 165 years, the state does not operate any inpatient facilities for children and youth under eighteen years of age. There are currently 712 (up from 672 last year and from 633 in the previous year) available child psychiatric beds in Kentucky. The average daily

census for the 712 beds is 549 and the average length of stay for patients is 25 days. The 712 beds are located in 13 hospitals that are geographically located in 8 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, non-profit and for-profit organizations and many 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 same Cabinet as DMS and DBHDID, is the regulatory agency for licensing all health care facilities, day cares, long-term care facilities, and child adoption/child-placing agencies in the Commonwealth. The child welfare and juvenile justice agencies are the only state agencies authorized to take custody of children. Neither licensing, nor "care, custody and control" of children are a function of the DMS or DBHDID.

Currently, there is great need and much optimism for expansion of services, all along the continuum, for adults and youth with, or at risk of, substance use disorders. In addition to contracted outpatient/intensive outpatient services, DBHDID contracts with several CMHCs and a few other non-profit entities to provide specialized residential treatment for men, women, pregnant women and parents with dependent children, youth, individuals with SMI and SUD, and individuals who are homeless.

Kentucky has been applauded over the years for making a small amount of funding go a long way but ultimately the behavioral health system in Kentucky has been underfunded and unbalanced between community based services and inpatient/institutional care. Over the last decade, some progress has been made to give more balance to the funding equation and increased access to much needed services in the community.

The availability and funding of behavioral health services in Kentucky is currently undergoing significant change due to a variety of factors. Since the time of deinstitutionalization in the 1960's, Kentucky's publicly-funded services system for community based, non-residential, mental health and substance use has relied, almost solely, on a network of fourteen Community Mental Health Centers (CMHCs) who provide a full continuum of behavioral health services to nearly five percent of the state's population of nearly 4.5 million people. However, within the past five years, a number of changes have impacted the behavioral health delivery system, including the implementation of Medicaid managed care, implementation of the Affordable Care Act with a state-run health exchange and expanded Medicaid coverage, several approved Medicaid State Plan amendments, an expansion of the behavioral health provider network and numerous new and amended state laws and regulations. Still, the CMHCs remain strong and viable safety net providers for Kentucky citizens enrolled in Medicaid or other insurance plans, as well as those that are uninsured, underinsured or transitioning onto and out of insurance coverage. The following offers a brief description of the change factors currently underway in Kentucky.

In November 2011, Kentucky transitioned its Medicaid program to managed care by initiating of contracts with three managed care organizations (MCOs) to provide services to approximately 540,000 Medicaid enrollees in seven of the Commonwealth's eight Medicaid regions. Behavioral health was included along with physical health in an effort to provide a more integrated service continuum to those it serves. Contracts were enacted for a 30-month period (through June 30, 2014). A subsequent procurement process was initiated and as of July 1, 2015, Kentucky's Department for Medicaid Services has contracts with five managed care entities for physical and behavioral health services for Medicaid enrolled citizens statewide. The contracted entities include Wellcare, Humana/CareSource, Coventry, Anthem and Passport Health Plan.

In partnership with the Department for Medicaid Services (DMS), the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) has had a significant role in oversight of the managed care rollout, with a focus on the effects on the public behavioral health system. DBHDID meets with each MCO about every six weeks to review data, discuss interface with DBHDID programs (especially continuity of care issues), and formulary and payment issues. DMS and DBHDID staff also convene regularly scheduled meetings with the Behavioral Health Directors from each MCO (collectively) aimed at specifically addressing behavioral health coverage (coding, billing, and service system development issues).

In May 2013, the decision to expand Medicaid eligibility in Kentucky pursuant to the Affordable Care Act was announced, allowing individuals and families earning up to 138 percent of the federal poverty line to enroll in an insurance plan. Kentucky created Kynect, an on-line health insurance marketplace to allow citizens to learn about and select health insurance plans. The system allows for Medicaid eligible individuals to sign up for coverage through the marketplace. Medicaid coverage for the expansion population began Jan. 1, 2014. The first enrollment period added more than 310,000 Kentuckians to the Medicaid program and another 17,000, who were eligible but not previously enrolled under traditional Medicaid criteria, also signed up. To date, 403,125 Kentuckians have enrolled in health coverage under Medicaid expansion and an additional 105,877 have enrolled in coverage through a Qualified Health Plan. The initial research showed expanding Medicaid would create 17,000 new jobs and add $15.6 billion to the state's economy between 2014 and 2021. A 2015 Gallup Poll showed that Kentucky had the second largest drop of uninsured adults in the country, decreasing more than 10 points from 20.4% to 9.8%. For more information about Kynect see: **https://kynect.ky.gov/**

The Kentucky Department for Medicaid Services has submitted a series of State Plan Amendments (SPAs) in recent years and several expand Medicaid benefits for clinic, rehabilitation and targeted case management services. Perhaps the most significant is the addition of coverage for services for substance use disorders. Historically, Kentucky was in the minority of states that did not have a Medicaid benefit for substance use treatment, except for pregnant women. Information about the Medicaid covered services under the approved SPAs is provided elsewhere in this application.

Along with developing new behavioral health services through the Medicaid SPAs, the decision was made to expand the eligibility of professionals and organizations that are eligible to apply for and become Medicaid providers. Today the behavioral health providers who are able to seek reimbursement for Medicaid payment, through the MCOs, is vastly larger than in the past. There are a greater number of licensed professionals who may apply to become Medicaid providers including, Licensed Clinical Social Workers, Licensed Marriage and Family Therapists, Licensed Professional Clinical Counselors, Licensed Psychologists, Licensed Art Therapists, Certified Behavioral Analysts, and most recently Licensed Alcohol and Drug Counselors are likely to be added to the list. Several new licensure categories have been created including, Behavioral Health Services Organizations (BHSOs) and Multi-Specialty Groups (MSGs). A few services are limited to the organizational categories (e.g., residential crisis units) but most services are open to all licensed professionals. A growing number of FQHCs, RHCs, and Primary Care Providers are developing new or expanded behavioral health services.

With the many changes that have occurred in the behavioral healthcare system, the need for a significant number of new laws and regulations has ensued. DMS and DBHDID, as well as many other state agencies have worked together to achieve mutual goals and negotiate differences. The Governor and the Cabinets' Secretaries have been instrumental in moving the system forward. The First Lady has taken a particular interest in ensuring that substance use prevention and treatment services, especially for women and youth, are being developed and made available statewide.

More about legislation and reg changes (SB 200, SB needle exchange, LADC, etc.)

Criterion 1.1: Establishment of System of Care

Narrative Question: Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.

The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (KDBHDID) administers a comprehensive, community-based system of behavioral health care for adults with serious mental illness (SMI) and children with severe emotional disabilities (SED), and their families. With guidance from SAMHSA's *Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015-2018*, the department strives to further promote system of

care principles and objectives, while at the same time ensuring autonomy at the regional level for service planning and decision making.

The fourteen fourteen private, not-for-profit Regional Mental Health/Intellectual Disabilities Boards (Regional Boards) with which DBHDID contracts to serve citizens in all 120 counties of the state are required to specifically describe their current adults and children's systems of care and to state their plans for development regarding key system components, including:

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

DBHDID is committed to working collaboratively with Regional Boards to continuously enhance service access and capacity, consumer, children/youth and family involvement, evidence-based clinical care, seamless transitions between care, integrated care, and positive outcomes for adults, children/youth and families. Current activities regarding each of the components listed above are discussed throughout this grant application.

Within the Division of Behavioral Health, there is an Adult Mental Health and Recovery Services Branch and a Children's Behavioral Health and Recovery Services Branch with staff and seasonal interns dedicated to the development and implementation of strong and progressive behavioral health services and coordinated systems of care for adults, children/youth and families.

Criterion 1.2: Adults with SMI: 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

Physical Health

Kentucky is a relatively unhealthy state and struggles with poor health outcomes overall. 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.

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

Several CMHC across the state have been working on integrating behavioral and physical health care. One CMHC in western Kentucky (Pennyroyal) received a SAMHSA grant to assist with developing primary care services within the CMHC in an effort to integrate care for adults with SMI. This funding consisted of $500,000 over a four (4) year period, ending September 30, 2013. Pennyroyal created a separate entity called Pennyroyal Healthcare Services, to provide physical health care to individuals, and co-located behavioral health services. At present, a staff psychiatrist from Pennyroyal behavioral health is located at the healthcare center and provides behavioral health services. Targeted case managers for adults with SMI provide case management services to individuals receiving care from both centers. Pennyroyal Center has since received a New Access Point (NAP) grant from Health Services Resources Administration (HRSA), and Pennyroyal Healthcare Services (one clinic in Princeton, Kentucky and one clinic in Hopkinsville, Kentucky) has been designated as a Federally Qualified Health Center (FQHC).

One CMHC in Northern Kentucky (Comprehend) has received several integration grants over the years and has been working for several years with local medical providers to integrate behavioral health care through co-location projects. As of SFY 2015 they have co-located staff at one local hospital and are working with two (2) other local hospitals and numerous local primary care providers regarding integrated care.

One CMHC in eastern Kentucky (Mountain) was awarded a grant in SFY 2013 regarding health care for individuals who are homeless. A "Homeplace Clinic" was located in the lower level of the CMCH outpatient clinic in Johnson County, a very rural location in Kentucky, and provides services to individuals from surrounding counties. These services began in November of 2012. This collaboration project has made an integrated, holistic approach possible for individuals served in this area. Services provided thus far include preventative care, disease management, basic laboratory services, health education, medication management, patient assistance programs, mental health and substance abuse services, as well as referrals to other medical providers for dental, vision, and specialized medical care. Referrals for behavioral health services require either a phone call or simply walking an individual down the hall. The current clinic team consists of a nurse practitioner, two nurses, three case managers, two support staff, program director and a consulting medical director. Mountain developed a Homeplace Clinic within the CMHC outpatient clinic in Floyd County, and is working to develop a clinic that will serve Lawrence and Pike Counties. They have also applied for funding for a clinic in Pike County that will focus on integrated care specifically for individuals with SMI.

Another region in Northern Kentucky (NorthKey) is working to integrate care for individuals with SMI during the fall of 2015. They are planning to convert some meeting space at an outpatient clinic to physical health examination rooms/offices and have hired a nurse practitioner with a specialization in primary care to staff the new clinic. They are working to educate existing staff on integrated care for the population. NorthKey already has collaborative agreements with a local hospital and the FQHC in their area to assure prompt referrals for specialty services. They have also received letters of agreement from the local health department and other community partners who have agreed to support the program with referrals. They plan to track health indicators such as blood pressure, smoking status, body mass index (BMI), etc.

Oral Health

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 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 individuals in need who have no ability to pay. However, overall access to dental care is generally considered poor.

Mental Health and Rehabilitation

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

Regional Availability of Community Support Services SFY 2015

	1	2	3	4	5	6	7	8	10	11	12	13	14	15
Services	**Consumer and Family Support**													
Consumer Support Group	X	X		X	X	X	X	X		X	X	X	X	X
Consumer Operated Program	X			X	X	X	X		X	X				X
Social Club Drop In					X	X	X		X					
Local NAMI Affiliates	X	X		X	X	X	X	X	X	X	X	X	X	X
Consumer Conferences			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	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Mobile Crisis Services	X			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													
Community Medication Support	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Specialized Co-occurring Disorder Services	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Case Management Services														
Case Management	X	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
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	
Supported Employment	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Educational Services					X	X	X	X			X			X
Illness, Management, Recovery				X	X	X		X	X		X		X	
Peer Support Services	X		X	X	X	X	X	X	X	X	X	X	X	X
Assertive Community Treatment	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other* (Psychiatric Rehab)				X										
Housing Options														
Supported Housing Program		X	X	X		X	X		X	X	X	X		X
Residential Support		X				X		X	X	X	X			X
Housing Development		X			X	X				X	X	X	X	X

Each Regional Board provides a full array of outpatient services including, but not limited to, individual psychotherapy, group psychotherapy, psychiatric evaluations, walk-in emergency appointments, psychopharmacology, medication education and peer support services. Every effort is made to place these outpatient clinics within close geographic proximity for consumers in order assure easy access to needed services. Additional areas of focus include:

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

In January of 2014, a new Kentucky Medicaid state plan amendment was approved by CMS. Included as part of the new Medicaid billable package of services available for adults with SMI were such services as Assertive Community Treatment, Peer Support Services, Comprehensive Community Support Services, and Intensive Outpatient Treatment for mental health. The DBHDID restructured CMHC contracts to include many of these services as requirements. For example, each CMHC is now required to provide Assertive Community Treatment and Peer Support Services to individuals with SMI who qualify for those services.

Criterion 1.2: Children with SED: Available Resources Children's Mental Health

Narrative Question: Describe 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

Integration with Physical Health

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 physical healthcare arena. Continuity of care across these systems is critical if children and families are to get the most beneficial services possible. Regional Boards are required to conduct a physical health screening of all clients served. Department staff continues to assist contracted providers in improving tools used to assess physical health concerns and to encourage further assessment and integration of physical and behavioral healthcare.

Early Childhood Mental Health

Staff from the Department for Public Health and KDBHDID meets regularly as they share oversight of the Early Childhood Mental Health Initiative and the designated Specialists. Additionally, Public Health and KDBHDID staff oversees implementation of Moving Beyond Depression (MBD). The Moving Beyond Depression (MBD) program is a comprehensive approach to identifying and treating depression in mothers participating in home visitation. The MBD was developed to (1) establish a screening process to identify mothers in need of treatment, (2) provide an evidence-based treatment for depression that has been adapted for home visitation in order to optimize outcomes. The MBD is incorporated into HANDS (Kentucky's first –time parent home visitation program); HANDS home visitors administer the Beck Depression Inventory and when indicated, refer the mother for a comprehensive assessment and In-Home Cognitive Behavior Therapy with an intensively trained clinician within the local community mental health center. MBD provides a much needed service, as research indicates that depression in the postpartum period occurs in about 50% of populations served in home visitation programs. Depression can undermine effective and nurturing parenting, interferes with normal child development, and negatively impacts home visitation outcomes.

Kentucky Strengthening Families

Kentucky Strengthening Families (KYSF) represents a multi-disciplinary partnership of over 20 national, state and local, and public and private organizations dedicated to embedding six research-based Protective Factors into services and supports for children and their families. Supporting families is key strategy for promoting school readiness and preventing child abuse and neglect. All families experience times of stress, and research demonstrates that children

grow and learn best in families who have the supports and skills to deal with those times. By supporting families and building their skills to cope with stressors, we can increase school readiness and reduce the likelihood abuse will occur in families. Kentucky Strengthening Families is using a nationally recognized strategy—Strengthening Families: A Protective Factors Framework – which is coordinated nationally by the Center for the Study of Social Policy. KYSF is funded by the Governor's Office for Early Childhood through the Race to the Top/Early Learning Challenge Grant Program and the Kentucky Department for Public Health through the Early Childhood Comprehensive Systems Grant Program. KDBHDID staff serve on the KYSF Leadership Team, subcommittees, and training cadre. Additionally, KYSF protective factors have been embedded into CMHC contracts and Trauma Informed Care training.

Mental Health and Rehabilitation Services

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

A review of the information from the SFY 2014 Annual Plan and Budget applications reveals that Regional Boards continually strive to address barriers and meet the clinical service needs of children and families. Some examples of this include: update?

- Nine regions can get a child in for an initial intake appointment for a non-emergency in the same week that they contact the center;
- Eight regions provide walk-in crisis services for children and their family members during the evenings and weekends after clinics have closed;
- All regions offer off-site therapy services at the home of the child and throughout the community;
- The CMHCs employ 359 Service Coordinators to provide targeted case management to children and adolescents with SED;
- Eight of the fourteen regions offer specialized summer programs;
- Thirteen 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. In addition, the regions report employing 352 additional staff who have experience serving children birth through five and their families;
- Three regions have a Youth Representative on the Regional Interagency Council; and
- Six regions have a Parent Representative on the Center's Board of Directors.

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 three 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 Kentucky IMPACT programs that offer targeted case management services, utilizing wraparound, to ensure that children with SED receive needed services and supports. Over $5 million in state general funds is allocated to the Regional Interagency Councils that govern these Kentucky IMPACT programs. These funds are used to

support program operation, including employment of Family Liaisons and flexible funds to meet the needs of youth and families. Kentucky IMPACT is available to children with SED regardless of whether they are Medicaid recipients. Most of the Kentucky 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 state.

Children's Array of Services: Availability by Region from Plan and Budget Application for SFY14

Children and Youth Services Array/Number of Counties														
Regions	1	2	3	4	5	6	7	8	10	11	12	13	14	15
Services														
Clinical Services (Individual, Collateral, Family - provided by a Child Clinician at least 50% of time spent serving children and families)	9	8	6	10	8	7	8	5	10	5	8	8	10	17
Psychiatric Services (provided by a Child Psychiatrist-with at least one year of specialized child training)	9	2	6	8	8	7	8	2		5	8	8	8	17
Early Childhood Specialist	9		5	1	8	7	8	5	10	5	3	1	9	17
Other Early Childhood Clinician (who has received training and is supervised by the ECMH Specialist)				10	8	7	8	5	10	5	5	8		4
Paid Full-time Family Liaison			6	10		7		5	5		1			4
Paid Part-time Family Liaison					8		8							
Paid Full-time Kentucky Family Peer Support Specialist			6		1	1	8		5					
Paid Part-time Kentucky Family Peer Support Specialist							8					1	1	
Service Coordination for	9	4	6	10	8	7	8	5	10	5	8	8	10	17

Children Age 0-5														
Therapeutic Child Support Services		8		6		7	8		10	5	2	8	10	
School-Based Services	9	7	6	10	8	7	8	5	10	5	8	8	10	17
Intensive In-Home Services				10	8	1			5			8	4	17
After School Program		4			4				1			8		
Specialized Summer Program				7	8	1	3	1	10	5	8	8	9	
Respite Care		5		6	8	1		5	10					
Day Treatment Program					2	1	8			5		1		
Treatment Foster Home(s)		5		7				5		5				
Partial Hospitalization Program	1		1				8							
Crisis Services (M=Mobile, U=Unit, O=Other)	O	M	O	U	U	U M	M	U	U	U	U	U	2U	M

EMPLOYMENT

Youth served in the Kentucky IMPACT programs 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 retaining employment.

Supported Employment services are a needed service for transition age youth and are being addressed through several targeted initiatives, including the Johnson & Johnson/Dartmouth Supported Employment grant and the Kentucky Partners for Youth Transition trainings.

Kentucky Partners for Youth Transition

The Department began coordinating an interagency workgroup in January 2008 to work collaboratively to promote and utilize best practices across all communities and systems that touch the lives of young adults (14-25 years old) with behavioral health concerns called Kentucky Partners for Youth Transition. Independent Living skills, employment skills and housing supports are important goals for the partners. The partnership includes seventeen agencies and advocacy organizations as well as youth/young adults and family members. The Partnership hopes through its efforts:

- Youth with serious behavioral health concerns will have earlier, faster and easier access to the developmentally appropriate care that they need.
- That the folks who work with youth will have the specialized skills necessary to adequately support youth through their transition age years – focusing on positive youth development and the transition domains of education, employment, living situation, and the life in the community.
- That youth will feel supported through the care they receive and that they will travel seamlessly through this care.

Successes around employment, housing and independent living from the Partnership and individual agencies that have/are taking place include the following:

- Kentucky's child welfare department, Department for Community Based Services, has made transition planning a priority and they have several initiatives occurring currently to better identify supports for youth prior to leaving care.
- Workgroup members are becoming educated on asset development and are sharing training and grant opportunities with young adults.
- The Kentucky Office of Vocational Rehabilitation is focusing on Asset Development by training staff on the FDIC Money Smart Curriculum to use with the young adults they work with. This will assist these young adults in becoming financially stable and increase their independent living skills, which will increase their opportunity to secure stable housing.
- The Partnership developed a best practice curriculum that can be used across disciplines and teaches the current best practices for working with transitioning youth. The six hour training for case managers/service coordinators is called Transition Age Youth Launching Realized Dreams (TAYLRD). The training has been held five times around the state to approximately 290 participants.

At their February 2013 quarterly meeting, the Partners engaged in a priority setting exercise to determine goals for the coming year. The top three priorities were improving access to resources, staff training and youth empowerment.

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.

KDHBDID does not assume custody of children within the state, nor do it operate a children's psychiatric hospital or any other residential program for children. The Regional Boards, under contract with the Department, do offer a limited amount of residential care. Therapeutic foster care is offered in four of the fourteen regions, with a total of 72 foster homes. 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 96 beds. Ten Regional 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 making recommendations to the courts. When deemed necessary, the Department for Juvenile Justice (DJJ), within the Justice Cabinet, also may assume custody of children. The Department collaborates with these two state agencies to ensure that the behavioral health needs of children are appropriately identified and addressed. DCBS and DJJ contract with Regional Boards and private providers to meet the residential needs of children in their custody.

Child Hospitalization Data

KDBHDID and Regional Board program staff, particularly emergency services staff, monitor children's psychiatric hospitalization rates. The Office of Health Policy within the Cabinet for Health and Family Services collects hospital utilization data and reports on it annually. In calendar year 2012, Kentucky experienced its first full year of managed care of Medicaid. There were 694 psychiatric beds within 13 hospitals available for youth aged birth to 17 years. 192 of these beds are for youth between the ages of 0-12 years old and 546 of these beds are for youth between the ages of 13-17 years old. The hospitals experienced 9,694 admissions, 165,045 inpatient days, and an average length of stay of 17.31 days for the year. On an average day, 451 children were utilizing these psychiatric beds (occupancy – 65%); *(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 612 beds, 8,536 admissions, 187,892 inpatient days and the average length of stay was 21.6 days.).* 43% of the children's psychiatric beds are located in the state's largest city, Louisville; there are no beds in far western Kentucky nor in the four far eastern CMHC regions of the state.

Psychiatric Inpatient Utilization - Statewide - Children 0-17 Years of Age

Year	Licensed Beds	# of Psy Beds	Admissions	Inpatient Days	ADC	ALOS
2012	1,285	694	9,694	165,045	451	17.31
2011	1,217	738	8,977	207,364	568	23.5
2010	1,220	735	8,532	215,193	590	25.23
2009	1,167	726	8,192	212,983	584	26.75
2008	1,183	712	7,949	200,754	549	25.23
2007	1,160	672	7,581	201,332	552	26.37
2006	1,118	633	7,705	195,533	536	25
2005	1,102	613	7,729	185,943	509	25.9
2004	1,102	612	8,536	187,892	513	21.6

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

KDBHDID 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.

Kentucky Educational Collaborative for State Agency Children

The Kentucky Educational Collaborative for State Agency Children (KECSAC) was established through legislation in 1992. KECSAC is a statewide collaborative that works with state agencies,

school districts and local programs to ensure that state agency children receive a quality education comparable to all Kentucky students. "State Agency Children" (SAC), are those children in the custody or supervision of the Commonwealth and who are being served in programs funded and/or operated by DJJ, DCBS, or DBHDID in the state of Kentucky. KECSAC Advisory Group members include representatives from the following six agencies:

- Kentucky Department of Education
- Department of Juvenile Justice
- Department for Community Based Services
- Department for Behavioral Health, Developmental & Intellectual Disabilities
- Eastern Kentucky University and the College of Education
- Local Education Agencies

KECSAC is a true partnership that links the schools, family and children's services, community mental health, juvenile justice, private providers, and institutions of higher learning. To accomplish the mission, all members of this statewide partnership must exemplify and publicly promote collaborative relationships with its partners and other associates.

School-Based Behavioral Health Screening Initiative

In January 2014, Attorney General Jack Conway announced legal settlements with two pharmaceutical companies totaling $32 million. The funds have been used to expand substance use treatment throughout Commonwealth, including $1 million for the Division of Behavioral Health (DBH) to implement school-based screening in collaboration with the Kentucky Department of Education (KDE) to intervene with students facing behavioral health challenges. The overall School-Based Behavioral Health Screening Initiative's goal is to help schools recognize when a student might be showing signs of a behavioral health need, respond to that student appropriately, refer them to a designated trained school-based screener for screening, and then based on identified need, refer for services, supports or further assessment, when appropriate. This initiative is currently being expanded across the state.

Project AWARE (Advancing Wellness and Resilience in Education)

In 2014, Kentucky's Department of Education was awarded a federal grant to address violence prevention and behavioral health promotion. The resulting program, designed to train school staff to identify students' behavioral health needs and to increase effective communication between school staff and behavioral health providers, is being piloted in three of the state's largest school districts. Kentucky's program includes an emphasis on Trauma-Informed Care, promoting this via learning collaboratives. The management team includes members from several different agencies including KDBHDID and also includes young adult and family members with lived experience.

TARGETED CASE MANAGEMENT SERVICES (SERVICE COORDINATION)

In Kentucky, targeted case management services for children through the Kentucky IMPACT program are referred to as "Service Coordination" provided by "Service Coordinators." Kentucky IMPACT is a strengths-based, highly individualized, and collaborative model of case management utilizing Wraparound to address needs across life domains. These life domains include family, financial, living situations, educational/vocational, behavioral/emotional, psychological, social/recreational, health, legal, cultural and safety.

Team Observation Measure

In SFY 2013, KDBHDID included the Team Observation Measure (TOM) as a new requirement in the CMHC contract. The TOM assesses adherence to standards of high-quality wraparound during team meetings. It consists of 20 items, with two items dedicated to each of the 10 principles of wraparound. Each item consists of 3-5 indicators of high-quality wraparound practice as expressed during a child and family team meeting. Working alone or in pairs, trained raters indicate the whether or not each indicator was in evidence during the wraparound team meeting session. These ratings are translated into a score for each item as well as a total fidelity score for the session overall. Trained Observers complete a TOM with 10% of each Wraparound Facilitator's active child and family teams within a 6 -month timeframe. Teams are selected for observation using a systematic random sampling method. Fidelity data is submitted via an online data entry system within two weeks of completion of the team observation. Regional reports are provided on a frequent basis.

SERVICES FOR YOUTH WITH CO-OCCURRING MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Services for youth with co-occurring mental health and substance use disorders are coordinated by the Adolescent Treatment Coordinator. This position began in the Department in 2009 as a result of work that stemmed from our Kentucky Youth First Adolescent Treatment Grant. The Adolescent Treatment Coordinator works with each of the CMHCs to implement and sustain evidence-based practices, applies for and implements federal grants for adolescent services, and is now active in increasing adolescent treatment providers. Kentucky Medicaid notified providers on July 3, 2013 that substance abuse services for children under the age of 21 are covered under the EPSDT program and that providers may bill for substance abuse services as a primary diagnosis for children under the age of 21 who are enrolled in the Medicaid program or the Kentucky Children's Health Insurance Medicaid Expansion Program (KCHIP).

The Department works closely with the Kentucky Adolescent Substance Abuse Consortium (KASAC). KASAC is a coalition of public and private providers of residential and community-based substance abuse services who are committed to enhancing the quality and types of treatment services available to adolescents through collaboration, support, education, and advocacy. For additional information please visit **www.kasac.org**.

The State Interagency Council (SIAC) has in their strategic plan to address the needs of youth with co-occurring mental health and substance abuse disorders. Recommendations have been established with regard to the role of SIAC and RIACs in serving youth with co-occurring disorders.

Operated within the Regional Boards' Prevention programs is the Early Intervention Program (EIP). EIP is a collaborative between KDHBDID and the Office of the Governor (Governor's Title IV Drug Free Communities and Schools funds) and provides multifaceted prevention and intervention services targeting specific needs related to alcohol, tobacco and other drug behavior and choices for youth and their parents. It was established in 2001 and operates under the authority of Kentucky Revised Statute (KRS) 189A in accordance with Kentucky Administrative Regulation 908 KAR 1:315. Target populations include:

- Youth convicted of "Under 21/Zero Tolerance", driving with a blood-alcohol content of .02-.08. These youth are required to go through an Early Intervention Program to satisfy the requirements of their offense. There are seventeen certified Early Intervention Specialists across the Commonwealth to provide these services.

- The second target population is juveniles who are at risk of becoming involved or who already are involved with the Juvenile Justice System and youth who are identified as using or at risk for using substances.

For additional information about this program, please visit their website at: **http://dbhdid.ky.gov/dbh/sa-rpc.aspx**.

OTHER ACTIVITIES LEADING TO REDUCTION OF HOSPITALIZATION

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

PERCENT OF CAREGIVERS REPORTING SPECIFIC LIVING ARRANGEMENTS THROUGHOUT THE 6 MONTHS BEFORE BASELINE FOR CHILDREN (N=795)

With parents (biological or adoptive)	79.7%
With other relatives	19.7%
Other Out-Of-Home living situations (e.g., foster care, inpatient psychiatric hospital, residential treatment, crisis stabilization, with friends)	11.9%

Children's Crisis Services

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

There are several models of community-based crisis stabilization in place across the state. Services in these models include the following:

- Mobile Crisis Services
- Crisis Stabilization Unit
- Intensive In-home Services
- Walk-in Crisis Services
- Intensive Outpatient Services
- Crisis Case Management
- Crisis Therapeutic Foster Care and Other Residential Overnight Services
- Crisis Respite
- Crisis Transportation Services

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

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

Criterion 2.1: Estimate of Prevalence – Adult Mental Health

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 originally published on May 20, 1993.

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

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

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).

Variable	Criteria
Age	Age 18 or older
Diagnosis	Major Mental Illness • Schizophrenia Spectrum and Other Psychotic Disorders • Bipolar and Related Disorders • Depressive Disorders • Trauma and Stressor Related Disorders
Disability	Clear evidence of functional impairment in two or more of the following domains: • Societal/Role Functioning: Functioning in the role most relevant to his/her contribution to society and, in making that contribution, how well the person maintains conduct within societal limits prescribed by laws, rules and strong social mores. • Interpersonal Functioning: How well the person establishes and maintains personal relationships. Relationships include those made at work and in the family settings as well as those that exist in other settings. • Daily Living/Personal Care Functioning: How well the person is able to care for him/herself and provide for his/her own needs such as personal hygiene, food, clothing, shelter and transportation. The capabilities covered are mostly those of making reliable arrangements appropriate to the person's age, gender and culture. • Physical Functioning: Person's general physical health, nutrition, strength, abilities/disabilities and illnesses/injuries. • Cognitive/Intellectual Functioning: Person's overall thought processes, capacity, style and memory in relation to what is common for the person's age, gender, and culture. Person's response to emotional and interpersonal pressures on judgments, beliefs and logical thinking should all be considered in making this rating.
Duration	One or more of these conditions of duration: • Clinically significant symptoms of mental illness have persisted in the individual for a continuous period of at least two- (2) years. • The individual has been hospitalized for mental illness more than once in the last two- (2) years. • There is a history of one or more episodes with marked disability and the illness is expected to continue for a two-year period of time

The following table uses the federal SPMI prevalence rate of 2.6% and the 2010 census data to estimate the percentage of the targeted population serviced by the Regional Board during SFY 2014.

Regional Boards	Adult Census 2010	Estimated Prevalence (2.6% of the Adult Census)	Kentucky Adults with SMI Served in SFY 2014	Penetration Rate - SMI Served
Four Rivers	161,545	4,200	2,325	55%
Pennyroyal	158,100	4,111	3,565	87%
RiverValley	161,977	4,211	2,130	50%
LifeSkills	217,231	5,648	1,967	35%

Communicare	200,640	5,217	3,850	74%
Seven Counties	730,843	19,002	7,630	40%
NorthKey	326,235	8,482	2,866	34%
Comprehend	42,757	1,112	704	63%
Pathways	170,601	4,436	2,882	65%
Mountain	119,756	3,114	3,089	99%
Kentucky River	89,550	2,328	2,250	97%
Cumberland River	181,110	4,709	3,220	68%
Adanta	160,202	4,165	2,239	54%
Bluegrass	595,449	15,482	4,270	28%
TOTAL	**3,315,996**	**86,216**	**42,987**	**50%**

Note: The data for SFY 2015 is not certified until October 15th thus SFY 2014 data is used.

Data Sources Used

- Kentucky MIS Client/Event Data Set
- Kentucky State Data Center/US Census Bureau 2010
- U.S. Census Bureau's Decennial Census and National Center for Health Statistics, processed by Kentucky Population Research at the University of Louisville Urban Studies Institute.

Kentucky Revised Statute 210.005 http://www.lrc.ky.gov/Statutes/statute.aspx?id=40795

Criterion 2.1: Estimate of Prevalence – Children's Mental Health

Narrative Question: An estimate of the incidence and prevalence in the State of serious emotional disturbance among children.

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

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

1. Is under age 18 or under age 21 and was receiving mental health services prior to age 18 and the services must be continued for therapeutic benefit;

AND

2. Has a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is listed in the current addition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders; and presents substantial limitations which have persisted for least one year, or are judged by a mental health professional to be at high risk of continuing for one year without professional intervention in at least two of these five areas:
    - Self Care
    - Interpersonal Relationships
    - Family Life
    - Self-Direction

- Education

OR

- Is a Kentucky resident and is receiving residential treatment for an emotional disability through the interstate compact; or
- Has been removed from the home by the Department for Community Based Services (Kentucky's child welfare agency) and has been unable to be maintained in a stable setting due to a behavioral or emotional disability.

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

Estimated 2010 Child Census – 1,023,371
Estimated Number of Children with SED (5% of Kentucky's child population) – 51,169
Kentucky MH Children Served SFY 2015– or % (of Kentucky's child population)
Kentucky MH Children Served SFY 2014 –57,476 or 6% (of Kentucky's child population)
Kentucky MH Children Served SFY 2013 –59,723 or 6% (of Kentucky's child population)
Kentucky SED Children Served SFY 2015 –or % (of the 5% SED population)
Kentucky SED Children Served SFY 2014 –29,389 or 57% (of the 5% SED population)
Kentucky SED Children Served SFY 2013 –29,242 or 57% (of the 5% SED population)

Regional Boards	Child Census 2010	Estimated Prevalence (5% of the Child Census)	Kentucky Children with SED Served in SFY 2015	Penetration Rate of Children with SED Served in SFY 2015		
Four Rivers	44,367	2,218	Edit this column	Edit this column	984	44%
Pennyroyal	51,686	2,584		24%	601	23%
RiverValley	51,495	2,575	873	34%	1,094	42%
LifeSkills	66,964	3,348	1,172	35%	1,270	38%
Communicare	68,477	3,424	3,500	102%	3,021	88%
Seven Counties	228,248	11,412	6,575	58%	6,862	60%
NorthKey	112,412	5,621	2,317	41%	2,383	42%
Comprehend	13,721	686	570	83%	606	88%
Pathways	48,935	2,447	1,624	66%	2,003	82%
Mountain	34,337	1,717	1,212	71%	1,480	86%
Kentucky River	25,212	1,261	1,268	101%	1,080	86%
Cumberland River	55,508	2,775	3,120	112%	3,088	111%
Adanta	47,054	2,353	1,794	76%	1,844	78%
Bluegrass	174,955	8,748	3,143	36%	3.073	35%
TOTAL	**1,023,371**	**51,169**	**29,242**	**57%**	**29,389**	**57%**

Kentucky's estimated prevalence rate falls in the low range of estimates derived from local studies and cited in "Prevalence of Severe Emotional Disturbance in Children and Adolescence" (Friedman et al, 1996). This study acknowledges the lack of epidemiological data and concludes that regardless of the estimated prevalence rate that may be used, children with severe emotional disabilities are greatly under-served, a conclusion Kentucky planners share.

Data Sources Used

- Kentucky MIS Client/Event Data Set
- Kentucky State Data Center/US Census Bureau 2010
- Friedman, R. M., Katz-Leavy, J. W., Manderscheid, R., & Sondheimer, D. (1996). Prevalence of Serious Emotional Disturbance in Children and Adolescents. In R. Manderscheid and M. Sonnenschein (Eds.) *Mental Health, United States: 1996* (pp. 71-89). Washington, DC: U.S. Government Printing Office, DHHS Publication Number (SMA) 96-3098.
- U.S. Census Bureau's Decennial Census and National Center for Health Statistics, processed by Kentucky Population Research at the University of Louisville Urban Studies Institute.
- **Kentucky Revised Statute 200.503**

Criterion 3.1: Children with SED – Integrated Systems *(There is no Criterion 3 for Adults with SMI)*

Insert fed Narrative Question here

At the regional and local levels, CMHC Children's Services Directors report the following specialized arrangements with Department for Community Based Services (social services) (DCBS) for providing priority behavioral health services for their clients:

- Designated clinical staff whose primary function is to provide mental health and substance abuse services to DCBS referrals at the DCBS offices.
- Providing therapy services in the local DCBS offices in counties that do not have a CMHC clinic.
- Providing therapeutic foster care services.
- Providing Emotional Injury Assessments and Emotional Injury Treatment.
- DCBS referrals receive priority scheduling and we reserve top priority funds to provide services to DCBS involved families at their request.
- Ongoing collaboration with DCBS staff, to include DCBS referral of all children 0 to 6-years-old with open abuse cases for triage and assessment;
- Agency staff on-site at DCBS weekly to provide consumer assessments, staff consultations, and to involve consumers and their families in the process of treatment.
- Team meetings to review high priority/intensive cases and discuss treatment goals and coordinate joint outcomes.
- Priority scheduling for DCBS clients.
- Arranged for a referral form to be used to guide DCBS referrals into their intake system and allowing the Center to contact those families directly upon receiving the DCBS referral.
- Timeframes for exchange of information. Associates (SRAA) on a quarterly basis to discuss new services, any change in service array, any possible grant collaborations, and any other issues that may arise.

- Arranged partnership referrals with DCBS for crisis stabilization units, parenting and crisis response.

EDUCATIONAL SERVICES, INCLUDING SERVICES PROVIDED UNDER THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT

KDBHDID 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.

Kentucky Educational Collaborative for State Agency Children

The Kentucky Educational Collaborative for State Agency Children (KECSAC) was established through legislation in 1992. KECSAC is a statewide collaborative that works with state agencies, school districts and local programs to ensure that state agency children receive a quality education comparable to all Kentucky students. "State Agency Children" (SAC), are those children in the custody or supervision of the Commonwealth and who are being served in programs funded and/or operated by DJJ, DCBS, or DBHDID in the state of Kentucky. KECSAC Advisory Group members include representatives from the following six agencies:

- Kentucky Department of Education
- Department of Juvenile Justice
- Department for Community Based Services
- Department for Behavioral Health, Developmental & Intellectual Disabilities
- Eastern Kentucky University and the College of Education
- Local Education Agencies

KECSAC is the responsible entity for assuring that the benefits of the Kentucky Education Reform Act (KERA) are extended to children in the custody of state agencies, in day treatment programs, and schools on the campuses of residential programs. KECSAC is a true partnership that links the schools, family and children's services, community mental health, juvenile justice, private providers, and institutions of higher learning.

Kentucky Post School Outcomes Advisory Group

KDBHDID is a partner on the **Kentucky Post School Outcomes Center (KyPSO) Advisory Group** (www.kypso.org). This group came together to fulfill the Federal Department of Education, Office of Special Education Programs requirement that all States follow up with former students who had Individual Education Programs (IEPS) to determine the percent of youth who are no longer in secondary school, had IEPs in effect at the time they left school, and were:

1. Enrolled in higher education within one year of leaving high school.
2. Enrolled in higher education or competitively employed within one year of leaving high school.
3. Enrolled in higher education or in some other postsecondary education or training program; or competitively employed or in some other employment within one year of leaving high school".

Kentucky's survey goes above the federal requirement and asks about other post school outcomes, such as:

- Satisfaction with work and school;
- Goals;
- Barriers;
- What Helped;
- Interaction with community agencies;
- Community involvement; and
- Free time.

This Advisory Group consists of various community partners such as Education, the Department for Community Based Services and the Office of Vocational Rehabilitation. They have partnered with the Human Development Institute and the University of Kentucky in the system development of this initiative.

In 2012, KyPSO published their first Youth One Year Out (YOYO) data (2011). The survey included 157 youth who had an IEP for an Emotional Behavioral Disability. Of those, 18% had been in higher education post school, 41% competitively employed, 13% enrolled in other higher education, 22% were employed with supports, and 28% had not been enrolled in higher education or working competitively post school.

Kentucky Interagency Transition Council for Persons with Disabilities

Chaired by the Division of Exceptional Children within the Kentucky Department of Education, the Kentucky Interagency Transition Council for Persons with Disabilities is comprised of representatives from 22 state agencies, including KDBHDID. The Council meets for the purpose of collaborating in the design, delivery, and improvement of statewide transition services for young adults (ages 14 - 21) with disabilities (of all kinds) from school to college and employment.

Regional and Local Voices

Ten of fourteen CMHC Children's Services Directors report offering educational and/or vocational services and supports to children or youth transitioning to adulthood. Examples of the services and supports include the following:

- Supported employment services
- Active coordination between Child and Adult Targeted Case Management 24 months prior to transition.
- Ongoing interface with supported employment and Vocational Rehabilitation services 12 months prior to transition.
- Share information about transitioning, training opportunities, Job Corps, community supports, and higher education.
- Transition to adulthood skills, services and supports incorporated into Service Coordination.

JUVENILE JUSTICE SERVICES

Kentucky Adolescent Treatment Dissemination & Enhancement Grant

Kentucky was fortunate to be awarded a SAT-ED grant in 2012, which is called the Kentucky Adolescent Treatment Dissemination/Enhancement Grant (KAT-ED), KAT-ED builds upon the work of a 2005 – 2009 CSAT Adolescent Treatment Infrastructure grant – *Kentucky Youth First*; over a decade of work with Robert Wood Johnson's *Reclaiming Futures*; and Kentucky's 2012 Policy Academy. Funds from this cooperative agreement will be used to implement evidence-based screening, assessment, treatment, and continuing care recovery services for youth with substance use disorders and youth with co-occurring substance use and mental health disorders and their families. Funds will be used for both infrastructure development and treatment enhancement in two high-need geographic regions of the State: Northern Kentucky (Campbell County) and Southeastern Kentucky (Whitley County). Efforts will build upon existing Reclaiming Futures Change Teams to enhance a coordinated network that will develop policies, expand workforce capacity, and disseminate evidence-based practices to improve integration and efficiency of the adolescent behavioral health service delivery system and to improve outcomes for youth and families. These local communities will serve as demonstration sites to support wide-scale replication across the state. The project period begins September 30, 2012 and will run through September 29, 2015. The award is for $961,386 per year for 3 years to cover costs of treatment for youth, training, infrastructure development, administration and evaluation.

The Grants Management Team will be comprised of state members that will include representatives from the Administrative Office of the Courts, KY Partnership for Families and Children, the Division of Behavioral Health and the State Interagency Council (SIAC) administrator. SIAC will provide oversight for the grant. SIAC members will receive information from an appointed interagency workgroup that will review and analyze required information from the sites. The SIAC will use this data to make recommendations regarding state level policy development; removal of barriers to implementation and dissemination; and assist with replication of best practices.

This grant selected local community-based treatment providers to work collaboratively with the community to improve access and delivery of treatment and supports. For the purposes of this project, the counties of Whitley and Campbell will serve as the implementation sites. These counties were selected based on high need as well as demonstrated readiness for system change. Whitley and Campbell Counties both detain youth for status offenses at rates surpassing the state average, and Campbell County is the among the highest counties in Kentucky with a disproportionate rate of complaints against Black youth filed at about 2 to 3 times greater than their representation in the general population. Both counties have operationalized the Reclaiming Futures Framework for youth with juvenile justice involvement and have participated in SAMHSA – funded system of care initiatives and both counties are participating in the Juvenile Detention Alternatives Initiative (JDAI). Finally, the counties represent geographic diversity that will allow for evaluative comparisons important to future replication.

The participants of focus are youth ages 12 - 18 who are at risk for having a complaint filed and those who have a complaint filed against them but are eligible for diversion and their families. These youth will receive an evidence-based screening at the pre-diversion or diversion level of the justice system. Overall goals of the grant include:

1. Divert youth with substance use and co-occurring mental health and substance abuse issues from juvenile justice to appropriate services and supports within their community using a KY adapted version of the Reclaiming Futures framework.

2. The two implementation providers (identified through an RFA process) will receive training and coaching in the use of the evidence based Global Assessment of Individual Needs (GAIN) screening and assessment instruments and in the use of the evidence based treatment approach, Adolescent Community Reinforcement Approach (A-CRA) while acting as a learning laboratory to provide feedback in order to assist the State with broader implementation efforts and replication;

3. The State will work to discover and remove barriers to successful access and utilization of quality treatment interventions for the population of focus and their families and expand workforce capacity and dissemination for both A-CRA and GAIN

4. Complete a Financial Map and develop a process to use this information for planning services and supports within the system of care for the population of focus and their families.

Currently, 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. Due to turnover and difficulty with adoption of the GAIN within some treatment provider agencies, the momentum of the assessment has waned. There is a need to encourage the use of the assessment tool as it is not being utilized by the CMHCs consistently.

The need to enhance treatment options for adolescents with juvenile justice involvement is especially pronounced. While some adolescents will engage in troubling behavior, appropriate and consistently-applied discipline can ensure youth have opportunities to learn from mistakes and become successful contributing adults. Unfortunately, Kentucky, like many states has responded to such troubling behavior by detaining youth, including those who commit status offenses, an approach shown to be ineffective and highly expensive (Nelson, 2008). In fact, Kentucky detains youth charged with status offenses at the second highest rate in the nation, even though the most populous county in the state does not use this practice (KYA, 2011). With national estimates of approximately 70% of youth with juvenile justice involvement meet criteria for a diagnosable mental health disorder and about 61% have a co-occurring substance use disorder (National Center for Mental Health and Juvenile Justice, 2006), adolescents with juvenile justice involvement present a unique challenge to the system of care. Not only is the intensity of their needs likely to be greater, but proper response to their multiple needs requires increased collaboration, continuity of care, and the ability to recruit and retain providers who are equipped to treat multiple needs. Unfortunately, many of the youth do not receive much needed behavioral health treatment that could prevent initial involvement with the juvenile justice system or reduce the likelihood of recidivism. The Kentucky Department of Juvenile Justice (DJJ), one of five departments under the Kentucky Justice and Public

Safety Cabinet within the Executive Branch, is responsible for statewide detention services, residential placement/treatment services, probation, community aftercare/reintegration programs and youth awaiting adult placement or court. Of Kentucky youth coming into contact with the juvenile justice system, 32% are committed to the DJJ, 28% are informally adjusted (diverted), and 40% of cases are probated (Kentucky Department for Juvenile Justice, 2006). Thus, the need for accessible and effective treatment is paramount throughout the system. All fourteen CMHC Children's Services Directors report that their Center gives priority to serving children and youth referred by the court system.

SUBSTANCE USE SERVICES

State Interagency Council

A fairly comprehensive array of services for youth with emotional disorders is available to varying degrees across Kentucky. This is less the case for youth identified with substance abuse treatment needs. While Kentucky has over 20 years of experience in providing behavioral health services to children, youth and their families through a system of care interagency infrastructure called Kentucky IMPACT and utilization of the State Interagency Council (SIAC). 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. The SIAC has established a workgroup to focus on adolescent substance abuse and juvenile justice. The purpose of this workgroup is to promote comprehensive, integrated services for youth with substance use or co-occurring substance use and mental disorders.

Reclaiming Futures

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 third Reclaiming Futures site established through a SAMHSA/MacArthur Policy Academy/Action Network grant has been established using the Kentucky version of the Reclaiming Futures implementation guide. This third site has focused on working with youth in a pre-diversion status that has focused efforts on screening, assessing, and treating youth on "the front end" of the juvenile justice system as a means of avoiding net widening into the juvenile justice system.

Kentucky Adolescent Substance Abuse Consortium

The Kentucky Adolescent Substance Abuse Consortium (KASAC) is a group of concerned individuals who come together to advocate for the quality of and access to adolescent substance abuse and co-occurring discorders treatment through collaboration and education. KASAC is committed to providing training opportunities that target the needs of professionals who work with

adolescents and focus on state-of-the-art and evidence based practices. KASAC is a partnership of many treatment providing agencies and other stakeholders, including KDBHDID.

HEALTH AND MENTAL HEALTH SERVICES

Physical Activity, Nutrition, Tobacco, Asthma Plus: A School Resource Guide

Staff from the Public Health, Behavioral Health and Education collaborated have collaborated to create two editions of the Physical Activity, Nutrition, Tobacco, Asthma Plus (**PANTA Plus**) School Resource Guide (2006 and 2011). The Guide assists schools as they work towards a coordinated approach to school health. It provides the framework, structure, tools and resources to strengthen and expand school health programs and policies. The Guide includes information about the connection between health and academics; emerging, promising and best practices; designing and planning policies and programs; assessing the school health environment and use of data; encouraging environmental change; and promoting overall health of students, staff and the school community.

Early Childhood Mental Health

Staff from the Department for Public Health and KDBHDID 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.

FAMILY AND YOUTH INVOLVEMENT

Kentucky Partnership for Families and Children

In creating a "family-driven and youth-guided" system of care, the Kentucky Partnership for Families and Children (KPFC) along with many partners are working to create an infrastructure that invites youth and parents across the state to "Join the Movement." The Kentucky Family and Youth Movement Steering Committee is working to increasingly empower youth with behavioral health challenges and their families through leadership development and advocacy skills. Furthermore, the principle of this movement focuses on the benefits of family peer-to-peer and youth peer-to-peer involvement. Peer-to-peer involvement gives hope, fosters support and allows for increased opportunities for our youth and families. As the movement grows and strengthens, Kentucky's youth and parent voice will be a tipping point for positive, long-term change. (**www.kypartnership.org**).

- Sit on various local and state committees.
- Serve as board members on the KPFC Board of Directors.
- Develop awareness materials for youth, parents, and professionals.
- Serve as Youth Trainers for various trainings such as the KY Family Leadership Academy, Service Coordination 101, Trauma Informed Care, Wraparound Fidelity.
- Speak at events such as Children's Mental Health Awareness Day to share experiences and concerns.
- Bring a focus on issues we are concerned about such as:
    - Reducing seclusions & restraints;
    - Successful transition to adulthood;
    - Youth rights and voice in treatment;
    - The need for peer to peer support; and
    - Adequate insurance coverage for youth and young adults.

Regional Youth Councils

Regional Youth Councils are active in eleven of the fourteen CMHC regions. The councils are usually (but not always) started and supported by the Kentucky IMPACT program within each region of the state. The Kentucky IMPACT program and the Community Mental Health Center decide how the council in their region is organized – when and how often they meet, where, ages of youth, and who is eligible (i.e. IMPACT only, any youth with an open chart, etc.). Generally, the youth council meets once a month for an hour and a half.

Regional Youth Councils support positive youth development by:

- Building assets that are supported by nurturing adults and communities.
- Ensuring that youth have the opportunity to explore talents and interests and to develop a sense of competence and personal identity.
- Encouraging youth to engage in leadership and develop a sense of control over their future.

The areas that the youth councils focus on are:

- Independent living skills – employment, education, medical, self-care, healthy relationships, housing, transportation, etc.
- Peer to peer support – having access to a peer group that has issues similar to their own, peer mentoring
- Community service – giving back, connecting with their community in a positive way, seeing that they have the ability to help others
- Leadership development – developing appropriate and effective skills to have a voice in their own treatment, on their own team, and possibly within their community or state

- Youth engagement and empowerment – strong partnerships with adults, understanding their diagnosis and symptoms as well as the services they are receiving or have access to.

Criterion 3.2: Integrated Children's Services - 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, substance abuse prevention, and substance abuse treatment 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. A Regional Board is:

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

Originally, the Regional Boards were totally aligned with the Area Development Districts but in recent years Pathways serves two Development Districts, FIVCO and Gateway.

The Department for Community Based Services has nine (9) regional districts. The Department for Juvenile Justice and the Administrative Office of the Courts follow judicial districts. For public health services, seventy-four (74) counties are served by 15 district health departments and forty-six (46) counties are served by a health department in their county. There are 174 school districts across the state.

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SUBSTANCE ABUSE TREATMENT AND PREVENTION OVERVIEW

In January of 2014, a new Kentucky state plan amendment was approved by CMS. In this new package of billable Medicaid services, services for individuals with substance use disorders

were included. New billable services for substance use disorders include Residential Services for Substance Use Disorders; Screening, Brief Intervention and Referral to Treatment (SBIRT); Medication Assisted Treatment; and peer support. In addition, services such as Individual Therapy, Group Therapy, and an array of crisis services including crisis intervention, residential crisis stabilization services and mobile crisis services became available for individuals with substance use disorders. In response to these changes, the DBHDID has been restructuring contracts to provide these services, restructuring data systems to define and collect data for all new services, and providing guidance to providers through the development of service standards and other technical assistance.

Substance use specific services provided primarily through contracts with Regional Boards 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;
- Detoxification centers, residential treatment programs, intensive outpatient treatment services, other outpatient services including peer support and targeted case management;
- Specialized treatment services for pregnant women, adolescents and intravenous drug users; and
- Medication Assisted Treatment to opiate dependent persons who are high-risk for HIV disease due to their intravenous drug use.

Training, consultation and client evaluations are made available, within budget limitations, to criminal justice agencies and other agencies within the Cabinet for Health and Family Services for individuals with 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 use will have a major impact on the health and well-being of every Kentuckian. From peer pressure of youth to use alcohol and drugs to the risks of being involved in a drunk driving accident, all Kentuckians are at risk for 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 affected by alcohol or drug use.

CO-OCCURRING DISORDERS

In 2009, the Division of Mental Health and Substance Abuse was renamed the Division of Behavioral Health. Formal steps have been taken by the KDBHDID towards the integration of mental health and substance abuse services across the Commonwealth.

Steps that have been taken by the Division include:

- Restructuring the Plan and Budget process to include plans for substance use disorder treatment, including planning for services for individuals with co-occurring mental health and substance use disorders.
- Including language in required Plan and Budget forms that address having programming that is co-occurring capable.
- Rewriting SFY 2016 contracts with Regional Boards to include a requirement for all programs, established by CMHCs to be Co-Occurring Capable as measured by either the Dual Diagnosis Capability in Addiction Treatment (DDCAT) or Dual Diagnosis Capability in Mental Health Treatment (DDMHT) tools.
- Requiring in SFY 2016 contracts with Regional Boards that all regions hire at least 2.0 Full Time Equivalent (FTE) peer support specialists with lived experience in substance use disorders or co-occurring substance use and mental health disorders.
- Providing some workshops at Kentucky School (which has traditionally been designed for substance use disorder staff only) that focus on providing mental health training to substance use disorder staff and substance use disorder training to mental health staff. (e.g. Motivational Interviewing; Peer Support).
- Contracting with Case Western Reserve University to provide training on Integrated Dual Diagnosis Treatment (IDDT) to all staff providing Assertive Community Treatment (ACT) services across the state.

Between SFY 2009 and SFY 2015, a team of integration specialists was developed by DBHDID to use DDCAT and DDMHT tools and to visit regional programming and assess co-occurring capabilities. All programs were offered the opportunity to use the data from their DDCAT/DDMHT reviews to make changes using the Network for Improvement of Addiction Treatment (NIATx) process improvement model to raise any scores below the score of three (3), which is considered co-occurring capable. The DBHDID provided technical assistance during this time period, regarding change projects as well as DDCAT/DDMHT fidelity assessments. A Transformation Transfer Initiative (TTI) grant, as well as securing a national consultant (Heather Gotham, co-creator of the tools), were instrumental in supporting regions in working towards co-occurring capability in their programming for adults. DBHDID continues to provide technical assistance or help with fidelity assessments as requested.

As a result of these statewide assessments, it became clear that programs did not include many peer led mutual support groups. Mutual support and mutual aid groups are identified as one of the ten guiding principles of recovery from SAMHSA. DBHDID leveraged funds from the TTI grant and later from the block grant, for purposes of hiring an individual in recovery from co-occurring disorders to consult with DBHDID staff, regional staff and peers, and develop co-occurring mutual support groups in many regions across the state. Specifically, this individual in recovery assisted with development of Double Trouble in Recovery (DTR) mutual support groups across the state. DTR is a twelve-step self-help group that is facilitated by individuals in recovery from both mental health and substance use disorders. DTR is considered a best practice. At present, there are at least nine (9) regions that provide DTR as a support for individuals and more groups are continuing to develop. DBHDID continues to offer technical assistance and materials to assist with the development of this support across the state.

During the 2015 legislative session in Kentucky, HB 92 passed into law. This law created a licensure category for Clinical Alcohol and Drug Counselors (CADC) and created a Registered Alcohol and Drug Peer Support Specialist. These new categories were directed to be defined and placed under the CADC Board in Kentucky. As a new licensure category for providers, the

Licensed CADC was included as a new billable professional in the new Medicaid state plan amendment for Kentucky that went into effect in 2014.

DBHDID has been working since SFY 2014 to implement Assertive Community Treatment as a service across the state for individuals with SMI. However, in working with ACT teams it became apparent that a large number of the individuals being served also had co-occurring substance use disorders. ACT teams have been ill prepared to provide good treatment to these individuals. In SFY 2015, the Department contracted with Case Western Reserve University to provide a series of training in Integrated Dual Diagnosis Treatment (IDDT), an evidence based practice that has been renamed Integrated Treatment for Co-Occurring Disorders by SAMHSA. Case Western provided three (3) separate training events in various parts of the state. Each training event consisted of three (3) days of training. All staff members of Assertive Community Treatment (ACT) teams across the state were trained in IDDT. At present, seventeen (17) ACT teams were trained in this model.

Kentucky has been training peer support specialists since 2006. However, initially, peers were only trained who were in recovery from mental health or co-occurring disorders. During the last few years, the DBHDID has been training peers in recovery from substance use disorders as well. When the new Medicaid state plan amendment was approved by CMS in January 2014, peer support was included as a billable service. The DBHDID changed the language in its peer support regulation to support training individuals in recovery from mental health, substance use or co-occurring disorders to become peer support specialists. Peer support for all populations is now a billable Medicaid service.

Move these to Step 2 ??

Goals/Objectives for SFY 2016/2017:

- To monitor the status of providing integrated care through co-occurring capable programs in the regions across the state;
- Continue to provide more cross training opportunities through Kentucky School and other training events, and more training on co-occurring topics in general;
- Continue to require the use of evidence based treatment practices, including Integrated Dual Diagnosis Treatment (IDDT);
- Provide technical assistance to ACT teams regarding IDDT through the use of fidelity assessments, consultations and continued training, until IDDT is implemented with fidelity through all ACT services;
- Increase the number of peer specialists in recovery from co-occurring disorders hired by providers and improve supervision and support for peer specialists who are employed; and
- Continue to support and facilitate new peer led mutual support groups;

SUPPORT TO INDIVIDUALS IN RECOVERY AND FAMILY MEMBERS

Since the mid-1980s, the DBHDID has been convinced of the importance of involvement by individuals in recovery and family members in program development and service delivery. In February of 2011, the DBHDID hired a full time Recovery Services Coordinator who is a self-identified individual in recovery from behavioral health issues.

In addition, the Department provides funds for a variety of statewide and local support initiatives for individuals in recovery and family members. 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 recommendations from individuals in recovery and family members to rewrite contracts to be awarded to statewide groups. Two (2) of these contracts, the Recovery Oriented Training and Technical Assistance contract and the Recovery Oriented Family Support Services contract 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 each of these contracts.

The Recovery Oriented Family Support Services contract was awarded to the National Alliance on Mental Illness (NAMI) Kentucky and the contract for SFY 2016 includes the following requirements:

- Provide a series of recovery oriented supports for family members across the state;
- Utilize established training modalities and implement other support groups across the state that are established as best and promising practices;
- Provide at least one (1) "Train the Trainer" session per year to individuals who are targeted to provide family support groups;
- Provide signature advocacy training across the state to NAMI affiliates as well as other organizations, that pertains to individuals with serious mental illness and their family members;
- Collaborate with other agencies and organizations with the goal of supporting improved and evidence based practices such as supported employment, stigma reduction and recovery;
- Assess regional needs with regards to mental health treatment and family member involvement and inclusion and diversity;
- Provide diversity awareness trainings to all NAMI affiliates and ensure all NAMI Kentucky recruiting and programming reflect principles of diversity;
- Maintain a NAMI affiliate in every CMHC region across the state;
- Provide at least monthly contact with all NAMI affiliates across the state in an effort to enhance community integration and inclusion and ensure coordination of family support services and outreach; and
- Maintain a mental health recovery listserv to promote health and wellness and to increase positive communication between stakeholders.

Since SFY 2012, NAMI Kentucky has maintained a NAMI affiliate in each CMHC region across the state. The most recent affiliate developed was in the Mountain region in Eastern Kentucky. NAMI Kentucky continues to provide an annual "Train the Trainers" for family support group facilitators and affiliates have provided dozens of Family to Family (NAMI signature family support) classes across the state, with hundreds of family members graduating. NAMI Kentucky continues to make contact with all affiliates with a monthly conference call, and has provided training across the state on ADMHT and other topics. NAMI Kentucky continues to assist with Individual Placement and Support (IPS) Supported Employment programs across the state by participating as a Kentucky IPS team member, and is instrumental in ensuring individuals in recovery and their family members are involved in the supported employment initiative. Several individuals from Kentucky have been sent by NAMI Kentucky to national training in support group facilitation. And over 2000 individuals from across the state have been included in a mental health listserv that is staffed by NAMI Kentucky.

During SFY 2015, NAMI Kentucky agreed to coordinate efforts for the DBHDID award of a Transformation Transfer Initiative (TTI) grant, related to utilizing peer support specialists in bridging services for individuals with mental illness transitioning in and out of psychiatric hospitals.

Goals for NAMI Kentucky for SFY 2016/2017 include:

- Working on growing and strengthening NAMI affiliates by making personal visits to their community and having community meetings to enhance community integration, inclusion, outreach and increased efforts in stigma reduction;
- Focusing on educating the local education system and business community on mental illness and resources;
- Increase the number of teachers and facilitators for NAMI signature programs;
- Enhance leadership in advocacy activities by providing advocacy training and opportunities to persons with serious mental illness and their family members;
- Working on growing and strengthening NAMI family advocates of the Individual Placement and Support (IPS) Supported Employment Team for Kentucky by strengthening communication and involvement of family advocates in the IPS initiative; and
- Increasing communication between family members, individuals with mental health disorders, and providers of mental health services, as well as promoting health and wellness for individuals by sending communications such as NAMI updates, information on various mental health topics, advocacy alerts and a quarterly newsletter to the public.

The Recovery Oriented Training and Technical Assistance contract was awarded to the National Alliance on Mental Illness (NAMI) Lexington affiliate, and initially required the development of a Technical Assistance Center for individuals in recovery and the provision of recovery oriented trainings across the state. Stakeholders were gathered from across the state, including individuals in recovery, family members and providers, and consensus was developed regarding formation of Kentucky System Transformation, Advocating Recovery Supports (KYSTARS), a training and technical assistance center focusing on statewide recovery oriented mental health services.

The contract for SFY 2016 includes the following requirements:

- Maintain the statewide training and technical assistance center with the goal of incorporating recovery principles throughout the public mental health system;
- Provide statewide evidence based recovery oriented training and support activities for individuals in recovery including Wellness Recovery Action Plan (WRAP) trainings, support groups, Advance Directive for Mental Health Treatment (ADMHT) training, education and skill building for individuals in recovery, etc.;
- Assess statewide needs regarding mental health recovery;
- Conduct at least two (2) Leadership Academy trainings across the state;
- Provide a statewide recovery oriented conference annually;
- Provide recovery oriented training for staff of Regional Boards and state psychiatric facilities; and
- Provide technical assistance to all programs with start-up funds to develop consumer operated service programs (COSP).

KYSTARS is located within Participation Station, one of the first peer run centers in Kentucky. During SFY 2012, after the SAMHSA COSP toolkit was developed, KYSTARS assisted Participation Station in adopting and implementing the Consumer Operated Service Toolkit with fidelity. Participation Station uses the Fidelity Assessment Common Ingredients Tool (FACIT) to measure fidelity and the Peer Outcomes Protocol (POP) to measure outcomes. Both of these instruments are from the SAMHSA toolkit. This experience by KYSTARS led the DBHDID to contract with KYSTARS to provide technical assistance to all newly developed COSPs across the state.

The COSPs typically provide a drop-in service, psychoeducational groups, support groups and other new and frequently innovative peer support services. During SFY 2014/2015, KYSTARS provided educational classes and technical assistance in implementing and developing policies and procedures, form development, grant writing and fundraising, program evaluation, and other issues, to the COSPs across the state.

During SFY 2014/2015, KYSTARS conducted a comprehensive training needs assessment for four (4) regions awarded start-up funds for COSPs. This needs assessment focused on four (4) primary areas that were determined critical to a COSPs success and sustainability: 1) Safety; 2) Recovery Philosophy; 3) Group Process; and 4) Leadership. This needs assessment corresponded with baseline fidelity reviews of each COSP. Fidelity for the COSP was measured through the Fidelity Assessment Common Ingredients Tool (FACIT), part of the COSP toolkit from SAMHSA. The methodology of this needs assessment consisted of interviews with program directors, program leaders, and participants in each program, examination of training records as available, and FACIT reviews. Results determined training needs for each program, with regards to the primary areas measured. All programs were determined to have a need for safety training, such as skills in handling safety issues for individuals experiencing a mental health crisis. Potential training identified in this area included Mental Health First Aid, Non-violent Crisis Prevention and Intervention, Question, Persuade and Refer, Cardio-Pulmonary Resuscitation, and First Aid. With regards to Recovery Philosophy, 60% of the programs were found to have a need for refresher training on recovery orientation and principles of recovery. While each program was found to have some recovery principles at the heart of programming, some recovery principles were not clearly demonstrated in all programs. With regards to Group Process, it was determined that 80% of the programs could benefit from training on group dynamics and Wellness Recovery Action Planning (WRAP) facilitation. With regards to Leadership, it was determined that 80% of the programs could benefit from training on administrative skills to assist with better everyday operations and sustainability.

As a result of this needs assessment, KYSTARS included a tract of workshops, specifically designed for individuals in recovery working at COSPs in their annual conference that occurred in May of 2015.

During SFY 2014/2015, KYSTARS provided education and technical assistance to individuals admitted to state psychiatric facilities, individuals in treatment at Regional Boards, staff of two (2) state psychiatric hospitals, staff of Regional Boards, and to peer support specialists and leadership academy graduates.

During SFY 2014/2015, KYSTARS provided four (4) Leadership Academy trainings across the state. The Leadership Academy is a three (3) day educational program for persons in recovery from 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. 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.

In addition, KYSTARS 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 practice. KYSTARS revised an existing curriculum and developed the KYSTARS Recovery Support Group, a general recovery based group targeted individuals with SMI. Groups have developed across the state and KYSTARS provides some financial assistance in the form of stipends and training for facilitators.

KYSTARS has presented a statewide recovery conference each year since SFY 2011. This conference is always very well attended by individuals in recovery across the state, including peer support specialists, individuals working in COSPs, and other individuals in recovery. In SFY 2014, the annual conference was attended by approximately four hundred (400) individuals. There was a specific tract offered for continuing education for peer support specialists. The conference in SFY 2015 was attended by approximately four hundred (400) individuals and included a tract for providers who work with or support peer support specialists, which included providers who are involved with COSPs. In addition, beginning in SFY 2014, KYSTARS solicited a sponsor for an awards banquet, and began recognizing exemplary peers from across the state through Kentucky Peer Excellence Awards, where an award is presented to one peer in each region across the state. In addition, one award is provided for a peer that is recognized as having a Lifetime of Achievement in peer support and one award is provided for a person identified as a Supporter of peers. The Lifetime of Achievement award is named after Molly Clouse, who received the first award in May of 2014. Molly is a peer support specialist who has been instrumental in operationalizing peer support in Kentucky and has spearheaded recovery based legislative changes. Kentucky Peer Excellence Awards continued in SFY 2015, with a ceremony occurring the evening before the annual conference.

KYSTARS maintains a functional website as a resource for recovery based programming in the state, to share programs and support groups, recruit new peer support specialists and educate the public. KYSTARS has experienced significant annual growth in website usage and has plans to expand their online support component.

Goals for KYSTARS for SFY 2016/2017 are to continue to provide the required elements of their contract with DBHDID, while continuing to expand recovery informed services across the state in a variety of ways.

Kentucky Peer Specialist Training is a thirty (30) hour intensive training program for persons in recovery from a mental health, substance use or co-occurring mental health and substance use disorder. The training program in Kentucky was traditionally modeled after the Georgia and South Carolina models of Peer Support. The training prepares individuals in recovery to provide peer support services to other individuals in the behavioral health service system.

In January of 2014, a new Medicaid state plan amendment was approved by CMS. Included in this package of newly billable services was peer support. In addition, due to Medicaid

Expansion in Kentucky and a workforce capacity study by Deloitte in May of 2013, the network of behavioral health providers through Medicaid was expanded in Kentucky as well. Due to the overwhelming number of potential behavioral health providers, many changes have taken place.

The manner in which individuals in recovery receive certification training to become billable peer support specialists has changed into the following model:

- A curriculum rubric has been developed by the DBHDID, outlining the required thirty (30) hours of training, based on the core competencies listed in the Medicaid state plan amendment and subsequent regulations;
- Agencies across the state will be able to submit curriculum, based on the rubric, for approval by the DBHDID;
- Once approved, agencies may provide their own certification training for peer support; and
- Agencies are required to submit names and numbers of peer support specialists who are certified.

Kentucky is now able to provide three (3) types of peer support that is billable through Medicaid: adult peer support; youth peer support; and family/parent peer support. Each type of peer support is representative to individuals with lived experience in either mental health, substance use, or co-occurring mental health and substance use disorders.

During SFY 2013, the DBHDID decided to provide start-up funding to Regional Boards to begin development of Consumer Operated Services Programs (COSP) in various regions. These COSPs would be required to meet fidelity of the SAMHSA Consumer Operated Services toolkit. The DBHDID issued a Request for Application (RFA) process to establish COSPs in four (4) regions during SFY 2013 (Communicare; Lifeskills; Mountain; and Four Rivers). Participation Station in Lexington, Kentucky, and the Personal Involvement Empowering Recovery (PIER) program in Northern Kentucky existed prior to this RFA process. During SFY 2014 and 2015, three (3) additional Regional Boards were awarded start-up funds for COSPs (Seven Counties; NorthKey; and Pathways). All new programs are continuing to work on development and strive towards fidelity. After peer support became a billable service, many regions began working toward making these programs billable as a peer support service.

The DBHDID and the Regional Boards encourage the participation of individuals in recovery family members in planning, evaluating, and service delivery. Priorities for SFY 2016/2017 include:

- Continue to encourage the involvement of individuals in recovery and their family members in the Behavioral Health Block Grant planning process and other DBHDID planning events;
- Continue to design and support statewide programs, trainings, and outcome measures that incorporate recovery principles;
- Continue to require the hiring of peer support specialists across the state;
- Develop more education and support for peer support specialists who are employed, through supervision training and continued training in recovery principles;
- Support the existing COSPs, ensuring fidelity to the SAMHSA model as well as ensuring a recovery oriented service in communities across the state; and
- Continue to support the development of additional peer run services in a manner that is sustainable;

While the DBHDID and the Regional Boards have come a long way in fostering involvement by individuals in recovery and family member in planning, evaluation, and service delivery, many challenges remain, including:

- Not enough access to peer run programming;
- Lack of education and understanding for providers regarding impact and importance of recovery oriented services, including peer support;
- Limited support for individuals providing peer support as a service;
- Few programs that fully incorporate recovery principles; and
- 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 serious mental illness (SMI) 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;
- Crisis Intervention Services;
- Overnight Crisis Beds;
- 23 Hour Observation Beds in Hospitals; and
- After Hours Face to Face Crisis Evaluations.

Regional Boards have flexibility in how they choose to provide emergency services based upon the unique needs and population within their region. As such, the ideal array is not available in every region. For example, thirteen (13) of the fourteen (14) regions offer residential Crisis Stabilization Units or overnight beds. This flexibility does enable the regions to expand crisis services to meet their unique needs and one region has set aside one (1) bed in their facility to serve the crisis needs of adults with Developmental and Intellectual Disabilities. This has become a need in other areas and the Adult Crisis Directors group shares information and specific protocols when an individual is admitted to a Crisis Stabilization Unit (CSU).

In January of 2014, a Medicaid State Plan Amendment was approved which included crisis intervention services, mobile crisis services, and residential crisis stabilization programs as Medicaid billable services. Regions have been adjusting to this change and working to develop programming that meets the required standards.

The fourteen (14) 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 twenty-four (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 twelve (12) regions and an additional region can offer overnight crisis respite beds;
- All regions provide walk-in crisis services in at least one (1) clinic in the region during business hours;
- Training is provided to law enforcement related to accessing emergency psychiatric care in every region; and
- Mobile Crisis Services are available in nine (9) regions.

A growing trend is the centralization of staff that performs various types of emergency evaluations, such as involuntary hospitalization certifications, jail triage emergency evaluations and walk in emergency evaluations. In the past all clinical staff was 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 individuals they serve, without disruption. Several regions has developed a central triage center where all crisis calls, emergency evaluations and involuntary hospitalizations are screened and triaged 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. Substance abuse detoxification programs and substance abuse residential treatment programs were added as newly billable services in the Medicaid State Plan Amendment approved in January of 2014. This has allowed for a better service array for individuals with co-occurring substance use disorders.

The goals for SFY 2016/2017 include:

DBHDID is refocusing Emergency Services as the public mental health safety net and expecting the regions to screen, triage and stabilize anyone presenting in crisis. Regions will either offer the full array of crisis services or have a memorandum of understanding with an adjoining region to provide that service and give that individual in need a warm hand-off to that level of care. Regional boards in three (3) urban areas are working with their local hospital programs (University of Louisville, University of Kentucky and St. Mary's) to discuss and jointly plan for high utilizers of emergency services that present at the emergency room.

Continue to look at technology and assessment protocols to strengthen the Jail Triage program. This programming is currently running very stable and anecdotal feedback from the jails always seems highly positive. Our jail triage funding held steady from recent years and we must continue to innovate to protect the gratifying success of the program and continued cooperation from the jail staff. To date the Jail Triage program provides emergency mental health services to eighty-six (86) county jails in Kentucky.

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 with Post Traumatic Stress Disorder, as well as other disorders, and their families.

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 individuals 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, KDBHDID 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 KDBHDID with a focus on improving the lives of persons with psychiatric disabilities by enhancing their use of skills and/or environmental supports to live, learn, work, and socialize in the community and role of their choice.

The DBHDID also promotes the use of SAMHSA's working definition of recovery, including the dimensions of health, home, purpose and community, as well as the ten guiding principles of behavioral health recovery.

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. In January 2014, a new Kentucky Medicaid state plan amendment was approved by CMS. The DBHDID provided much consultation regarding the new service package for adults with SMI. Psychiatric rehabilitation was referred to specifically in several of the newly billable services.

The DBHDID supports the provision of key rehabilitative services at the regional level: **therapeutic rehabilitation**, **supported employment**, **supported education**, **illness management and recovery, peer support services** and **assertive community treatment.** While they each rely on psychiatric rehabilitation foundations, they are supported in very different ways.

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

- The Division of Behavioral Health designates a statewide community support program coordinator;
- Contracts with Regional Boards require designation of a regional Community Support Director and attendance at quarterly meetings;
- Technical assistance and training is provided for Community Support Program Directors who coordinate services for the state's 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;

- An interagency agreement with the Office of Vocational Rehabilitation that uses CMHS Block Grant funds to leverage supported employment services for adults with serious mental illness. As of SFY 2015, all regions across the state have supported employment programs utilizing the Individual Placement and Support (IPS) model, to support adults with SMI; and
- Contracts with Regional Boards require all regions to provide access to Assertive Community Treatment (ACT) and Peer Support services for adults with SMI. As of SFY 2015, all regions across the state have developed ACT teams and are providing ACT services to adults with SMI. In addition all regions across the state have hired at least one peer support specialist (most regions have hired several peer specialists) and are providing peer support as a service to adults with SMI.
- Seven (7) regions are providing access to Illness Management and Recovery services, an evidence based practice for adults with SMI;
- One (1) region has hired a psychiatric rehabilitation specialist to work in the agency, to assist in incorporating psychiatric rehabilitation principles into programming for adults with SMI; and
- Six (6) regions provide access to educational services to adults with SMI. According to the Kentucky Adult Literacy Survey, over 340,000 people lack the literacy skills 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 serious mental illness in accessing and maintaining employment, and can negatively impact their quality of life. Providing access to educational support services should remain a priority.

Plan and Budget submissions for SFY 2016 reveal that access to rehabilitation services is available in all 120 of Kentucky's counties in the following manner:

- All fourteen (14) regions have traditionally provided access to therapeutic rehabilitation program services. However, as of SFY 2015 only nine (9) of fourteen (14) regions provide access to therapeutic rehabilitation services;
- Seven (7) regions are providing access to Illness Management and Recovery services, an evidence based practice for adults with SMI;
- One (1) region has hired a psychiatric rehabilitation specialist to work in the agency, to assist in incorporating psychiatric rehabilitation principles into programming for adults with SMI; and
- Six (6) regions provide access to educational services to adults with SMI. According to the Kentucky Adult Literacy Survey, over 340,000 people lack the literacy skills 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 serious mental illness in accessing and maintaining employment, and can negatively impact their quality of life. Providing access to educational support services should remain a priority.

Although adult rehabilitation services are available, 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.

The delivery of quality, timely rehabilitation services has been enhanced since approval of the new Medicaid state plan amendment in January 2014, and since Kentucky's adoption of Medicaid Expansion under the Affordable Care Act. Many of the rehabilitation services are now

billable through Medicaid. However, quality, timely, delivery remains challenged by a number of factors including:

- Kentucky Medicaid rates for therapeutic rehabilitation, assertive community treatment, and peer support are quite low and significantly below the reimbursement rate for outpatient treatment services;
- Funding sources other than Medicaid do not reimburse for therapeutic rehabilitation services, assertive community treatment or peer support services, or else have challenging processes of reimbursement, so individuals without Medicaid have difficulty accessing this service;
- Some rehabilitation services are inconsistent and do not have a specific model of practice with stated values, principles, practice guidelines, and expected outcomes of service;
- Supported employment is not reimbursed by Medicaid and there is limited funding for the long term employment supports needed by adults with a serious mental illness;
- The advent of Managed Care, and Kentucky's contracts with five (5) separate Managed Care Organizations, has led to numerous difficulties with gaining authorization for therapeutic rehabilitation, assertive community treatment, and other rehabilitation services;
- Supported education is not reimbursed by Medicaid and is actually interpreted by some centers as being discouraged due to the possible interpretation of duplicity of services; and
- Difficulties with transportation, especially for individuals 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 other safe, secure locations 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.

KDBHDID has intensified efforts to build an integrated service system for individuals with serious mental illness who are involved in the criminal justice system, by collaboration between KDBHDID, law enforcement agencies, the Kentucky Department of Corrections, and other stakeholders in our communities' "safety net" to serve persons with mental illness.

Regional Boards provide training to a number of entities in the criminal justice system in order to assure that persons with serious mental illness are diverted into treatment whenever possible rather than being arrested and booked into jail. In Jefferson County, Louisville Metropolitan area, the Crisis Intervention Team (CIT) within the Police Department has been in place for over (nine) 9 years and has successfully diverted thousands of individuals into care. In SFY 2014, 96 (ninety-six) Louisville Metro Officers received CIT certification. The total number of Louisville Metro Officers trained to date is nine hundred, eighty-eight (988), and represents over 50% their

total police force. Their goal is to make sure at least one (1) CIT trained officer is on each shift in each division of the city. CIT trainings in Jefferson County are not funded by mental health block grant or state mental health monies.

Jefferson County's circuit and district courts also have mental health diversion programs which work with regional boards to operate post-booking interventions to divert many individuals into treatment and aftercare rather than long-term incarceration. Female clients with trauma history are represented at rates higher than the national average in therapeutic courts in Jefferson County. This led to a Bureau of Justice Assistance expansion grant. Thru the technical knowledge gained, assessment protocols and more formal treatment modalities to address co-occurring issues were implemented. This region plans for continued expansion of mental health court programs to include Circuit court and a track for Assertive Community Treatment (ACT). Programming continues to include: Illness Management and Recovery (IMR), Integrated Dual Diagnosis Treatment (IDDT), and trauma informed and gender specific groups (including the Hands Off program to address the link between trauma and theft behavior). Cognitive Behavior Therapy (CBT) programming will focus on criminogenic factors that impact recidivism.

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

The relationship between Regional Boards and local jails has continued through the delivery of the mental health and suicide prevention triage assessments the Boards have been providing. Funding was also included to provide consultation to the jails on an as needed basis to improve jail personnel's response to inmates with behavioral health needs. KDBHDID has budgeted $1,200,000 for SFY 2016, the program has more than doubled in size and scope since SFY 2014. Regional Boards have entered into formal agreements with local jails in eighty-six (86) counties across the Commonwealth.

With the passage of Senate Bill 104 in 2007, the Kentucky Legislative Session established a statewide, curriculum for training of law enforcement officers in the Crisis Intervention Team (CIT) Memphis model. The goal for SFY 2016/2017 is to continue to expand CIT trainings throughout the state, and to create regional Crisis Advisory Committees in the two regions that don't currently have them. In SFY 2014, two hundred, ninety-nine (299) Kentucky Law Enforcement Officers, outside of Jefferson County, received CIT certification. Over one thousand, nine hundred, forty-four (1,944) Kentucky law enforcement officers (including sheriff's departments, local police departments, state police officers, etc.), outside of Jefferson County, have been trained as members of Crisis Intervention Teams since the program's implementation. Twelve of fourteen regions to date have CIT Advisory Committees, with trainings scheduled in the remaining two areas in the fall of 2015. CIT Advisory Committees involve mental health professionals, advocates and consumers alongside local law enforcement officers to enhance community collaboration.

KDBHDID has also partnered with the Kentucky Department of Corrections (DOC) on a re-integration project, partially funded by block grant funds. This program allows for strategic planning and case management for inmates with serious mental illness who are exiting

Kentucky prisons and returning to their communities. The Boundary Spanner project employees a re-integration case manager who works to form a bridge of services between the prison system and the individual's home community. This enables the connection to behavioral health services to be planned and provided a "warm hand off" to the community mental health center. In SFY 2014, twenty-six (26) individuals with serious mental illness received intensive case management services. This program has been challenged by the passage of HB 463, which qualifies some offenders to be paroled or released early under mandatory release supervision conditions. This has created a demand for assistance in applying for Social Security benefits and behavioral health services months before the previously anticipated release dates.

DBHDID also provides a 40-hour course for law enforcement, considered Mental Health 101 by the Kentucky Department for Criminal Justice Training (DOCJT) twice annually. This course serves as an elective for any law enforcement officer in the state who wants to 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. An individual in recovery from a behavioral health disorder participates as an instructor in this training.

Other projects that the Department is involved in include a diversion program being led by the Kentucky Department for Public Advocacy, which places a social worker in public defenders' offices across the state to develop diversion alternatives for persons with behavioral health issues.

KDBHDID's Community Mental Health Centers (CMHC's) contract language includes individuals within the Department of Corrections' Correctional Psychiatric Treatment Unit (CPTU), an all-male unit within the Kentucky State Reformatory and the Psychiatric Care Unit (PCU), an all-female unit within the Kentucky Correctional Institute for Women, who are serving out or being paroled, to be designated as a priority population by the Regional Boards. This will allow high risk individuals who are serving out or being released from the CPTU and PCU to be seen within fourteen (14) days of release at a CMHC for mental health services. By designating this group a priority, the goal is that this population can maintain a stable lifestyle in the community after incarceration. KDBHDID's Adult Mental Health Services and Recovery Branch and the Department of Corrections Mental Health Division are working collaboratively to develop a Memorandum of Understanding to include data sharing and collection mechanisms, and to gather information to help facilitate a smooth transition for all parties.

KDBHDID 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 2016/2017 are to continue to collaborate with state and local behavioral health, housing, employment, peer support, community based services, kynect (Affordable Care Act), and physical health entities in order to improve overall outcomes for individuals with behavioral health issues who are involved in the criminal justice system as well as improve access to substance abuse treatment services. Another goal is to continue to provide Mental Health 101 training to law enforcement officers through DOCJT.

Services to Persons who are Deaf and Hard of Hearing

"The need and right to communicate is the most fundamental of human rights. To deny it is to harm the human spirit; to foster communication is to reveal all of the possibilities of life." – Lawrence Siegel, 2000

"Psychiatry is unique among the medical fields in that most of the symptoms are conveyed by or through communication, and communication is also the primary method and nature of treatment." –Robert Pollard, Ph.D.

Availability of direct services in American Sign Language (ASL) to individuals who are Deaf decreased in the past two years with the loss of one .2 FTE at Seven Counties Services. In the CMHC system, we currently have four (4) therapists who are Deaf or fluent in ASL and one (1) part-time case manager who specializes in work with the population. Despite the opening up of the Medicaid network during SFY 2015, no new providers have been identified to develop or sustain private services.

Efforts have focused on improving the quality and availability of a trained workforce, addressing the unique needs of individuals who are Hard of Hearing, and using the System of Care approach to bring together traditional Deaf-Services providers with those serving in state agencies and partner organizations.

Highlights:

- A Deaf and Hard of Hearing Services (DHHS) "Point Person" is now required as part of each contract with the Regional Boards.
- Seven (7) additional interpreters have completed Mental Health Interpreter Training in Alabama
- Five (5) AmeriCorps members completed 1,873 service hours before funding was eliminated.
- One (1) Master's level psychologist completed his internship at Kentucky School for the Deaf with a stipend from the department and graduated from his program.
- The DHHS program offered scholarships to consumers, family members, providers, and both active military members and veterans to attend the 2013 Hearing Loss Association of America Kentucky Chapters "World of Resources" regional conference.
- The Kentucky Initiative for Collaborative Change (KICC) sponsored a Deaf and Hard of Hearing services track at the 2015 System of Care Conference. For the first time, providers from the Statewide Educational Resource Center on Deafness, Commission for Children with Special Healthcare Needs, Commission on the Deaf and Hard of Hearing, Lexington Speech and Hearing Center, Vocational Rehabilitation, Department of Community Based Services, and Community Mental Health Centers came together to address systems issues in serving the population. Relationships were generated and renewed and partnerships developed.
- The DHHS Program Administrator was appointed to the Early Hearing Detection and Intervention (EHDI) Statewide Advisory Committee providing a voice on the impact of hearing loss on social and emotional development and opening doors to collaboration with audiologists, speech language pathologists, early interventionists, and researchers at universities.
- A partnership with the KentuckyOne Health Culture and Language Services department has led to joint trainings for interpreters, shared resources, and creative problem-solving for Deaf individuals with limited resources for discharge. Ongoing collaboration to address the lack of a specialized acute unit for individuals who are Deaf is planned.

- A monthly support group for individuals who are Hard of Hearing has been offered continually since April 2014.
- A short-term grief support group in ASL was offered in 2013.
- The first two classes of Mental Health First Aid in ASL were offered in June 2015 as a means to educate non-mental health-focused Deaf Services providers and to reduce stigma in the Deaf community.

Plans for FY2016-FY2018

Unfortunately, multiple leadership changes at the DBHDID prevented the accomplishment of past objectives. The Advisory Committee on the Need for Services for Individuals who are Deaf or Hard of Hearing would like the DBHDID to focus on the following:

- Reviewing the use of department, state general, and Federal block grant funds to focus on supporting direct services in ASL and purchasing services that are non-billable under Medicaid but necessary to the cultural and linguistic integrity of equal service provision for the Deaf community.
- Supporting the ongoing efforts of the Hearing Loss Association of America through sponsoring Michael Harvey and additional scholarships at the 2015 World of Resources conference.
- Offering Mental Health First Aid to interpreters and to the Hard of Hearing community using CART (Computer Assisted Real Time captioning).
- Re-applying for AmeriCorps positions for the SFY 2016 service year.
- Advocating for an increase in staffing for DHHS within the Department.
- Focusing on holding contracted agencies accountable for ensuring effective communication at all points of service.

Targeted Case Management Services

Targeted 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. Targeted case management has been available through Regional Boards since 1985 and was first covered by Kentucky Medicaid in 1991. Adults with serious mental illness who have the greatest difficulties accessing resources and those with more intense service needs are targeted by this service. 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).

In SFY 2014, four (4) certification trainings were held at locations in eastern and western Kentucky and 123 targeted case managers were trained.

During SFY 2015, two (2) certification trainings were held at locations in eastern and western Kentucky and 87 targeted case managers were trained.

In October of 2014, CMS approved a new state plan amendment for targeted case management for Kentucky. This new plan added some new categories for targeted case management including, targeted case management for individuals with substance use disorders, and targeted case management for individuals with SMI plus a co-occurring chronic physical health condition.

This state plan amendment and subsequent regulations from DMS required the DBHDID to be responsible for training of all new targeted case managers and supervisors. In response to the new state plan amendment in addition to a larger pool of Medicaid providers for behavioral health services, the DBHDID restructured the process of certification trainings for several programs, including targeted case management.

Beginning in SFY 2015, the DBHDID provided curriculum rubrics and required providers to submit curricula for approval, so providers could begin providing their own certification trainings. Through DBHDID regulation, providers are required to follow the core components outlined in the curriculum rubrics, provide the required trainings following DBHDID approval, and then submit to the DBHDID the names and numbers of persons certified in each specific program. (e.g. the names and numbers of certified targeted case managers for adults with SMI; the number of certified adult peer support specialists).

In March of 2015, the DBHDID provided a two (2) day training event for targeted case managers and their supervisors in Louisville, Kentucky. This training provided many workshops focusing on all types of targeted case management, including the new types approved through Medicaid. It also included a keynote speaker, Janis Tondora, PsyD., of Yale University, who spoke about person centered planning as an aspect of case management. This training was very well attended and included very good evaluations despite being in the middle of a monumental spring snowstorm across Kentucky. Many staff from outlying areas in the state, some areas which received approximately two (2) feet of snow, came to the hotel and remained there until the snowstorm ended.

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

- The Division of Behavioral Health designates a statewide coordinator of targeted case management services for adults with SMI;
- KDBHDID approves curricula for agencies so they may provide their own certification training for targeted case managers to allow the provision of billable Medicaid services; and
- The KDBHDID provides additional training opportunities for case managers and case management supervisors.

Targeted case management services are available in all 120 of Kentucky's counties. During SFY 2014, targeted case managers employed by Regional Boards provided support to 7,534 individuals with serious mental illness.

Community Medication Support Program (CMSP)

KDBHDID 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, KDBHDID, 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 KDBHDID criteria of SMI (diagnosis, disability and duration). KDBHDID 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 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 behavioral healthcare system to provide a continuum of care for those individuals being served.

Housing Services

The KDBHDID 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.

KDBHDID and KHC have a long history of close cooperation, dating back to 1999 when KDBHDID and KHC jointly-funded the position of a Supportive Housing Specialist at KHC tasked with focusing on permanent supportive housing options for special needs populations. Currently, KDBHDID and KHC collaborate on several programs serving persons with a serious mental illness that will greatly expand the limited affordable housing opportunities currently available. These programs are:

Olmstead Housing Initiative –DBHDID continues to implement a plan to ensure that individuals with serious mental illnesses who have been institutionalized or are at risk of institutionalization have viable transition plans that ensure community-based housing and services. Assistance through the Olmstead Housing Initiative can come in the form of tenant-based rental assistance (TBRA), one-time security or utility deposit assistance, furnishings, and essential household goods necessary for the housing set-up.

HUD 811 Grant – This program will enable KHC, in partnership with DBHDID, to serve 150 very low-income persons with disabilities and to offer a wide array of service choices and opportunities, through project-based housing vouchers for persons exiting, or at risk of entering, personal care homes or other institutions. DBHDID will provide referral clients to the program in addition to offering a wide array of service choices and opportunities.

Multifamily Development – DBHDID works with KHC's Multifamily Department to assist with trainings for housing developers regarding set-aside units for the Olmstead population. These trainings include material on the Olmstead population, the CMHC system, services provided and local contacts within the CMHCs. DBHDID also facilitates contact between the developers and the CMHCs. CMHCs have agreed to refer a specified number of individuals to each development complex, and to provide the services needed, including ACT, to assist these persons in successfully transitioning to the community.

Other Housing Contracts

Wellspring – Wellspring promotes mental health recovery for adults with serious mental illness by providing quality housing and rehabilitative services for nearly 700 clients annually.

Wellspring operates two Crisis Stabilization services and several Supported Housing programs in addition to affordable housing options throughout Jefferson County and a Shelby County site.

Activities include linking clients to services and activities of their choosing, accessing subsidies, locating suitable housing, negotiating leases, acquiring household items, moving the individual into the residence, teaching basic life skills and other skills that strengthen recovery and promote community integration.

New Beginnings –New Beginnings provides community-based, recovery-oriented housing and supportive services to persons with serious mental illness in the least restrictive environment possible; and offers a variety of housing programs ranging from staffed residences with 24 hour supervision to outreach services offering periodic supports to individuals living independently in the community.

Activities include linking clients to services and activities of their choosing, accessing subsidies, locating suitable housing, negotiating leases, acquiring household items, moving the individual into the residence, teaching basic life skills and other skills that strengthen recovery and promote community integration.

Staffed Residences – A Request for Applications was sent out to the CMHCs in January 2015 to fund approved proposals for staffed residences. Three CMHCs were awarded funding and provide supportive housing services to individuals with serious mental illnesses who meet Level of Care Utilization System (LOCUS) Level 5 criteria and are transitioning from an institutional setting to integrated community housing. These activities include linking clients to services and activities of their choosing, accessing subsidies, locating suitable housing, negotiating leases, acquiring household items, moving the individual into the residence, teaching basic life skills and other skills that strengthen recovery and promote community integration.

Regional Boards use a variety of strategies to develop housing options for individuals with serious 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 2016 reveals that:

- There are approximately 941 units in 61 projects operated by the CMHCs;
- All regions have a Housing Coordinator, and have developed a housing plan;
- All regions provide specialized housing training to agency staff;
- Ten regions have organized formal supported housing programs;
- Ten regions are involved in housing development; and
- Nine regions operate housing projects that provide residential support.

Goals for SFY 2016:

- To address a pressing need for housing for people who are currently in, or at risk of entering, institutions, such as psychiatric hospitals or personal care homes, or who have a history of frequent institutionalizations. By moving individuals from institutional settings to living independently in communities of their choice, Kentucky can better serve this population and implement the mandates of the Olmstead decision;
- To bring as many HUD 811 housing units online as possible early into the program. Will then want to move individuals into these units as quickly as possible.; and
- Provide supportive housing opportunities for individuals with high service needs.

Goals for SFY 2017:

- To identify additional steps that we can take to achieve our goals around integrating Medicaid resources as supports for housing. Will work towards providing as many resources as possible through mainstream resources and have less reliance on general fund projects;
- Continue to work with housing developers to set-aside units for the Olmstead population and to develop additional housing opportunities across the state;
- Continue to promote establishing local SSI/SSDI Outreach, Access and Recovery (SOAR) and other 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 hospital stay is critical to reducing readmission rates, and improving quality of life. Through contract, the Department requires a Regional Board to provide an outpatient appointment for adults with SMI within fourteen (14) calendar days of discharge from a state psychiatric facility. KDBHDID also requires the assignment of a targeted case manager and provision of targeted case management services to adults with serious mental illness who are discharged from a state psychiatric facility within fourteen (14) calendar days. Since SFY 2013, the DBHDID contract language with the Regional Boards has also included a requirement that individuals within the Department of Corrections' Correctional Psychiatric Treatment Unit (CPTU), an all-male unit within the Kentucky State Reformatory and individuals within the Psychiatric Care Unit (PCU), an all-female unit within the Kentucky Correctional Institute for Women, who have SMI and are serving out or being paroled, have an outpatient appointment within fourteen (14) calendar days of release.

The fourteen (14) Regional Boards and the state operated/contracted psychiatric hospitals must work closely together to assure continuity of care. Contracts with all parties address continuity issues such as medications, discharge plans, case management and outpatient referrals. Some Regional Boards function as a single portal of entry for some of the hospitals. Continuity of Care meetings occur quarterly within each state operated/contracted psychiatric hospital, and include DBHDID staff, CMHC staff, other community partners, as well as hospital staff, in order to facilitate collaboration between the hospitals and the Regional Boards. The agenda for each meeting includes the following system wide issues:

- Admission and discharge processes;
- 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, the 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 individuals that they both serve.

The 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 serious mental illness who are in crisis.

In May of 2015, DBHDID leadership convened a continuity of care summit, "Bridging the Gap", which included state psychiatric staff, CMHC staff, DBHDID staff and others. This summit focused on creating a "warm hand-off" approach for behavioral health care and the development or reaffirmation of policies and procedures that address this issue. Participants were challenged to develop a regional action plan that outlined the next steps for improving continuity of care.

Also in SFY 2015, the DBHDID was awarded the Transformation Transfer Initiative (TTI) grant to focus on working with state psychiatric facilities and Regional Boards to create partnerships in providing peer support at many levels in order to enhance continuity of care and bridge the transition in and out of higher levels of care.

The DBHDID also monitors the Kentucky Olmstead Initiative in each of the four state operated/contracted psychiatric hospital regions. Transition teams comprised of representatives from the hospital, the Regional Board, DBHDID staff, and other community stakeholders meet monthly to review transition plans that assure a smooth and timely discharge to the community for individuals identified through Olmstead. State General Funds are appropriated each year to each state hospital catchment area specifically for the Olmstead initiative. These funds are for individualized and specialized wraparound services to assure the community tenure for each Olmstead individual. Kentucky's statewide Olmstead Plan is in the process of being updated and is currently involved in obtaining comments from the public.

In January of 2014, a new Medicaid state plan amendment was approved by CMS. A new package of billable services for Kentucky was established. Regional Boards, through contracts with DBHDID, have been recreating the system of care for adults with SMI by developing newly billable services such as Assertive Community Treatment and peer support. Three (3) levels of crisis services became Medicaid billable as well as outpatient and residential service for individuals with substance use disorders. In addition, Kentucky adopted Medicaid Expansion through the Affordable Care Act and opened the network of behavioral health providers to include agencies other than CMHCs. Regional Boards have also been adjusting to Managed Care. Kentucky now contracts with five (5) Managed Care Organizations for behavioral health services and each Regional Board must develop contracts and negotiate with each company regarding procedures, processes and reimbursement rates. DBH leadership has been making efforts to clarify reimbursement procedures and improve relationships between stakeholders across the state.

Continuity of care is a major priority for the Department. Challenges include:

- Increasing the utilization of crisis stabilization programs and other crisis services as alternatives to hospitalization;

- Poor reimbursement rates for specialty services such as crisis stabilization;
- Limited availability of supervised housing in the community, thwarting efforts to discharge individuals with complex and higher end service needs;
- Limited availability of safe, affordable housing for adults with SMI, especially in rural areas of Kentucky;
- Limited availability of housing assistance for adults with SMI, including housing vouchers, rental assistance, etc.; and
- Lack of consistency in beliefs about the reality of recovery for individuals with SMI, and subsequent lack of adoption of recovery mindset for all providers.

A project entitled DIVERTS (Direct Intervention: Very Early Treatment System) was implemented in the Western State Hospital Catchment area beginning in SFY 2007, as a partnership between the DBHDID, the four (4) respective Community Mental Health Centers (CMHC) in that catchment area, 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 (4) Regional Boards serving that hospital catchment area.

In August of 2013, the Cabinet for Health and Family Services entered into an Interim Settlement Agreement (ISA) with Kentucky Protection and Advocacy to avoid litigation concerning the institutionalization of individuals with SMI who resided in personal care homes. Estimates of individuals impacted under this agreement range as high as 2,300 statewide, with an original list of expressers (persons expressing their desire to live in the community) of approximately 130 people. Since that time, concerted efforts have been taken to establish a new and expanded service delivery system for adults with SMI that include ACT services, targeted case management, supported employment, supportive housing and peer support. The Adult Mental Health Services and Recovery Branch underwent a major reorganization in an attempt to better focus energies on developing these services across the state. In addition, agreements with the Department for Aging and Independent Living (DAIL), Department for Community Based Services (DCBS), and other agencies have been instrumental in developing necessary infrastructure for the ISA project.

DAIL, which includes the state guardianship office, has provided multiple training and technical assistance regarding individuals under the ISA who have been assigned state guardians. DCBS rewrote state supplementation guidelines and now the state supplement that traditionally supported individuals with SMI in personal care homes, now support the same individuals in their own home in the community.

As of January 2015, hospitals and other entities were able to directly refer individuals who were either living in personal care homes or at risk of being placed in personal care homes, through a web based data tracking system. At the end of SFY 2015, referrals in the tracking tool number over 1,000 persons who are awaiting transition to a community setting.

The original funding that had gone to Regional Boards in the Western State Hospital Catchment area was redirected to create services for the ISA population. In addition, during SFY 2014, approximately five (5) million additional dollars were reallocated from the state psychiatric facility budget to provide funding for community ISA services. At least six (6) million dollars of reallocated funding is guaranteed for ISA through SFY 2016. Discussions are taking place to possibly provide funding on a more permanent basis for this project.

During SFY 2014, the DBHDID redesigned contracts with Regional Boards to include the new package of services for adults with SMI. This package of services was called DIVERTS, but now included a very specific population with specific services across the state, not just in the western part of the state.

Regional Boards were required to develop ACT teams, hire peer support specialists, hire supported employment specialists and hire housing coordinators to provide services through DIVERTS. As ACT and peer support have become Medicaid billable services in Kentucky, Regional Boards have been adjusting to changes in reimbursement. National recognized experts and consultants were brought to Kentucky by DBHDID and were utilized across the state in implementation efforts through training, technical assistance and fidelity assessments. Full implementation efforts continue.

At the end of SFY 2015, two (2) state psychiatric hospitals were showing a substantial reduction in admissions. One (1) state psychiatric hospital in western Kentucky serves a largely rural population and appears to be trending towards a reduction in admissions. One (1) state psychiatric hospital in central Kentucky opened in a new facility in 2014 and is experiencing an upward trend in admissions, particularly because of an influx in admissions from the northern part of the state.

Goals for SFY 2016/2017 are to continue to strive for full implementation of all services across the state for individuals with SMI. The DBHDID intends to continue providing technical assistance in the form of national consultants, trainings, fidelity monitoring, data tracking systems and performance based contracting. Also, the DBHDID would like to see dedicated funding for the ISA.

II. Planning Steps

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

Identify the unmet service needs and critical gaps within the current system. This step should identify the unmet service needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the populations relevant to each block grant within the state's behavioral health system, especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet these unmet needs and gaps. The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), the National Facilities Survey on Drug Abuse and Mental Health Services, the annual State and National Behavioral Health Barometers, and the Uniform Reporting System (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance abuse prevention, 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 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:

- Provider Forums;
- Out-of-State Children's Workgroup/ Children's System of Care Redesign;
- Technical Assistance from Multiple Consultants; and
- Priorities and Supporting Research from Federal Funders, including SAMHSA.

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

- Implementation of Medicaid Expansion in Kentucky, with over 400,000 new individuals covered by Medicaid
- Opening the network of Medicaid billable behavioral health providers to those other than CMHCs
- Implementation of new services as outlined in new Medicaid state plan amendment approved by CMS in January 2014 (especially substance abuse services, crisis services and evidence based practices for adults with SMI)
- Development of new regulations, in collaboration with DMS, DAIL, DCBS, and other agencies, in order to adequately outline new available services and supports
- DBHDID evaluating purchasing options and subsequently redesigning CMHC contracts and implementing performance based contracting
- Due to the success of ACA implementation in Kentucky, Governor's Office decision to reduce behavioral health funding in state budget for SFY 2015 and SFY 2016, due to expected savings due to more services being Medicaid billable and more individuals receiving Medicaid as a benefit ($21 Million in SFY 2015; $30 Million in SFY 2016)

- CHFS entering into an Interim Settlement Agreement (ISA) with Kentucky Protection and Advocacy, as of August 2013, agreeing to move at least 600 individuals with SMI out of personal care homes and into permanent supportive housing in communities of their choice within a 3 year period
- Rebalancing of DBHDID facility funds into community funding for Direct Intervention Very Early Response Treatment System (DIVERTS) services to support individuals identified through ISA. ($6 - $7 Million for a three year period)
- Kentucky Attorney General Securing Settlement Funds from pharmaceutical companies to be used for Substance Abuse programming
- Statewide Managed Care Organizations (MCOs) coordinating behavioral health care (five separate MCOs across the state)
- Legislative Actions (including unfunded mandates)
- Returning Service Members, Veterans and their Families with Behavioral Health Needs
- Workforce Issues and Shortages
- Underfunded Pension System and Increased Retirement Contribution by CMHCs

Division of Behavioral Health – Unmet Service Needs

Mental Health

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/adequate insurance coverage, even if periodic.

During SFY 2014 & SFY 2015, Colette Croze, MSW, a private consultant specializing in public resource management, provided technical assistance to DBHDID regarding the substance use continuum of care in Kentucky. This assisted DBHDID with preparation for ACA implementation, including Medicaid expansion, workforce readiness/expansion, Health Benefits Exchange, creating a substance abuse benefit package through Medicaid, and other topics. Results from this technical assistance included a more clearly define Plan and Budget process with DBH contractors, an evaluation of purchasing options regarding substance abuse services, and an evaluation of contracts with Managed Care Organizations.

A Gap Analysis was calculated by DBHDID based on 2010 Census numbers and certified 2013 KY MIS Client/Event data. This data was based on prevalence data regarding adults with SMI 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.

In May 2013, Deloitte issued a report entitled, "The Commonwealth of Kentucky Health Care Workforce Capacity Report". This study assessed current access to all health care in Kentucky, considering that 640,000 were estimated to be uninsured at the time of the study. This report determined that large gaps appear in the health care workforce, especially in rural and underserved areas across the state. It noted that over 80% of Kentucky counties had a major

gap in behavioral health providers, including psychiatrists/psychologists. As a result of this study, CHFS opened the available network of Medicaid providers for behavioral health services and created regulations outlining processes for providers, other than CMHCs, to become Medicaid billable organizations.

The Center for Mental Health Services (CMHS) conducted a mental health block grant monitoring visit June 17-19, 2014. The monitoring team met with DBHDID Commissioner and other Department leadership, financial administrators, as well as Department staff in children and adult programming. The team attended a Behavioral Health Planning and Advisory Council meeting and interviewed a group of individuals in recovery and family members from across the state. Some recommendations following this visit included:

- DBHDID should include individuals in recovery when meeting with Managed Care Organizations and DMS should consider providing incentives to MCOs to promote positive outcomes;
- DBHDID should implement a formal cultural competency program and assign a program coordinator;
- DBHDID should enhance the use of geographic information systems to assist in advocacy and regional planning efforts;
- The Cabinet and DBHDID should carefully track and analyze outcome data regarding programs and services to improve return on investment;
- DBHDID should provide training about behavioral health issues and resources to inmates who staff reentry councils and reentry hotlines;
- DBHDID should consider expanding school based mental health services;
- The Behavioral Health Planning and Advisory Council should plan a retreat with activities designed to focus Council efforts and highlight areas for collaboration. In addition the Council could receive SAMHSA technical assistance regarding orientation to Department data collection and mandated responsibilities of their use;
- DBHDID should increase involvement of individuals in recovery in the development of regulations; and
- DBHDID should expand the use of telehealth for individuals in rural areas, and work with multiple state agencies to improve transportation issues.

At the Finance and Data Committee meeting of the Behavioral Health Planning and Advisory Council (BHPAC) in April of 2014, Council members suggested priorities for block grant funding allocations. The Council listed Trauma and Justice and Recovery Support as top strategic priorities. Supported employment, peer support, adolescent recovery groups, and quality, safe child care for parents in treatment at consumer run programs were listed as top service priorities. The Council recommended the following priority populations:

- Individuals with substance use disorders
- Individuals who are homeless
- Mental health support groups in schools
- Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ)

At the Finance and Data Committee meeting of the BHPAC in April of 2015, Council members again suggested some priorities for block grant funding. Council members suggested funding of programs such as Youth Drop-In Centers, Oxford House (an evidence based practice for

individuals with substance use disorders) projects involving both supported employment and case management services, Homeless Prevention Projects, and emergency preparedness funding.

During SFY 2015, Kentucky System Transformation Advocating Recovery Supports (KYSTARS) conducted a needs assessment regarding consumer run programs across the state. This assessment gathered information regarding four (4) primary areas:

- Safety
- Group Process/Wellness
- Recovery Philosophy
- Leadership

A KYSTARS review team interviewed leadership and participants of each consumer run program funded by DBH at that time. (e.g. five (5) programs). KYSTARS found that all programs would benefit from additional training in various program areas. All programs could benefit from safety training, four (4) of the programs could benefit from wellness education, three (3) programs could benefit from training on recovery philosophy, and four (4) programs could benefit from leadership training. KYSTARS used these findings to design beneficial workshops at their annual conference for peers and providers in May of 2015. KYSTARS will continue to work with these programs, and others, through contract with DBH.

During SFY 2015, the Kentucky chapter of the National Alliance on Mental Illness (NAMI KY) conducted a statewide needs assessment regarding the mission of NAMI and unmet needs of individuals in recovery and their family members. Some findings included:

- Underrepresented community groups needing outreach (African American groups; Hispanic groups; private hospitals, therapists, doctors; Immigrant refugees; young siblings of persons with SMI; children in general)
- More programming implementation needed (provide training for each signature NAMI program every year; expand training opportunities for rural affiliates; more supported employment assistance; fundraising; continue assistance to end seclusion and restraint)
- Additional supports needed (peer to peer; ending the silence; parents and teachers as allies; NAMI BASICS; provider education; services for young people; NAMI support group in every county; more opportunities for individuals in recovery to provide training)

Co-occurring Disorders

Prevalence Data

In SFY 2014, 7,637 individuals over the age of 18, diagnosed with co-occurring mental health and substance use disorders were served by the Regional Boards.

In January 2014, a new Medicaid state plan amendment for Kentucky was approved by CMS. In this new billable service package, substance use disorder services were added, as well as several evidence based practices, including peer support and ACT.

Until then, individuals in Kentucky who were diagnosed with substance use disorders were required to provide payment through other insurance, self-pay, or by providers who were funded through grants. Many individuals did not receive treatment, or were not given adequate treatment, and many were not diagnosed appropriately due to fear of not being reimbursed if substance use was even mentioned in a medical record. Beginning in SFY 2015, Kentucky's

data should improve and identification and services for individuals with co-occurring disorders should increase as well.

Between SFY 2009 and SFY 2015, a team of integration specialists was developed by DBHDID to use DDCAT and DDMHT tools and to visit regional programming and assess co-occurring capabilities. All programs were offered the opportunity to use the data from their DDCAT/DDMHT reviews to make changes using the Network for Improvement of Addiction Treatment (NIATx) process improvement model to raise any scores below the score of three (3), which is considered co-occurring capable. The DBHDID provided technical assistance during this time period, regarding change projects as well as DDCAT/DDMHT fidelity assessments. A Transformation Transfer Initiative (TTI) grant, as well as securing a national consultant (Heather Gotham, co-creator of the tools), were instrumental in supporting regions in working towards co-occurring capability in their programming for adults. The DBHDID continues to provide technical assistance or help with fidelity assessments as requested.

The DBHDID has been working since SFY 2014 to implement Assertive Community Treatment as a service across the state for individuals with SMI. However, in working with ACT teams it became apparent that a large number of the individuals being served also had co-occurring substance use disorders. ACT teams have been ill prepared to provide good treatment to these individuals. In SFY 2015, the Department contracted with Case Western Reserve University to provide a series of training in Integrated Dual Diagnosis Treatment (IDDT), an evidence based practice that has been renamed Integrated Treatment for Co-Occurring Disorders by SAMHSA. Case Western provided three (3) separate training events in various parts of the state. Each training event consisted of three (3) days of training. All staff members of Assertive Community Treatment (ACT) teams across the state were trained in IDDT. At present, seventeen (17) ACT teams were trained in this model. When SFY 2015 data is analyzed, Kentucky should be able to more accurately assess the level of comorbidity of diagnoses for individuals receiving ACT as well as other services.

Unmet Needs and Critical Service Gaps

As a result of these statewide assessments, it became clear that programs did not include many peer led mutual support groups. Mutual support and mutual aid groups are identified as one of the ten guiding principles of recovery from SAMHSA. The DBHDID leveraged funds from the TTI grant and later from the block grant, for purposes of hiring an individual in recovery from co-occurring disorders to consult with DBHDID staff, regional staff and peers, and develop co-occurring mutual support groups in many regions across the state. Specifically, this individual in recovery assisted with development of Double Trouble in Recovery (DTR) mutual support groups across the state. DTR is a twelve-step self-help group that is facilitated by individuals in recovery from both mental health and substance use disorders. DTR is considered a best practice. At present, there are at least nine (9) regions that provide DTR as a support for individuals and more groups are continuing to develop. DBHDID continues to offer technical assistance and materials to assist with the development of this support across the state.

Kentucky's behavioral health service system continues to have workforce development needs for those serving individuals with co-occurring mental health and substance use disorders. The statewide system that has traditionally served adults with SMI needs much more in the way of training, implementation techniques, and technical assistance/coaching to make quality integrated services a reality for all individuals in Kentucky. In addition, the statewide system that has traditionally served adults with substance use disorders need much more in the way of training, and technical assistance/coaching on treating mental health issues as well.

Kentucky's ACT teams need to fully implement integrated principles of co-occurring disorder treatment into their services. This is very important due to the vulnerability of the population being served by ACT teams. The individuals being served by ACT have very intense treatment needs and many require integrated treatment in order to be successful.

There is also a gap regarding intensive outpatient treatment for individuals with co-occurring disorders in Kentucky. There are several intensive outpatient treatment programs offered for individuals with substance use disorders across the state. In the new 2014 service package offered through Medicaid, integrated treatment programs for individuals with mental health disorders was added as a billable service. In response, a few of those programs have developed across the state as well. However, it is unclear how either of these programs serves individuals who have co-occurring disorders. Either program, whether through the substance use disorder providers, or through the mental health providers, should be able to serve individuals with co-occurring disorders and ensure quality outcomes.

Kentucky has been training peer support specialists since 2006. However, initially, peers were only trained who were in recovery from mental health or co-occurring disorders. During the last few years, the DBHDID has been training peers in recovery from substance use disorders as well. When the new Medicaid state plan amendment was approved by CMS in January 2014, peer support was included as a billable service. The DBHDID changed the language in its peer support regulation to support training individuals in recovery from mental health, substance use or co-occurring disorders to become peer support specialists. Peer support for all populations is now a billable Medicaid service. More work needs to be done in this area to ensure adequate numbers of peer support specialists to work with all populations and to ensure adequate support and supervision.

Priorities for SFY 2016/2017:

- To monitor the status of providing integrated care through co-occurring capable programs in the regions across the state;
- Continue to provide more cross training opportunities through Kentucky School and other training events, and more training on co-occurring topics in general;
- Continue to require the use of evidence based treatment practices, including Integrated Dual Diagnosis Treatment (IDDT);
- Provide technical assistance to ACT teams regarding IDDT through the use of fidelity assessments, consultations and continued training, until IDDT is implemented with fidelity through all ACT services;
- Increase the number of peer specialists in recovery from co-occurring disorders hired by providers and improve supervision and support for peer specialists who are employed; and
- Continue to support and facilitate new peer led mutual support groups.

Data Sources Used:

- DBHDID SFY 2015/2016 Plan and Budget Documents
- Institute of Pharmaceutical Outcomes and Policy (IPOP) Data
- DBHDID/CMHC SFY 2016 contracts
- http://media.samhsa.gov/co-occurring/news-and-features/integrated-treatment.aspx (Toolkit for Integrated Treatment for Co-Occurring Disorders)
- http://ahsr.dartmouth.edu/html/ddcat.html (DDCAT/DDMHT information)
- http://www.hazelden.org/web/go/dtr (Double Trouble in Recovery)

- http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=13 Double Trouble in Recovery)
- http://www.samhsa.gov/recovery
- http://www.niatx.net/Home/Home.aspx?CategorySelected=HOME

Outreach to Service Members, Veterans and their Families in Kentucky:

Prevalence Data, Unmet Needs and Critical Service Gaps:
The Division of Behavioral Health is striving to meet the behavioral health needs of the Service Members, Veterans and their Families (SMVF) in Kentucky. The Substance Abuse and Mental Health Services Administration (SAMHSA) through its Service Members, Veterans, and their Families (SMVF) Training and Technical Assistance Center has held Policy Academies to help states and territories strengthen the behavioral health service systems supporting the SMVF population. Since 2012, Kentucky has been selected to participate and highlight their efforts at multiple SMVF Policy Academies including: Behavioral Health, Suicide Prevention, and most recently, Substance Use Disorders. Kentucky is very fortunate to have a strong representation at the table of Military leaders, Veterans Administration Hospital, state-wide service organizations, higher education representatives, and the backing of Military leadership.

Kentucky has a strong military presence with approximately 64,000 current personnel, predominately Army (35,713), Reserve and National Guard (18,538), with two large army military bases located within our borders – Ft. Campbell and Ft. Knox. More than 36,000 personnel are presently considered active duty. More than two-thirds of those military connected individuals live within our communities and access community resources for behavioral health needs. Approximately 334,000 military Veterans reside in Kentucky. There were an estimated 30,000 children and youth (ages 0 to 18) from Guard, Reserve and active duty families residing in Kentucky. Military families and Veterans in Kentucky are recognized as underserved populations as it pertains to physical and behavioral health needs.

Soldiers/Veterans from the Kentucky National Guard are scattered across Kentucky's 120 counties and it is difficult for them to get behavioral health treatment when and where they need it. Most individuals are typically not located near a military base or a Veterans Administration (VA) Hospital. If Service members/Veterans live near a bordering state they may leave the state for treatment or they may seek treatment in Kentucky or hide their affiliation with the military while seeking treatment.

Some Service members and Veterans in Kentucky are seeking services at the Community Mental Health Centers (CMHCs) and private providers to keep the 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 individual is paying out of pocket and in cash to hide the visit from the military insurance.

Kentucky communities and behavioral health providers have recognized an increase in the number of Service members returning from Operation New Dawn, Operation Enduring Freedom and Operation Iraqi Freedom with undiagnosed traumatic brain injury (TBI), Post-Traumatic Stress Disorder (PTSD), and other behavioral health disorders. There are not currently enough behavioral health providers or enough services to address these specific needs in Kentucky. Awareness and service capacity is building, but the services are often fragmented and not specifically designed for this population.

In 2013, DBH inserted language into the Community Mental Health Center contract that required each CMHC to identify at least one individual to act as a liaison to the SMVF population within their region. These individuals are known as Military Behavioral Health Coordinators (MBHC) and function as a point of contact, help the client to navigate the system and identify additional resources/benefits. The coordinators have attended Operation Immersion and Operation Headed Home events in order to gain perspective and insight into the needs of SMVF.

Operation Headed Home Conferences

The Operation Headed Home (OHH) workgroup began in 2008 with a core group of just three (3) individuals and has grown to over one hundred (100+) members who are connected and committed to providing counseling, information, resources, and support to Service members, Veterans and their Family members.

Since 2010, DBH has hosted four (4) Operation Headed Home conferences and trained more than one thousand (1,000+) individuals for FREE. Conference participants and presenters include: Past and present military Service members, Veterans (all branches) and their families/caregivers, local, state and national leaders, subject matter experts, and those serving on the "front lines" of behavioral healthcare and supportive services. The conference address the following identified needs: Traumatic Brain Injuries (TBI), Post-Traumatic Stress Disorder (PTSD), suicide prevention, reintegration, family and caregiver support, available resources and benefits, transitioning back to work and school, polytrauma, polypharmacy, substance abuse prevention and treatment, and hearing loss and tinnitus from blast injuries. Normal attendance for this event is over 300 individuals.

Upcoming conferences will strive to strengthen the community-based resources for returning Service members, Veterans and their Families. We will focus on reintegration of the Service member/Veteran back into the community. This will be accomplished by the development of region wide support systems. Participants will also be educated in the areas of TBI, PTSD, suicide prevention and ways to identify additional access points for care. The resources, partnerships and funding opportunities gained after the previous conferences have helped to build relationships across the state and fill tremendous gaps. It has also laid the groundwork for future community collaboration around TBI, PTSD and suicide prevention in our state.

Operation Immersion

Operation Immersion is designed to remove barriers and ease soldier apprehension and increase access to treatment. The Kentucky Division of Behavioral Health and the Kentucky National Guard have teamed up to present a comprehensive four (4) day training in military culture and issues unique to Service members, Veterans and their families. This training immerses behavioral health providers and professionals into aspects of military culture and the deployment experience. Attendees sleep in barracks, participate in early morning physical training, chores and inspection, learn about military culture/structure, experience the Field Leadership Reaction Course, experience combat simulators unique to the military, experience combat missions, enjoy MREs (Meal, Ready-to-Eat), and network with military personnel and resource providers. In addition, workshops are provided on TBI, PTSD, Combat Stress, Suicide Prevention, Substance Abuse Prevention and Treatment, Military Sexual Assault and Prevention Program, Trauma Informed Care and current best practices to treat military clients and their families.

Kentucky has held five (5) Operation Immersion events since inception in 2012 at the Wendell H. Ford Regional Training Center. This site is one of the premier Kentucky National Guard

training venues. Two hundred and seventeen (217) behavioral health professionals/providers have attended this hands-on event for FREE to learn about military culture and focus on how to help the SMVF population in Kentucky.

- Kentucky has approximately 4.4 million residents with a Veteran population of 330,599.
- As of September 2014 there were a total number of 24,493 women Veterans in Kentucky and that number is down 5,917 from the 30,410 reported from the September 2012 data. Unfortunately women are not aggressive in seeking services as many do not consider themselves a Veteran. However, as more awareness is raised, such as the Governor's recent proclamation of 2015 as the "Year of the Women Veterans", more women are beginning to register at conferences and events and for their benefits.
- During SFY 2014, the Community Mental Health Centers (CMHCs) in Kentucky reported treating 769 active duty Service members. This is a .99 % increase from the CMHCs SFY 2012 data.
- During SFY 2014, the CMHCs in Kentucky reported treating 2,301 Veterans. This is a 1.06 % increase from the CMHCs SFY 2012 data.

Veteran and Active Duty Counts by Region

	FY2012					FY2014				
	Active Duty		Veterans		All Clients	Active Duty		Veterans		All Clients
Region	Count	Percent	Count	Percent		Count	Percent	Count	Percent	
01 - Four Rivers	50	0.54%	183	1.99%	9,192	33	0.26%	245	1.95%	12,559
02 - Pennyroyal	98	0.70%	313	2.24%	13,949	108	0.84%	403	3.14%	12,844
03 - River Valley	54	0.54%	50	0.50%	9,978	35	0.36%	34	0.35%	9,667
04 - Lifeskills	42	0.31%	60	0.45%	13,447	43	0.33%	63	0.49%	12,931
05 - Communicare	15	0.13%	139	1.17%	11,891	85	0.56%	237	1.58%	15,047
06 - Seven Counties	65	0.15%	290	0.69%	42,035	74	0.17%	240	0.56%	42,930
07 - NorthKey	40	0.38%	126	1.20%	10,470	29	0.22%	125	0.96%	13,026
08 - Comprehend	50	0.93%	82	1.52%	5,399	39	0.75%	86	1.65%	5,211
10 - Pathways	63	0.36%	288	1.65%	17,469	47	0.28%	265	1.58%	16,756
11 - Mountain	71	0.65%	63	0.58%	10,899	54	0.46%	90	0.77%	11,729
12 - Kentucky River	104	0.78%	76	0.57%	13,369	109	0.68%	104	0.64%	16,128
13 - Cumberland River	4	0.02%	7	0.04%	18,631	6	0.03%	9	0.04%	22,210
14 - Adanta	36	0.31%	166	1.43%	11,612	37	0.33%	147	1.31%	11,188
15 - Bluegrass	74	0.30%	312	1.26%	24,765	70	0.30%	253	1.09%	23,211
State Totals*	**766**	**0.36%**	**2,155**	**1.01%**	**213,106**	**769**	**0.34%**	**2,301**	**1.02%**	**225,437**

*State Totals may include duplicates when clients were seen in multiple regions.

Report Date: July 13, 2015

Areas of Focus

- Provide effective behavioral health services
- Increase help-seeking behavior
- Reduce access to potentially lethal means
- Strengthen leadership, structure, and sustainability
- Develop opportunities to discuss current and future plans/partnerships for the expansion of the state-wide SMVF initiative.

Kentucky will continue the multiple policy academy teams that began as a result of SAMHSAs SMVF TA Center. Currently, these teams are separate and will be combined during a site visit from the SMVF TA Center in the Fall of 2015. As each team progresses toward their goals, they have identified that all of the unmet needs are related. One of the overarching goals of the combined groups will be to develop and implement a comprehensive statewide strategic plan serving behavioral health needs of the SMVF population.

Goals and Priorities for FY 2016/2017:

Priority 1. Provide Effective Behavioral Health Services

Goal:

1. **Encourage help-seeking behavior by increasing access in utilization of available services by SMVFs.**
2. **Continue to train, educate and develop the behavioral health workforce as it relates to the SMVF population in Kentucky.**

Kentucky Military Provider Designation:

- Utilizing already developed and/or endorsed programs and trainings, DBHDID is developing a Military Behavioral Health Provider Designation. This designation offers providers an opportunity to receive coordinated training efforts to increase knowledge and provide more adequate care to Kentucky's SMVF population. This designation targets both clinical and non-clinical providers working in behavioral health. Prior to receiving the designation, providers will participate in Operation Immersion, complete web-based educational sessions, receive two (2) day in-depth training in suicide prevention and intervention (non-clinical), or assessment, management, and treatment (clinical). Following designation, providers will be required to maintain designation through continued education opportunities, some of which will be provided through the regular Operation Headed Home event. Designated providers will then be considered preferred providers for those in the SMVF population seeking behavioral health services.

Peer Support Phase

- The Division of Behavioral Health has identified twenty (20) Veterans in recovery from a behavioral health disorder that desire to become a Certified Peer Support Specialist with the intent to establish a Veteran/Military Peer Support Network. The Peer Support Specialists will receive certification after successful completion of a week-long training course and passing a written and oral exam. The Peer Support Specialists may have the opportunity to provide peer support at the 14 Community Mental Health Centers (CMHC) across Kentucky, as well as other through other behavioral health provider organizations.

Priority 2. Increase Help-Seeking Behavior

Goal 1:

Provide TA to CMHCs and Managed Care Organizations regarding TRICARE, the military insurance benefit, and encourage agencies to accept and work with TRICARE for the SMVF population in Kentucky

Goal 2:

Create and distribute marketing information linking SMVF population to services in their area, as well as statewide services

Goal 3:

Increase help-seeking behavior by raising awareness of available resources and encouraging utilization of services by SMVF

Develop Provider Directory/Database for SMVF population

- Determine the mechanism to house the resource directory of available SMVF services
- Investigate the cost of creating and maintaining a database/resource directory
- Collaborate with other state agencies that currently have similar programming (i.e.- a statewide 211 telephone information program), or add to current Kentucky DBH Provider Directory

Review Resources and Capacity to Create Branding and Marketing Materials

- Utilize/rework current available materials for distribution
- Work with the Kentucky Broadcasting Association and Kentucky Press Association for distribution of materials and assistance
- Request TA from SMVF TA Center regarding evaluation and marketing

The DBHDID and the Kentucky National Guard have partnered to include a screening, brief intervention, referral and treatment (SBIRT) process into the Guard's annual periodic health assessment conducted among all 7,000 National Guard members every fiscal year. An initial proof of concept was conducted in May 2014 and refinements to the process are awaiting further approval.

Priority 3. Reduce Access to Lethal Means

Goal:

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

Engage multiple entities including the Regional Prevention Centers, VA Medical Hospitals and the Kentucky Department of Veterans Affairs as part of the education/outreach to reduce access to lethal means.

- Work with community organizations to increase Naloxone education and promote the use of Naloxone kits in community in order to reduce the number of deaths associated with prescription opioid and heroin overdose
- Distribution of gun locks at Veteran Events acquired from the VA Medical Centers
- Provide safety plan handouts at events
- Promote medication take back days with SMVF emphasis
- Distribution of medication lock boxes with the National Crisis Hotline numbers on lock boxes
- Brief intervention and referral should be available at all events; ensure that MBHCs have a clinical person available to help with the warm hand off
- All materials and events should follow the safe messaging guidelines and Framework for Successful Messaging

Priority 4. Strengthen Leadership, Structure and Sustainability

Goal: A comprehensive SMVF needs assessment will be conducted as part of the Zero Suicide Initiative.

Capture Data to Support Decision Making

- Effective July 17, 2014, Gov. Beshear assigned the military behavioral health initiative to DBHDID, with continued input from KDVA, KDMA, KCMA and AOC at the discretion of the Cabinet for Health and Family Services.
- Improvement in SMVF Data:
  - DBHDID's Information System Coordinator is working to update and clarify language for providers funded by DBHDID in order to identify the SMVF population seeking services. Better identification will provide the Department with an improved understanding of the services needed and provided through the CMHC.
  - Providers will be encouraged to utilize the updated language to identify SMVF individuals and address their needs, especially for Veterans with less-than-honorable discharge.

Data Sources Used:

- http://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml U.S. Census Bureau| American FactFinder
- http://www.va.gov/vetdata/Veteran_Population.asp U.S. Department of Veterans Affairs
- http://www.va.gov/vetdata/Maps.asp U.S. Census Bureau
- http://www.va.gov/vetdata/Veteran_Population.asp, http://www.va.gov/vetdata/Report.asp U.S. Department of Veterans Affairs, The National Center for Veterans Analysis and Statistics (NCVAS)
- DBHDID Client Event Data Set
- http://www.samhsa.gov/veterans-military-families SAMHSA's Veterans and Military Families
- http://store.samhsa.gov/shin/content//PEP14-LEADCHANGE2/PEP14-LEADCHANGE2.pdf The federal Strategic Initiatives- used to list Military specifically as a strategic goal- new plan- woven into several-although not mentioned as often as we used to see: e.g.,
- http://www.samhsa.gov/veterans-military-families/samhsas-efforts SAMHSA's Efforts to Support Veterans and Military Families
- http://www.samhsa.gov/veterans-military-families/critical-issues Critical Issues Facing Veterans and Military Families
- http://www.samhsa.gov/veterans-military-families/at-risk-populations At-Risk Populations among Veterans and Military Families
- http://www.samhsa.gov/veterans-military-families/reintegration-into-civilian-life Reintegration into Civilian Life
- http://www.samhsa.gov/veterans-military-families/grants Grants Related to Veterans and Military Families
- http://www.samhsa.gov/veterans-military-families/publications-resources Publications and Resources on Veterans and Military Families

Substance Abuse Prevention

The KY-SEOW, originally constructed by the Kentucky DBHDID, is housed and managed by REACH of Louisville. Since the creation in 2010 the SEOW works to support the implementation of a public health approach to substance abuse prevention as originally outlined by the Strategic Prevention Framework-State Incentive Grant (SPF-SIG). The SEOW utilizes state and community-level data to inform planning, implementation, and evaluation activities directed toward the prevention of substance abuse and the promotion of positive mental health. The SEOW systematically evaluates the correlates and consequences of Alcohol, Tobacco, and Other Drug (ATOD) usage throughout Kentucky. These evaluations will serve to advise the BHDID as well as facilitate the continued surveillance, analysis, and reporting of ATOD usage. The SEOW functions to:

1. Suggest appropriate data analyses, facilitate appropriate interpretation of findings, suggest methods for sharing data across disciplines, determine underutilized data sources, and promote new forms of data collection.
2. Ensure that relevant state and community planners have useable survey, demographic, risk/resilience, enforcement, morbidity/mortality, and treatment data.
3. Expand the data warehouse managed by REACH of Louisville, Inc. to further facilitate the dissemination of relevant ATOD and mental health data.
4. Serve as a technical resource for the Division of Behavioral Health and any other relevant organization or entity.

The SEOW consists of a Chair and Co-Chair from the BHDID Division of Behavioral Health. Project staff and technical support will be provided by a contract with REACH of Louisville, Inc. SEOW members are responsible for attending scheduled SEOW meetings, providing relevant data pertaining to substance use and mental health, guiding the analysis and interpretation of state and community date, and providing guidance for the development of state and community profiles.

Current SEOW members are:

Steve Cambron	Div. Behavioral Health
Dr. Richard Clayton	University of Kentucky
Ron Crouch	State Workforce Cabinet
Bob Illback	REACH of Louisville
Van Ingram	Off. Drug Control Policy
Teresa Mcgeeny	REACH of Louisville
Mike Razor	Alcoholic Bev. Control
Dr. Vestena Robbins	Div. Behavioral Health
Dr. Ramona Stone	University of Kentucky
Jan Ulrich	Div. Behavioral Health

Area of Focus:
Reduce Underage Youth Access to Cigarettes, and E-Cigarettes

Prevalence Data/Unmet Needs and Service Gaps:
According the most recent (2013) Youth Risk Behavioral Survey, 23.6 of the respondents under the age of 18 reported that they had bought cigarettes in a convenience store during the 30 days prior to the survey. The Kentucky Synar Survey reveals that the percentage of retail outlets that sold cigarettes to underage youth increased from 5.4% in SFY 2014 to 7.8% in SFY 2015. Kentucky ranks 6th highest in the U.S. for youth smoking rate (17.9%). A review of the Regional Prevention Center Work plan shows that out of 120 counties served only 39 has a youth tobacco access component. Over the past few years tobacco prevention in Kentucky has

lost ground to Methamphetamine and Prescription drug abuse. We need to revitalize our efforts to implement environmental strategies that target the retail environment.

The 2014 Kentucky Incentives for Prevention (KIP) survey reveals that 6th and 8th graders use e-cigarettes more often than regular cigarettes. 1.6 % of 6th graders reported smoking cigarettes in the last 30 days compared to 3% for e-cigarettes. 8.2% of 8th graders reported smoking cigarettes compared to 9% for e-cigarettes. 10th and 12th graders smoke cigarettes at slightly higher rates than e-cigarettes. 16.3% compared to 16% for 10th graders and 22.5% compared to 17% for 12th graders. This is the first year we have collected data on e-cigarettes and youth use is likely to increase as e-cigarettes become more and more popular. A review of Regional Prevention Center work plans reveals that out of the 120 counties served by the Regional Prevention Center network only two are implementing prevention strategies that address E-cigarettes. Considering the data, this is a significant gap in services. Much more needs to be done to prevent increased use of e-cigarettes among underage youth in Kentucky.

Goal for SFY 2016/2017:

- A reduction in the number of Kentucky youth under the age of 18 who report that it is "sort of easy" or "very easy" to get cigarettes as measured by the Kentucky Incentives for Prevention Survey
- A reduction in the number of Kentucky youth under the age of 18 who report that they have bought cigarettes at a retail store in the last 30 days as measured by the Youth Risk Behavior Survey. (YRBS)

Objective #1

- Upgrade the audio visual quality and content of the online Tobacco Retail Underage Sales Training (TRUST) with higher quality video clips, more interactive learning features and information on E-cigarettes and other alternative tobacco products.

Strategy:

- Solicit feedback from the Tobacco Retail Advisory Council, the Tobacco Prevention and Cessation and the Prevention Branch of the Division of Behavioral Health, and the Tobacco Prevention Enhancement Site as to the needed enhancements.

Goal for SFY 2016/2017:

- Purchase requisition reflecting the agreed upon enhancements to the TRUST training
- Posting of the new online module Department for Alcoholic Beverage Control website within the first quarter of FFY 2016.

Target Population

- Tobacco Retailers

Objective # 2

- Increase the number of tobacco retail clerks who complete TRUST by 50%.

Strategy

- Market TRUST through a variety of ways: Postcards, articles in trade Journals

Goal for SFY 2016/2017

- Increase number of certificates generated by the TRUST online training system.

Objective #3

- Develop TRUST Window Cling which reminds customers that anyone who looks under twenty seven years of age will be asked for an ID if they attempt to purchase cigarettes.

Strategy

- Develop window cling with input from the Tobacco Retail Advisory Council, the Tobacco Prevention Enhancement Site, the Prevention Branch of the Division of Behavioral Health and prevention specialists across the state.

Goal for SFY 2016/2017

- Increase number of TRUST Window clings distributed.

Target Population:

- Tobacco retail clerks

Objective # 4

- Draft an action plan for a Kentucky Tobacco Retail Licensing Law

Goal for SFY 2016/2017

- A draft plan approved by the Kentucky Synar Program.
- References to the licensing law action plan as reflected in Synar Program Meeting Minutes

Target Population:

- Prevention Specialists, state level stakeholders, legislators.

Objective #5

- Build Capacity with Tobacco Retailers

Strategy

- Offer trainings to Prevention Specialists and coalitions on how to build effective working relationships with tobacco retailers in their regions.

Goal for SFY 2016/2017

- Increase number of trainings given

Target Population:

- Prevention Specialists, Tobacco Prevention Enhancement Site

Objective # 6

- Develop a data report on E-cigarette consumption based on KIP 2014 data and Tobacco Prevention Enhancement Site data. The data report would shed light on the following areas:
    - How does e-cig consumption in urban areas compare with that in rural?
    - What does e-cig usage look with regard to race, gender and age?
    - How many youth who report using e-cigs also smoke regular cigs?
    - Areas/counties of the state that have higher levels of e-cig consumption compared to state and national averages.

Strategy

- Convene and engage the State Epidemiology Outcomes Workgroup (SEOW) to create a data report on E-cigarette consumption

Goals for SFY 2016/2017

- SEOW meetings minutes reflecting discussion and work around E-cigarette data report
- Data Report
- Presentations to Regional Prevention Center staff based on the data report

Target Population

- Kentucky Prevention Professionals
- RPC staff
- State Stakeholders (Alcoholic Beverage Control (ABC), DPH, DBH, Kentucky Office for Drug Control Policy (KY-ODCP)
- Center for Substance Abuse Prevention

Objective #7

- Increase awareness of the harmful health consequences of E-cigarettes

Strategy

- Draft Press releases, articles, editorials that reflect the most recent and credible research on E-cigarettes, provide training/presentations on E-cigarettes to prevention specialists and coalition members. Collaborate with the Tobacco Prevention Enhancement site to coordinate E-cigarette messaging on the state & Local Levels.
- Consult with the KY-SEOW for other data sources on E-cigarettes

Goal for SFY 2016/2017

- Increase number of press releases, articles, presentations
- An increase in strategies addressing E-cigarettes in RPC Work Plans.

Target Population

- Kentucky Prevention Professionals
- RPC staff
- State Stakeholders
- The general public

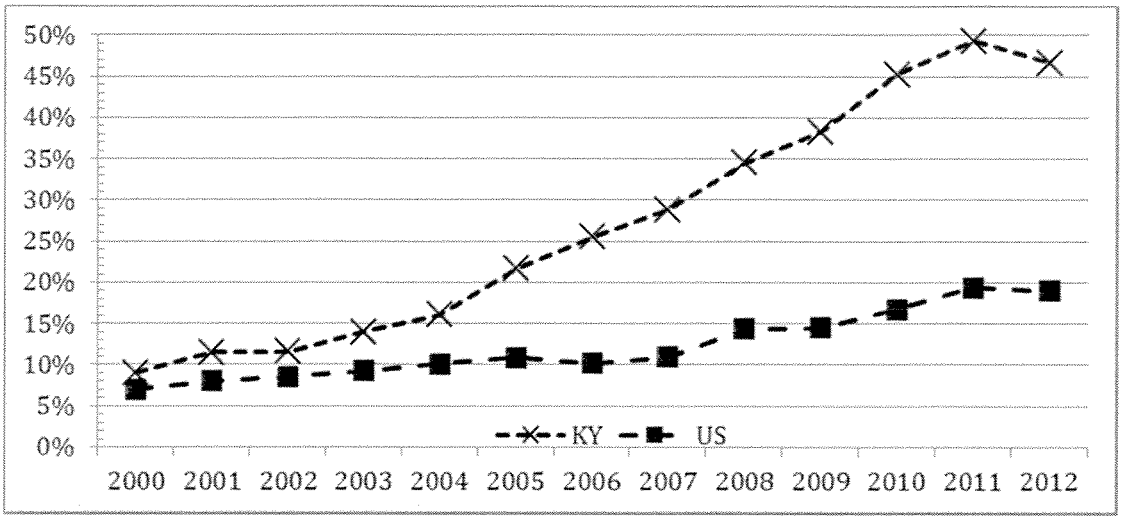
Area of Focus:

Reduce prescription drug misuse and abuse among 12 to 18 year olds.

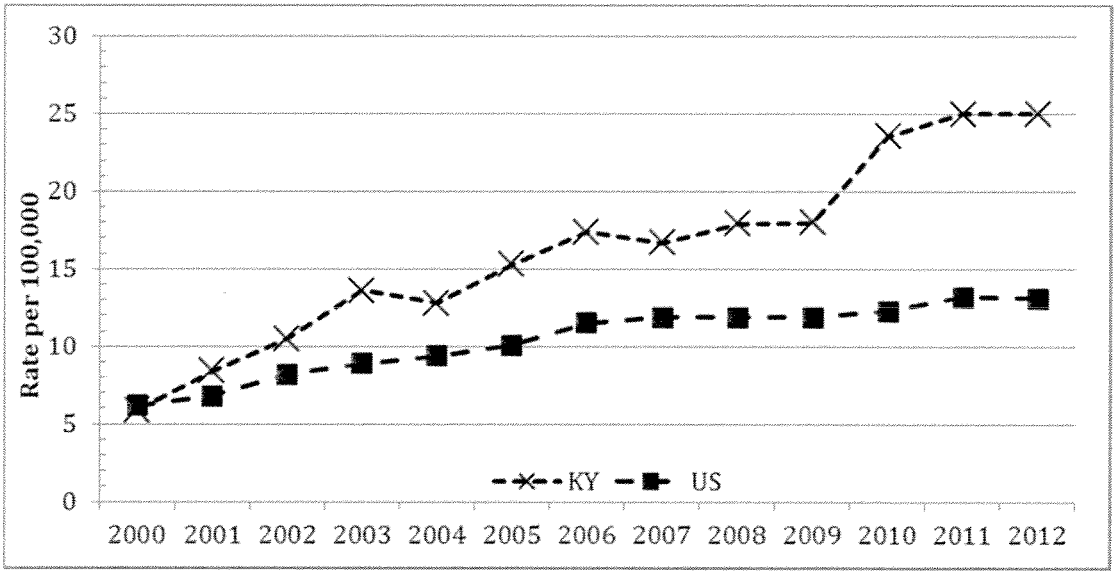
Prevalence Data/Unmet Needs and Service Gaps:

Kentucky has been significantly impacted by Prescription Drug (PD) use and its consequences over the past 15 years. According to admission data from the Treatment Episode Dataset (See graph below), the percentage of incident admissions reporting any prescription drug significantly increased from 9% in 2000 to an alarming 46.7% in 2012 This is in stark contrast to the US that has witnessed a much more gradual increase from 7% to 19%. Similarly, large disparities in prescription drug overdose mortality were also found between Kentucky and the US during this time (Figure 2). Although KY's rate was similar to the US in 2000 (6 per 100,000), the rates began to noticeably diverge after 2002. By 2003, KY's rate was approximately 14 per 100,000 compared to 9 per 100,000 nationally. KY's rate then drastically increased to 25 per 100,000 in 2012, while the national rate slowly increased to 13 per 100,000.

Trends in Incident Prescription Drug Admissions (TEDS-A 2000-2012)



Trends in Prescription Drug Overdose Mortality (CDC WONDER 2000-2012)



Data are now emerging regarding the behavioral health needs of this segment of the military community, such as through the Screening, Brief Intervention, and Referral to Treatment (SBIRT) practice. SBIRT is a tool to identify those potentially at high risk for or experiencing substance abuse, suicide ideations and/or behavioral health concerns. For example, recent screening of the National Guard population revealed that since October 2012, 458 Kentucky National Guard (KYNG) soldiers tested positive during unit urinalysis drug screenings. Since 9/30/11, KYNG has recorded 10 suicide attempts and 46 suicidal ideations. Four completed suicides have been confirmed since 2008 within the KYNG. In Kentucky, there are an estimated 30,000 children and youth (ages 0 to 18) from families of Guard, Reserve, and Active Duty military members. For the first time in 2014, the Kentucky Incentives for Prevention (KIP) survey included a question on family military status: Is anyone in your family currently serving on active

duty or retired/separated from the Armed Forces, the Reserves, or the National Guard? A remarkable 41.9% overall responded exactly one or more than one, with the Communicare (47.9%) and Pennyroyal (44.8%) region communities having the highest concentration.

With regard to the relationship between military family membership, prescription drug use, and behavioral health, several alarming findings emerge. According to the KY-SEOW needs assessment that was conducted for the Partnership for Success 2015 application, 10th graders with exactly one or greater than one military family member consistently had higher 30-day rates of PD use. Those with one or more consistently had the highest rates and this pattern also emerged for behavioral health. Comparing this group to the No/Don't Know students, the percentage point differences ranged from 2.7% to 5% across each behavioral health indicator.

	Family member on active duty or veteran		
Factors	**No/Don't Know n (%)**	**Yes, exactly one n (%)**	**Yes, 1+ n (%)**
30-Day PD Use			
Any prescription	522 (3.3)	184 (3.7)	263 (3.9)
Opioids	619 (4.0)	200 (4.1)	359 (5.3)
Tranquilizers	216 (1.4)	62 (1.3)	119 (1.8)
Stimulants	261 (1.7)	91 (1.8)	138 (2.0)
Mental/Behavior			
SPD[1]	2,663 (17.0)	883 (17.8)	1,382 (20.4)
Self-harm	2,732 (18.8)	921 (20.0)	1,506 (23.8)
Suicide ideation	2,190 (13.9)	769 (15.4)	1,261 (18.5)
Suicide plan	1,764 (11.2)	624 (12.6)	1,038 (15.3)
Suicide attempt	1,136 (7.2)	412 (8.3)	677 (9.9)

Strategies

- Implementation of media campaigns to raise awareness about the risks of prescription drug and heroin abuse and about the proper method of prescription drug disposal
- Implementation of the Parents' Pledge Campaign,
- Use of the Wellness Initiative for Senior Education (WISE) curriculum with seniors to protect against inappropriate youth access
- Implementation of the Monitor, Educate, Dispose or Secure (MEDS) campaign,
- Distribution and use of prescription lock boxes.
- Collaborate with the Military Behavioral Health Program Administrator and other experts to identify specific factors that need to be addressed in order to deliver prevention services to the military population.
- Identify types of prevention services needed to suit the needs of the military population.
- Consult with the KY-SEOW and Advisory Council for effective ways to deliver appropriate prescription prevention strategies to the military population.

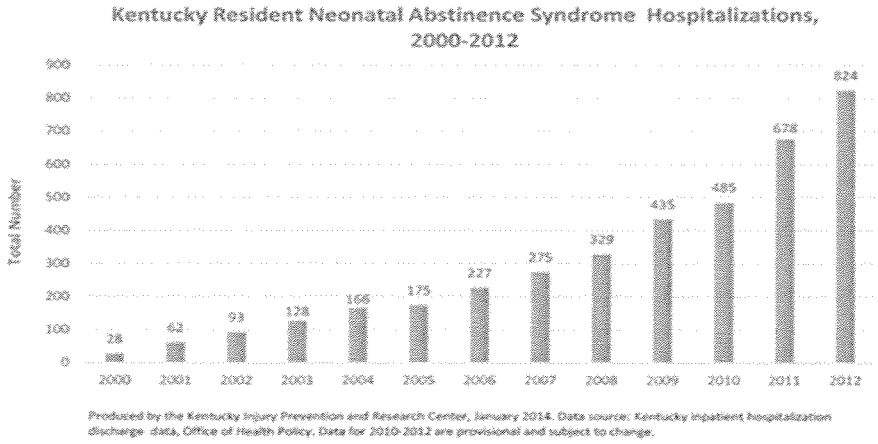
Goal for SFY 2016/2017

- A statewide reduction in past 30 day use of prescription drug without a doctor's prescription as measured by the 2016 Kentucky Incentives for Prevention Survey.
- Number of people served by prescription drug abuse prevention programs
- Number of prescription drug lock boxes distributed
- Number of PSAs, brochures and other awareness material distributed

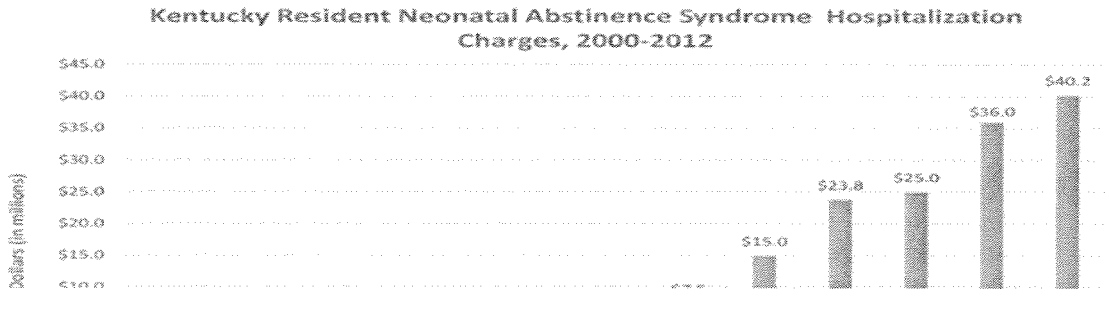
Area of Focus:
Reduce Alcohol Tobacco and Other Drug Use Among Pregnant Women

Prevalence Data/Unmet Needs and Service Gaps:
In Kentucky, 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 11.6% of pregnant women used alcohol or drugs, then approximately 6,772 infants were born prenatally exposed. The number of pregnant women who received substance abuse services at the fourteen (14) CMHCs during SFY 2013 was 1,120, or 16% of pregnant women who needed or are estimated to have needed services. Pregnant women who are dependent on prescription substances face tremendous stigma from their family, social networks, and society. This stigma causes fears within the community and with medical providers, creating a barrier for pregnant women to receive adequate and appropriate treatment for their substance use/misuse; especially when it comes to treating substance use in pregnant women with Medication Assisted Treatment. The DBH Prevention Branch plans to partner with the Substance Abuse Treatment Branch and other key stakeholders to develop and implement strategies to reduce stigma on the community level, specifically with reference to the benefits of Medically Assisted Treatment (MAT).

From 2000 to 2012, there has been a drastic increase in the number of Kentucky infants that have been hospitalized with Neonatal Abstinence Syndrome (NAS). In 2000, there were 28 NAS babies hospitalized in the state, by 2012, 824 babies were reported hospitalized with NAS. (See table below)



As this rise in diagnoses occurred, the cost to treat children with NAS significantly increased from $235,423 in 2000 to $40,200,000 (+/-) in 2012. Substance exposed infants and children have also been shown to have significantly higher rates of early mental health and behavioral problems, as well as higher rates of adverse birth outcomes, and required increased health care utilization after discharge. (See table below)



Public schools do not currently provide prevention education related to substance use during pregnancy. Given the magnitude of the problem this is a glaring service gap. By delivering prevention education to pregnant women through the RPC network we hope to reduce the number of substance exposed infants and improve birth outcomes in Kentucky.

Goal for SFY 2016/2017

- Expand substance abuse prevention services for pregnant women to thirteen (13) Regional Prevention Centers.
- Increase knowledge of the effects of substance use during pregnancy, Neonatal Abstinence Syndrome and substance exposed infants
- Increase number of pregnant women served
- Increase number of referrals for pregnant women who need substance use disorder treatment.
- Increase number of information graphics distributed.

Strategies:

- Provide community education on risks associated with substance use and pregnancy
- Outreach to develop referral sources
- Create collaborative relationships with community partners to enhance and improve services to pregnant women at risk for drug and alcohol abuse
- Provide direct prevention/education services to pregnant women at risk for substance abuse during pregnancy
- Collaborate with KY-SEOW to develop a Neonatal Abstinence Syndrome Info Graphic

Area of Focus:

Prevent suicides and attempted suicides among populations at high risk, especially military families, LBGTQ youth, and American Indians and Alaska Natives.

Prevalence Data/Unmet Needs and Service Gaps:

Kentucky's rate of suicide for youth and young adults age 10-24 has risen substantially since 2010 (5.17 per 100,000 in 2010 to 9.45 per 100,000 in 2012; National Violent Death Reporting System (NVDRS), 2005-2012) when compared to other states. And, the rate for youth and young adults has risen over time more dramatically than the general population during this time (rate increase of 4.28 for youth and young adults and 2.24 for all ages; NVDRS, 2005-2012). Certain risk factors increase the odds of suicide among Kentucky middle and high school students. Those who experience dating violence are between 6 and 7 times more likely to attempt suicide, those who experience sexual assault at school are 6.5 times more likely, and students who experience bullying (including cyberbullying) are between 4.5 and 6 times more likely to attempt suicide compared to students who do not experience these risk factors (KIP, 2014). Students who have one or more family members or people close to them who have

served in the military are significantly more likely to attempt suicide than students who do not have a family member or someone close to them that has served in the military (7.2% versus 6.3%; KIP, 2014). Thirty-three percent (33%) of Kentucky high school students that reported sexual activity with the same sex (or with both sexes) attempted suicide, compared to 8.2% of students who reported sexual activity with only those of the opposite sex (YRBS, 2013).

Objective:

- Fuller integration of suicide prevention in substance abuse prevention activities

Strategies

- Develop and implement Prevention Specialist Workforce Survey around suicide
- Increase support for regional suicide prevention gatekeeper trainings, such as Question, Persuade and Refer (QPR) and Mental Health First Aid
- Engage Regional Prevention Center staff to conduct annual surveys with Middle and High schools in their regions around suicide prevention and planning needs, and follow up assistance with these needs, including emergency planning
- Engage Regional Prevention Center staff to assist with suicide prevention community readiness, needs assessment and resource scans

Goals for SFY 2016/2017

- Increase number of suicide related trainings sponsored by the Regional Prevention Centers
- Increase number of RPC work plans that contain suicide prevention strategies and related activities
- Increase number of Prevention Specialists that participate in the Work Force Survey around suicide
- Increase number of suicide-related need assessments and resource scans

Data Sources Used:

Youth Risk Behavioral Survey (YRBS) 2013
Kentucky Synar Survey
Kentucky Incentives for Prevention Survey
Regional Prevention Center Work Plans
Tobacco Retail Underage Sale Training (TRUST)
Treatment Episode Data Set (TEDS) Data
Center for Disease Control (CDC) Wonder 2000-2012
Kentucky Office of Health Policy
Kentucky Injury Prevention and Research Center, January 2014
National Violent Death Reporting System (NVDRS)
State Epidemiology Outcomes Workgroup (SEOW)

Substance Abuse Treatment

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

Kentucky has embraced the Affordable Care Act, expanding Medicaid coverage to a larger population and developing a successful Health Benefits Exchange. However, most critical to this population is the ACA parity requirement that ensures substance abuse and mental health

services are covered. Prior to this, Medicaid SUD services were only available to pregnant and post-partum (up to 60 days) women, including case management and prevention services.

Pregnant women are identified as a priority population in accordance with Center for Substance Abuse Treatment (CSAT) regulations. The CMHCs screen at initial contact and provide care within twenty-four (24) hours, the remainder within forty-eight (48) hours. The CMHCs now have a set protocol for asking about pregnancy at first contact with new female clients, including adolescents. Therefore the consistency of immediate admission has increased.

Kentucky has six (6) substance abuse programs designed specifically for pregnant women that receive public funding.

1. **KIDS NOW Plus (KN+)** Substance Abuse and Pregnancy Program provides Universal, Selective, and Indicated 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 Contingency Management program. KN+ services have recently expanded and are now providing prevention and case management services in thirteen (13) of fourteen (14) regions.

2. **Project LINK** provides intensive case management to pregnant and postpartum women in the Louisville area. KIDS NOW Plus provides their services in the six surrounding counties. The program offers outreach and case management services designed to identify, assess, and link pregnant and postpartum women to 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. Located in Corbin, in Southeastern Kentucky, it serves women from all over the state.

5. **Chrysalis House** is a comprehensive agency located in Lexington, KY with three residential facilities, a (40) forty-unit apartment complex, eighteen (18) scattered-site apartments, an 18,000 square foot, multi-purpose community center, and two playgrounds. This agency specializes in treating pregnant and parenting women who can keep their newborns and toddlers on-site with them while in residential treatment.

6. **Freedom House** provides a holistic and comprehensive program that is designed to treat the women's chemical dependency in a residential treatment program for alcohol and/or drug dependent pregnant women and women with young children.

Currently, Kentucky's statewide prevention and treatment infrastructure is growing due to the recent expansion of Medicaid to the larger population and the inclusion of Substance Use Disorder (SUD) services. Across the state there are approximately fifteen (15) residential treatment programs and thirty six (36) intensive outpatient programs available (including private providers) that serve pregnant women. Four (4) of the residential programs that accept

pregnant women, allow the woman's dependent children to live on-site with her during treatment.

In Lexington, KY, Polk Dalton Clinic (part of UK Healthcare) provides evidence based comprehensive care for opioid dependent pregnant population in a structured clinic workflow that will include prenatal care, substance abuse counseling, and neonatology consultation. It is anticipated that birth outcomes for the women and children involved in this program will improve. Additionally, there is a goal of decreasing length of stay and admissions to Neonatal Intensive Care Unit (NICU) for any babies who experience Neonatal Abstinence Syndrome (NAS). Through an increasing skillset for successful long-term recovery and sobriety, it is hoped that there will be a seamless transition of postpartum patients to community partners.

The state of Kentucky currently has twenty (20) Narcotic Treatment Programs/Opioid Treatment Programs that accept pregnant women, along with approximately 430 Buprenorphine DATA 2000 waivered Physicians. The Methadone/Opiate Rehab and Education (M.O.R.E.) Center located in Louisville, Kentucky receives SAPT grant monies to assist in the treatment for this priority population along with the Bluegrass Narcotics Treatment program in Lexington, Kentucky. All of these programs consider pregnant women a priority population.

Kentucky has several initiatives to address prescription drug use such as: Partnership for Success II grant (PFS II), Kentucky All Schedule Prescription Electronic Reporting (KASPER) system, development of House Bill 1(HB1), Medicaid expansion, Regional Prevention Centers (RPCs), KY Health Now, and the development and implementation of the Kentucky Agency for Substance Abuse Policy (KASAP). KY has strived to move forward with prevention and treatment measures to help improve quality of life for our residents and to develop drug-free communities.

Multiple trainings for health care providers have been hosted around the state providing hundreds of health care professionals with specific training and information on this topic. These have included state and regional meetings sponsored by a wide variety of agencies and organizations including; the Kentucky Perinatal Association, Norton Healthcare, the University of Louisville, the University of Kentucky Division of Neonatology, and the Kentucky Chapter of ACOG. In addition, the Governor's Office of Drug Control Policy has recruited physicians with obstetric, neonatal, and addiction medicine expertise for trainings providing continuing medical education to physicians at no charge.

The Kentucky Chapter of the American Academy of Pediatrics, representing some 400 pediatricians across the state, recently completed strategic planning, and selected positive parenting as one of the top three strategic goals for the organization in the next five (5) years. They have also been advocates for increasing access to children's behavioral health services including infant mental health. Most recently, they have included in trainings on toxic stress and adverse childhood experiences, which are a significant factor in the outcomes of these substance-exposed infants.

Kentucky is working with many agencies and departments to collect data annually that is related to substance-exposed births and/or substance usage during pregnancy. There are many Kentucky data sources that include but not limited to the State Epidemiology Outcomes Workgroup (SEOW), Child Welfare data, and Vital Statistics data to assist in identifying and collecting data in this area. The Kentucky All Schedule Prescription Electronic Reporting (KASPER) system can provide statistics on the number of controlled substances dispensed to

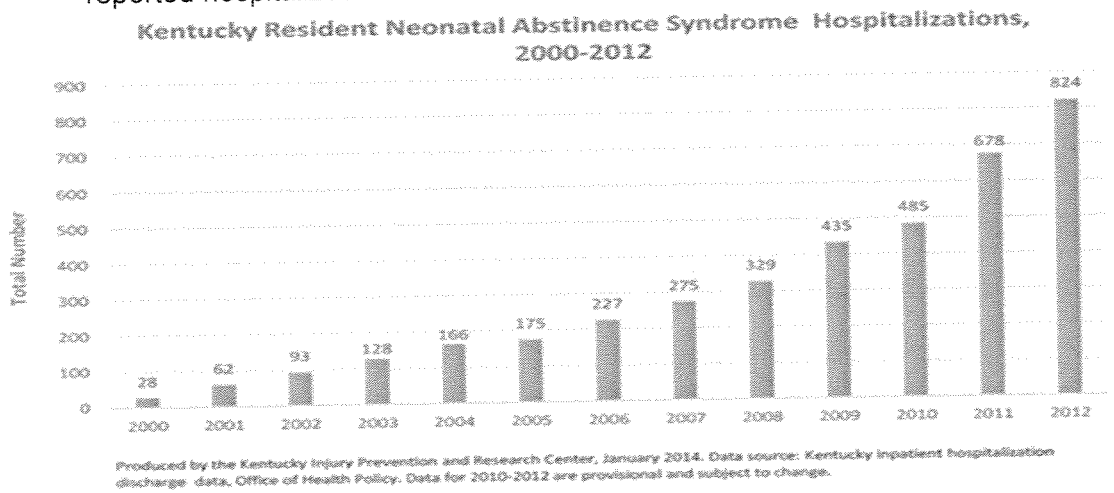
women of child bearing age; further identifying the population that needs to be monitored for potential substance exposure during pregnancy or NAS.

***Unmet Needs and Prevalence Data*:**

- Substance abuse is an increasing problem for women. More than 4 million women in the U.S. use drugs and 3.7 million women have taken prescription drugs non-medically during the past year. Pregnant women that use and/or abuse substances, face tremendous stigma from their family, social networks, and society. This stigma impacts the treatment that they need and require, due to the potential risks of harm to the fetus.
- According to the 2013 National Survey on Drug Use and Health, 5.4% of pregnant women aged 15-44 reported to using illegal drugs and 9.4% reported using alcohol during their pregnancy.
- Pregnant women, who chronically abuse prescription medications, also have a greater-than-normal risk for medical complications. The most frequent resulting in the highest percentage of complications are various infections in the pregnant mother and her fetus.
- Due to being primarily a rural state there is a disconnect between service providers that has resulted in a poorly developed treatment provider community. It is this disconnect that makes it difficult to exchange data, resulting in an underestimation of need for services and/or treatment, resulting in a lack of readily available resources in many regions across the state. In developing policies that have the potential of positively affecting women of child-bearing age that abuse prescription drugs, Kentucky will be taking specific actions to improve and inhance services.
- With the expansion of services and coverage, there is a need for a larger provider pool and that is in the process of being developed.
- Residential substance abuse treatment is minimally available to pregnant women partially due the federal Medicaid Institute for Mental Disease (IMD) restrictions requiring facilities to have a maximum of sixteen (16) beds. Specific support services are also limited due to the specific needs of pregnant women. Although effective screening of pregnant women for substance abuse by medical providers is limited in Kentucky, the state in collaboration with other agencies and through KIDS NOW Plus, has developed an implementation plan for SBIRT with pregnant women and continues to advocate its use.
- Kentucky has a state law in place allowing health care providers to screen mothers for substances of abuse [KRS 214.160], however, there is no agreed-upon standard for screening mothers or babies. As a result many babies are not being diagnosed and/or treated, leading to increased chances of complications and increased potential for neglect and abuse once the child leaves the hospital. Hospitals who have instituted a policy to screen all newborn infants have found rates as high as 30% positives (for substance exposure) in some areas of the state. HIPAA restrictions also make it difficult for the physician treating infants to gain access to the mother's medical record and may limit the ability of that physician to identify risk factors for Substance Exposed Infants (SEI) and/or NAS and screen infants appropriately.
- 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. These fears

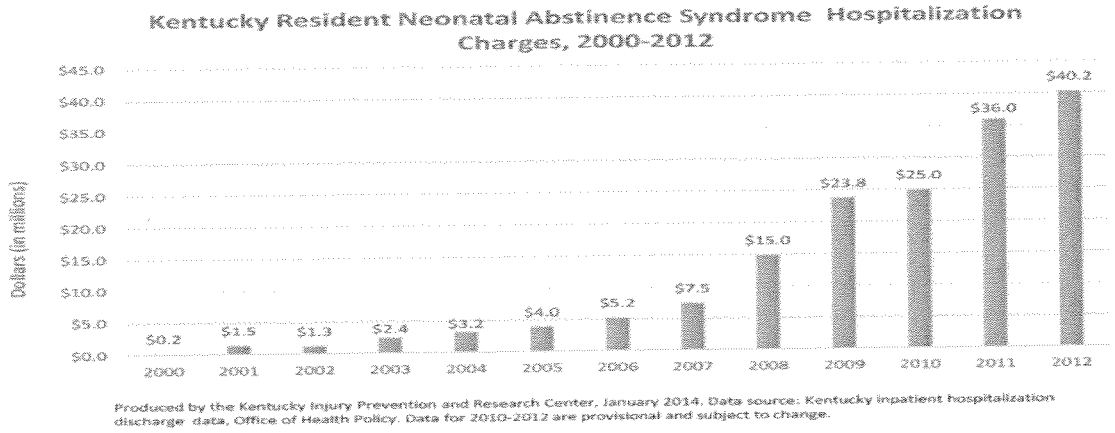
continue to rise due to recent legislation change in a neighboring state making substance abuse/misuse during pregnancy a criminal offense.

- Pregnant women that are dependent on prescription substances face tremendous stigma from their family, social networks, and society. This stigma causes fears within the community and with medical providers, creating a barrier for pregnant women to receive adequate and appropriate treatment for their substance use/misuse. This is true especially when it comes to treating substance use in pregnant women with Medication Assisted Treatment. DBHDID hopes to educate and inform a broad array of treatment providers and community members surrounding the benefits of MAT with this population in particular and the broader opiate dependent population in general.
- Public schools do not currently provide prevention education related to substance use during pregnancy. However, Prevention Specialists with KIDS NOW Plus in various regions have begun providing substance abuse prevention outreach in their local high schools.
- From 2000 to 2012, there has been a drastic increase in the number of Kentucky infants that have been hospitalized with Neonatal Abstinence Syndrome (NAS). In 2000, there were twenty eight (28) NAS babies hospitalized in the state, by 2012, 824 babies were reported hospitalized with NAS.



- As this rise in diagnoses occurred, the cost to treat children with NAS significantly increased from $235,423 in 2000 to $40,200,000 (+/-) in 2012. Substance exposed infants and children have also been shown to have significantly higher rates of early mental health and behavioral problems, as well as higher rates of adverse birth outcomes, and required increased health care

utilization after discharge.



- Another factor to consider in surveying our expectant mother population is having a closer look at addressing the needs of women living in Appalachia. Excluding marijuana, rural Appalachian Kentucky has one of the highest occurrences of illicit drug use for person's 12 and older.

Priorities for SFY 2016/2017:

- Continue to monitor and support the CMHCs compliance with screening for pregnancy on the first contact.
- Provide continued funding for services supporting pregnant women including; residential services, life skills, parenting, supported housing, employment assistance and recognizing specified needs.
- Expand treatment capacity for pregnant women and strengthen the use of Evidence Based Practices in women's treatment.
- Continue collaboration with the Department for Public Health, toward addressing the issue of smoking during pregnancy.
- In collaboration with the Kentucky Chapters of the American College of Obstetrics and Gynecology, and the American Medical Association, a statewide initiative is needed to expand universal screening and provide brief intervention and referral to treatment services as a routine part of pre-natal care through promoting the use of a pregnancy specific SBIRT protocol by medical providers. The protocol should include specialized instruction on how to address the unique fears and barriers faced by pregnant women with substance use disorders. This initiative would increase the identification of substance use/abuse during pregnancy and allow for earlier intervention, thus minimizing the adverse affects on the baby.
- Collaborate with the Department for Community Based Services (child welfare) to adopt a strategy for addressing pregnant women's fears of having their children removed and their resulting reluctance to seek help for their substance use disorders.
- Improve KIDS NOW Plus services that are currently provided, by focusing on the use of Evidence Based Practices and Evidence Informed Practices, by monitoring for service outcomes, and through expanding substance abuse prevention services to women of child bearing age, both prior to and during pregnancy. Focusing additional educational/prevention services on women prior to pregnancy allows for the opportunity to educate them regarding the risks and complications associated with drug abuse and provide them with the information and resources they need to make better lifestyle choices before they become pregnant.
- Continue to collaborate with state partners and agencies that are focused on bettering the lives of pregnant women who are using substances.

- Move towards a system of care to address the concerns surrounding substance use prior to pregnancy through post-delivery and beyond. Allowing intervention during all stages of pre- and post- pregnancy, resulting in service provision that is interrelated and interconnected.

Data Sources Used:

- Substance Abuse and Mental Health Services Administration, *2011 Opioid Treatment Program Survey: Data on Substance Abuse Treatment Facilities with OTPs.* BHSIS Series S-65, HHS Publication No. (SMA) 14-4807. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.
- Substance Abuse and Mental Health Services Administration, *Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings*, NSDUH Series H-46, HHS Publication No. (SMA) 13-4795. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.
- Halfon N, Mendonca A, and Berkowitz G, *Health status of children in foster care. The experience of the Center for the Vulnerable Child.* Arch Pediatr Adolesce Med, 1995. (149(4): 386-92.
- Office of Drug Control Policy, Annual Report
- CDAR: Center for Drug and Alcohol Research, Kids Now Plus Annual Report for 2014
- Substance Abuse and Mental Health Services Administration, *Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings*, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

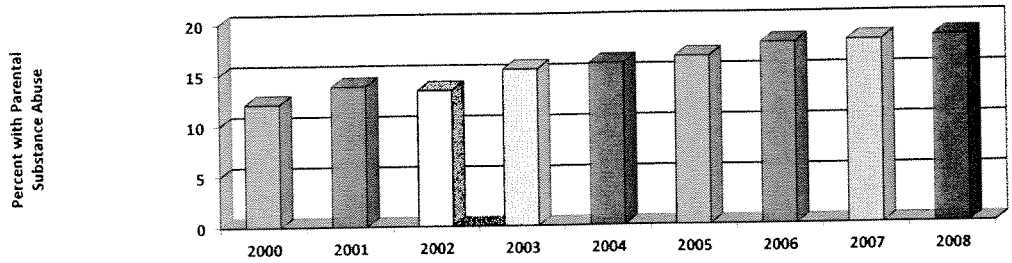
Parents with Substance Abuse and/or Mental Health Disorders with Dependent Children

Prevalence Data:

In Kentucky, substance abuse is having an increasingly negative effect on child and family well-being with reports of the profound effects of diverted prescriptions, pain medications and now heroin. We know that among young children coming into out of home care (OOHC) in Kentucky; more than 80% of families have risks to child safety due to substance abuse. For children ages 3 years and younger, nearly 90% of these children had parental substance abuse as a risk factor. These substance abusing families are likely to have an average of four additional safety and risk factors including poverty, domestic violence, criminal history, and multiple adult partners in the home. The children have an average of six prior referrals before entering OOHC compared to four referrals for children where parental substance abuse is not a risk factor. The multiple recurring referrals reflect a tendency toward ambiguous responses to assessment and intervention for substance abusing families because of limited treatment resources for the families.

The percent of children entering out of home care (OOHC) as infants increased from 12% in 2002 to more than 18% in 2009. Figure 1 shows the increase among infants identified as

having parental substance abuse (alcohol or drugs) as a condition for entry to OOHC.



Between 2008-2013, Kentucky has continued to see an increase in reports of substance exposed infants, by looking at all children in our statewide data system ages 0-2 weeks, with a report for abuse/neglect with parental substance abuse as a risk factor. According to this data, during the calendar year 2008, The Department for Community Based Services (DCBS) received 748 reports statewide of newborns citing substance abuse as a risk factor. Of those reports, 536 were substantiated for abuse or neglect. In 2010, DCBS received 1142 reports of newborns citing substance abuse as a risk factor. Of those reports, 685 were substantiated. In 2013, DCBS received 1495 reports, substantiating 818.

It is believed, with the rise of opiate addiction in our state, we are seeing more awareness and reporting of substance exposed infants and in particular the opiate exposed infants who are experiencing NAS. Front line DCBS staff struggle with how to best work with this population of families, considering the sharp increase of opiate use in Kentucky, mainly the use of pain medication and most recently heroin.

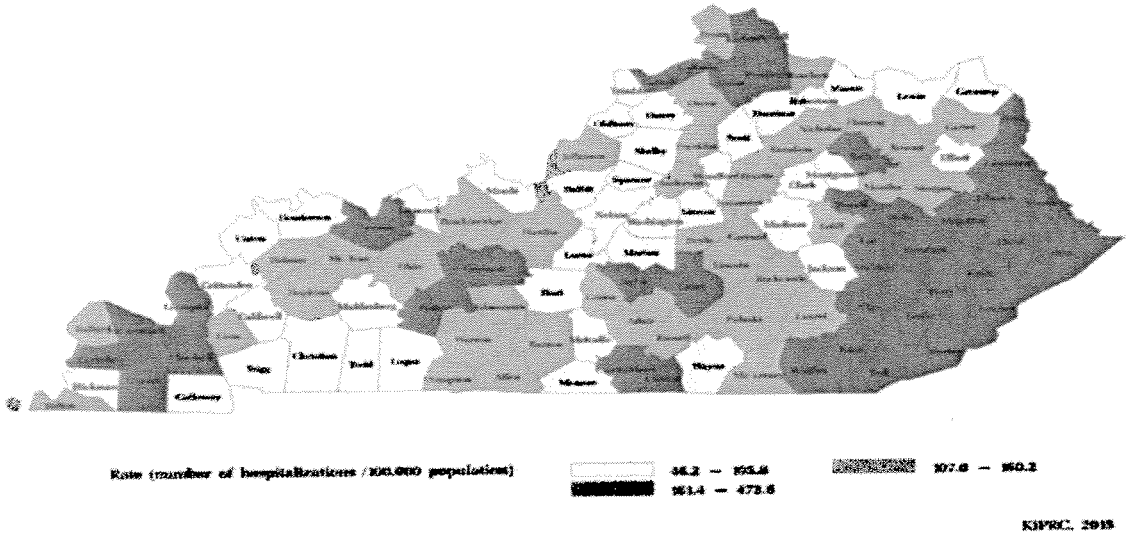
Heroin use has increased across the US among men and women, most age groups, and all income levels. Some of the greatest increases occurred in demographic groups with historically low rats of heroin use: women, the privately insured, and people with higher incomes. Addiction to prescription painkillers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

- 45% of people who used heroin were also addicted to prescription opioid painkillers (CDC Vital Signs)
- Kentucky has the fourth highest rate of painkiller prescribing in the US at 128 opioid painkiller prescriptions for every 100 people (CDC National Prescription Audit 2012)

Opioids drive continued increase in drug overdose deaths: *Drug overdose deaths increase for 11th consecutive year (CDC press release)*

- Heroin overdose deaths in Kentucky increased by 207% from 2011 to 2012
- Kentucky's rates of drug overdose deaths more than doubled from 1999 to 2010
- Kentucky ranks 2nd in the nation at 24.6 drug overdose deaths per 100,000 (2011-13 three year average)
- Since 2008, more Kentuckians have died from drug overdoses than motor vehicle accidents

Annual Rate of Drug Overdose Hospitalizations, 2009-2013



In March 2015, The Heroin Bill (SB 35) was signed. The key elements of this bill include;

- Enhanced Penalties for high level traffickers.
- Good Samaritan Clause for calling for assistance.
- Some funds for treatment services in specific settings.
- Naloxone rescue for First Responders.
- Local option for Harm Reduction through Needle Exchange program.

The Needle Exchange program implements a harm reduction program in local health departments. Individuals may exchange used hypodermic syringes or needles for free, sterile hypodermic syringes and needles to be provided by the local health departments. DBHDID participated with DPH to develop protocol for the Needle Exchange Program.

The goal of the program is to;

- Reduce the spread of blood-borne infections, HIV and Hepatitis C.
- Provide support to drug users and links to services such as drug treatment and medical care.
- Acknowledge that IV drug use threaten public health and takes the necessary steps to address the problem.

By utilizing funds provided by a recent Kentucky Pharmaceutical Settlement, DBHDID has contracted with hospitals located in KY's three most-populated areas to increase the availability of and use of Narcan kits (Naloxone) to effectively disrupt deaths due to opioid misuse.

Naloxone is useful both in acute opioid overdose and in reducing respiratory or mental depression due to opioids. It is included as a part of emergency overdose response kits distributed to heroin and other opioid drug users, and this has been shown to reduce rates of deaths due to overdose.

In 2003 the number of new HIV cases without AIDS in KY was 109. In 2013 it was 268. Center for Disease Control (CDC) ranks KY #1 in the rising rate of Hepatitis C. In Kentucky, the number

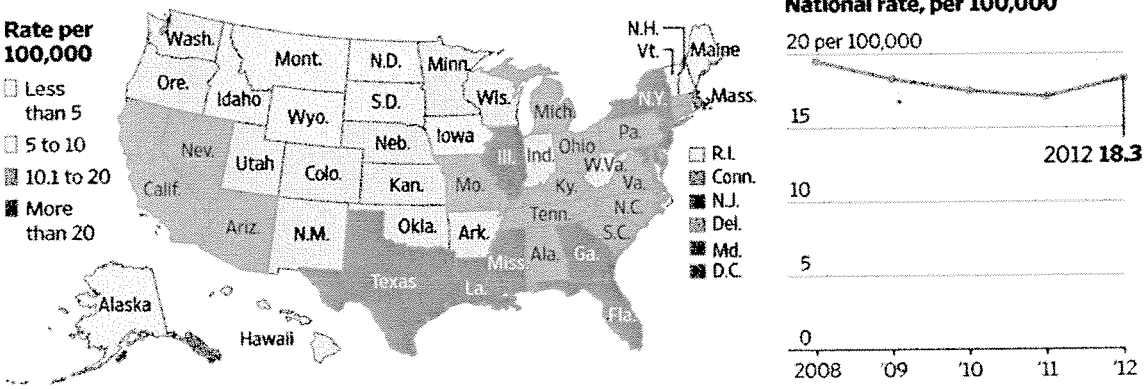
of people discharged from hospitals with a dual diagnosis of hepatitis and dependence on opioids increased from 39 in 2000 to more than 1,500 in 2012

- Hepatitis C (HCV)
    - Over 70% of persons who inject drugs long term may be infected with approximately 73% of young adults (≤30) with hepatitis C report injection drug use as their principal risk factor Kentucky rates of acute hepatitis C increased by 357% from 2007-2011 In 2013, Kentucky had the nation's highest rate of acute hepatitis C (5.1 per 100,000).

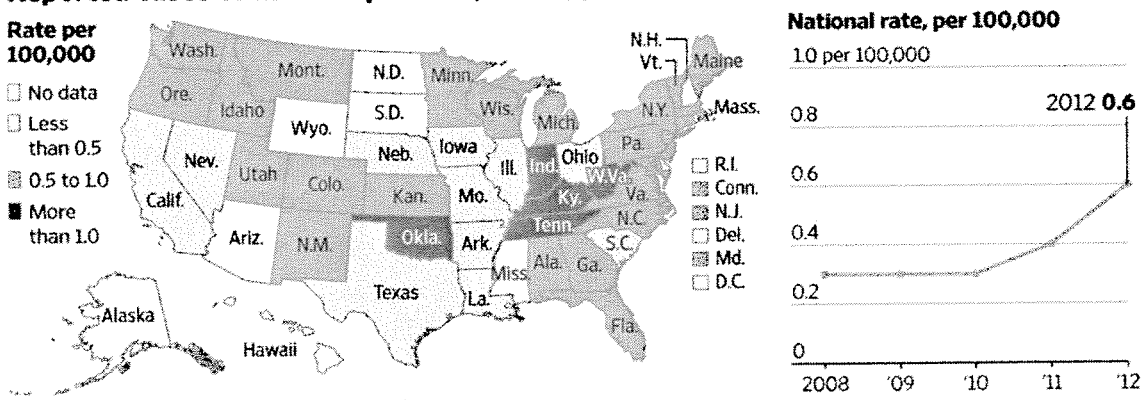
Growing Problem

HIV and hepatitis C infections have risen recently. With hepatitis C, many acute infections go unreported and usually progress to chronic hepatitis C, a long-term illness affecting an estimated 2.7 million Americans.

New diagnoses of HIV, 2012 (47,746 nationwide)



Reported cases of acute hepatitis C, 2012 (1,778 nationwide)



Note: Data for 2012 are most recent available. Source: Centers for Disease Control and Prevention THE WALL STREET JOURNAL.

DBHDID participated in the SAMHSA Policy Academy on prescription drug abuse and was subsequently awarded In Depth Technical Assistance (IDTA) provided by the National Center on Substance Abuse and Child Welfare (NCSACW) to work on developing a System of Care for Women of Child-Bearing age and Pregnant Women who are using substances. The core team involved in the project includes; DCBS, Family Drug Courts, Public Health, Office of Drug Control Policy, Medicaid, Office of Inspector General and Community Partners including CMHCs, Narcotic Treatment Programs, Veterans of America Freedom House, Chrysalis House and The Polk Dalton Clinic.

Multiple trainings for providers have been hosted around the state providing specific training and information on how to recognize, assist, treat and refer opioid-dependent pregnant women. These have included state and regional meetings sponsored by a wide variety of agencies and

organizations including; the Kentucky Perinatal Association, Norton Healthcare, the University of Louisville, the University of Kentucky, Division of Neonatology, and the Kentucky Chapter of ACOG. In addition, the Governor's Office of Drug Control Policy has recruited physicians with obstetric, neonatal, and addiction medicine expertise for trainings providing continuing medical education to physicians at no charge.
Kentucky has embraced the Affordable Care Act, expanding Medicaid coverage to a larger population and developing a successful Health Benefits Exchange. Kentucky's statewide prevention and treatment infrastructure is growing due to that expansion and the inclusion of SUD services. Medicaid services for SUD have historically been only available to pregnant and post-partum women, including case management and prevention services. However, now the fathers, husbands, boyfriends, and significant others are being provided access to substance abuse treatment services. Not only allowing for the mother to receive SUD treatment services, but the whole family is now able to receive services to treat and heal the whole family. DBHDID does not require the CMHCs to prioritize parents with dependent children, but they are strongly encouraged and many CMHCs report that they prioritize parents from the child welfare system.

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

Unmet needs and Service Gaps:

- 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:
  - The assessment process frequently 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.
  - 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.
  - 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.
- As the result of the rise in Substance Exposed Infants (SEI) and NAS there is a need for standardized protocols to address the needs of the infants and families. Standards would include; screening and assessment, referrals to DCBS and/or treatment services, aftercare services, and follow up services once the child is discharged home.
- Currently within the treatment and recovery community, there is resistance from the Abstinence Based Only Philosophy toward the use of Medication- Assisted Treatment (MAT).

- More training and supervision toward workforce development in EBP is needed to ensure the provision of appropriate treatment particularly to the opiate addicted clients.
- Integration with primary care providers to identify and refer individuals at risk, including pregnant women.

Goals for SFY 2016/2017

- Develop workgroups to identify standards of care that reflect best practices for treatment and working with pregnant and parenting women who are dealing with Substance Use Disorders. Establish a continuum of treatment that matches the intensity and level of individual substance use needs.
- Require Universal Screening by medical providers using SBIRT Principles
- Identify Barriers to Universal Screening
- Support Community-Based collaborative efforts by providing funding for community-based facilitators and a state liaison
- Establish local/regional comprehensive multi-disciplinary teams to implement statewide standards of care.
- Develop a continuum of treatment programs. Expand home visiting programs
- Enhance childcare and transportation services to increase accessibility
- Create a "no wrong door" web-based resource for providers across systems
- Work with insurance carriers to establish a continuum of reimbursable services for this population across funding streams
- Expand Medicaid coverage for postpartum women for up to one year
- Create a workgroup to develop materials and identify opportunities for outreach and education for professionals, individuals, families and agencies.
- Provide education about substance exposed infants and maternal substance abuse for maternal healthcare providers through residency programs, continuing medical education, graduate medical education and continuing education units
- Include injury prevention education and strategies as part of SA treatment and NAS discharge to prevent injuries and fatalities to infants (shaken infant, sleeping babies, abuse)
- Develop a workgroup to identify best practices and educational resources for clinicians in pain management during pregnancy; screening, counseling, referral, treatment for substance abuse; patient education
- Help provider associations collaborate with other experts on inter-disciplinary educational opportunities on best practices and community resources, including drug mortality data.

Data Sources Used:

- DCBS TWIST (The Worker's Information System),
- TEDS (Treatment Episode Data Set)
- NOMS (National Outcome Measures) data set.
- Halfon N, Mendonca A, and Berkowitz G, *Health status of children in foster care. The experience of the Center for the Vulnerable Child.* Arch Pediatr Adolesce Med, 1995. (149(4): 386-92.
- HCV (CDC Health Advisory http://emergency.cdc.gov/han/han00377.asp#_ENREF_18)
- http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6417a2.htm?s_cid=mm6417a2_w

- http://www.cdc.gov/nchhstp/stateprofiles/pdf/Kentucky_profile.pdf
- http://www.cdc.gov/hepatitis/statistics/2013surveillance/index.htm
- http://healthyamericans.org/reports/injuryprevention15/release.php?stateid=KY
- http://www.cdc.gov/hepatitis/statistics/2013surveillance/index.htm

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 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 from SFY 2014 to SFY 2015. Of the 19,079 individuals treated for substance abuse in the Community Mental Health Centers (CMHCs) during SFY 2014, 4,335, or 23%, reported having used IV drugs.

Approximately 10,766 individuals who sought substance abuse treatment services at Kentucky Opiate Treatment Programs (OTP) between SFY 2013 and SFY 2014 reported having an injection drug use history. This number was obtained by an informal data poll from the DBH Program Administrator for OTP.

Overall, there were a total of 74,462 individuals over the course of about four (4) years who sought addiction treatment in Kentucky and had a history of injection drug use. This represents a significant increase. However, this data only includes individuals who were treated within CMHC treatment programs. At present, there is no way of systematically gleaning data from other private substance abuse programs including, Kentucky Recovery Centers, private suboxone clinics, Alcohol and Drug Entities, across the state.

Addiction to prescription painkillers is the strongest risk factor for heroin addiction (CDC Vital Signs)

- 45% of people who used heroin were also addicted to a prescription opioid painkiller
- Kentucky has the fourth highest rate of painkiller prescribing in the US at 128 opioid painkiller prescriptions for every 100 people (CNC National Prescription Audit 2012)

Opioids drive continued increase in drug overdose deaths: *Drug overdose deaths increase for 11th consecutive year (CDC press release).*

- Heroin overdose deaths in Kentucky increased by 207% from 2011 to 2012
- Kentucky's rates of drug overdose deaths more than doubled from 1999 to 2010
- Kentucky ranks 2nd in the nation at 24.6 drugs overdose deaths per 100,000 (2011-2013 average)
- Since 2008, more Kentuckians have died from drug overdoses than motor vehicle accidents

Hepatitis C (HCV)

- Over 70% of persons who inject drugs long term may be infected with HCV (CDC Health Advisory)

- Approximately 73% of young adults with hepatitis C report injection drug use as their principal risk factor
- Kentucky rates of acute hepatitis C increased by 357% from 2007-2011
- In 2013, Kentucky had the nation's highest rate of acute hepatitis C (5.1 per 100,000)

Kentucky currently has twenty (20) licensed OTPs, two (2) publically funded and eighteen (18) 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.

Kentucky has relatively low rates of HIV AIDS, but a much higher rate of Hepatitis C, as self-reported by each individual.

Unmet Needs and Critical Service Gaps:

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) MAT is seldom presented as a treatment option to patients; 2) the majority of CHMC programs are abstinence-based and do not accept individuals utilizing MAT. Over the past few 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 served by the CMHC using IV drugs normally are detoxed in a social setting, without any pharmacological assistance.

3. Most individuals with substance abuse traditionally served through public funds are indigent, and private OTPs have been out of reach. Also, traditionally the two publically funded programs are in the main urban areas, and have such an extensive waiting list that there was normally over a year waiting list. However, because of Medicaid Expansion in Kentucky and because of a new Medicaid state plan amendment that included substance use disorder treatment, including opiate treatment, waiting lists are now only ten (10) days to two (2) weeks. Also, because of Kentucky opening the network of behavioral health providers to include Medicaid approved private providers, accessibility has improved. Because the state is mostly poor, rural, and mountainous, accessibility needs to continue to improve. Since 2011, four (4) full OTPs and five (5) medication stations have been added to address capacity issues. Access and service capacity remains a major issue in Kentucky.

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.

5. DBHDID has traditionally collected data from the CMHC client/event data set. However, the majority of programming serving individuals with opioid addiction are private programs or else or licensed as Alcohol and Drug Entities through the Office of the Inspector General (OIG). The DBHDID does not have good data collection methods for programming, other than for those served through CMHCs.

6. Individuals with opioid addiction do not typically go to CMHCs for services due to stigma and lack of necessary programming for their specific treatment.

7. Although Medication Assisted Treatment is now a Medicaid billable service in Kentucky, progress has been slow regarding establishing reimbursement rates for the various components of Medication Assisted Treatment, so provision of this service has been hampered. In addition, organizations are having difficulty with procedures related to becoming a Medicaid billable entity in order to be able to provide this service.

Priorities for SFY 2016/2017

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.

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.

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

5. Data needs to be collected from providers of opioid treatment, other than just CMHC data. In addition, data regarding prevalence of IV drug use, 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, Administrative Offices of the Courts, and others.

6. DBH needs to work with Medicaid to clearly identify the process for organizations to become Medicaid billable agencies (e.g. Behavioral Health Service Organizations) and develop methods of providing that information to private organizations across the state.

Data Sources Used:

- Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (July 19, 2007). The National Survey on Drug Use and Health (NSDUH) Report: Demographic and Geographic Variations in Injection Drug Use. Rockville, MD.
- Center on Drug and Alcohol Research (CDAR) University of KY.
- CDC Vital Signs
- CDC National Prescription Audit 2012
- NQF Standard of Care regarding Withdrawal Management
- http://healthyamericans.org/reports/injuryprevention15/release.php?stateid=KY
- http://emergency.cdc.gov/han/han00377.asp#_ENREF_18
- http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6417a2.htm?s_cid=mm6417a2_w
- http://www.cdc.gov/nchhstp/stateprofiles/pdf/Kentucky_profile.pdf
- http://www.cdc.gov/hepatitis/statistics/2013surveillance/index.htm
- Informal Data Survey of OTPs

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 81 cases of TB were reported for 2013, which is a rate of 1.8 per 100,000. Kentucky has seen a nearly continual decline since 2000, when the rate was 3.7 per 100,000.

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

Data Sources Used:

- Department for Public Heath

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 as of 12/31/2013, the number of new HIV disease cases diagnosed among Kentuckians in 2013 was 372. This translates to a rate of 8.4 per 100,000. This is comparatively lower than the US estimated rate of 15.3 per 100,000 for 2012. The reports for 2012 identify 366 HIV disease cases that have been diagnosed among Kentuckians. Cumulatively, 84 pediatric cases of HIV disease have been diagnosed in Kentucky since 1982, with less than five (5) new cases diagnosed annually for the most recent years.

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 so the most appropriate services may be coordinated. Although Kentucky has been a lower risk state for HIV/AIDS for several years, DBHDID staff has recognized that there is a need to address Hepatitis C more

intensively in substance abuse services as well as increasing education about Hepatitis A and B. 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.

Data Sources Used:

- Department for Public Health

Adolescents with Substance Use Disorders and/or Mental Health Disorders

Prevalence Data/Unmet Needs and Service Gaps:
Previously barriers in Kentucky to improve adolescent substance abuse services included a lack of state funds, a lack of service options, and a lack of community awareness about the problem. However, much of that has changed.

As of January 2014, the new Medicaid state plan included reimbursement for substance abuse services that would allow for youth to obtain substance abuse treatment services without having to go through Early and Periodic Screening Diagnostic and Treatment (EPSDT) funding thus making it much easier for youth and their families to obtain services. At the same time as the Medicaid state plan changed there was also the opening of the Medicaid behavioral health provider network that made available a wider variety of geographically accessible treatment options.

Currently, 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). With a recent pharmaceutical settlement fund a small portion of money was earmarked for school based behavioral health screening. A demonstration project and implantation plan has allowed for forty-four (44) schools and 107 trained screeners to implement the Global Assessment of Individual Needs-Short Screening (GAIN SS) as a screening instrument with plans to move statewide over the course of the next two years. There have been clinical staff trained in assessment methods/tools is most every CMHC and several private providers in the state. Kentucky continues to provide training and coaching on the use of the Global Assessment of Individual Needs (GAIN) family of screening and assessment tools.

Previously the need to enhance treatment options for adolescents with juvenile justice involvement was especially pronounced. Kentucky, like many states historically, has responded to certain behaviors by detaining youth, including those who commit status offenses, an approach shown to be ineffective and highly expensive (Nelson, 2008). In fact, Kentucky had been one of the states with the highest rate in the nation, that detained youth charged with a status offense. (Kentucky Youth Advocates (KYA), 2011). With national estimates of approximately 70% of youth with juvenile justice involvement meet criteria for a diagnosable mental health disorder and about 61% have a co-occurring substance use disorder (National Center for Mental Health and Juvenile Justice, 2006), adolescents with juvenile justice involvement present a unique challenge to the system of care. Not only is the intensity of their needs likely to be greater, but proper response to their multiple needs requires increased collaboration, continuity of care, and the ability to recruit and retain providers who are equipped to treat multiple needs. 2014 legislation substantially overhauled Kentucky's Juvenile Justice System with the creation of a Senate Bill. This bill amended or created new obligations for the Administrative Office of the Courts (AOC), the Department of Juvenile Justice (DJJ) and other organizations that pushed the state to recognize and expand training and usage of evidence based screening, assessment, and treatment as community based as possible for youth

experiencing substance use and behavioral health issues thus possibly preventing and/or reducing the likelihood of deep end involvement or recidivism in to the justice system. Thus, the need for accessible and effective treatment is paramount throughout the system.

With the benefit of the SAMHSA State Adolescent Treatment Enhancement and Dissemination grant and the Attorney General's pharmaceutical settlement, dollars were earmarked for the training and expansion of evidence based practices and treatment services. Clinical staff across the state have been trained with fidelity measures in place for Adolescent Community Reinforcement Approach (A-CRA), GAIN, Seven Challenges, Functional Family therapy and Cognitive Behavioral Therapy as well as trainings to build competency in adolescent treatment providers with regards to group skills, gender specific treatment, brain development and motivational interviewing. Services were also expanded outside of the CMHCs and Intensive Outpatient Programs (IOP) and residential treatment programs were started. A fairly comprehensive array of services for youth with substance use disorders is now available to varying degrees across Kentucky. Services for adolescents are provided by CMHCs, private providers, and Psychiatric Residential Treatment Facilities that have become licensed as Alcohol and Drug Entities and by Medicaid as Behavioral Health Services Organizations.

Kentucky has made strides in promoting evidence based practices and has implemented now many evidence based practices across the state in various treatment milieus with both public and private providers. . Additionally, statewide trainings to treatment providers and other youth-serving staff have been offered through partnerships with the Kentucky Adolescent Treatment Consortium, the System of Care Academy funded in part by a System of Care Grant and by securing a portion of the Kentucky School for alcohol and drug studies to offer an adolescent specific track, including evidence based treatment models.

Some Kentucky specific data reveals:

- Approximately 26% of Kentucky high school students are current smokers compared to 18.2% nationally (YRBS, 2009).
- Among youth, 21% of Kentucky 10th graders report being drunk in the past month compared to 14.7% nationally (KIP, 2010; MTF, 2010).
- Among those 18 and older, Kentucky had the highest frequency of past-month binge drinking in the nation, with an average of 5.9 episodes compared to 4.4 episodes nationally (BRFSS, 2010).

The following data depict the extent of prescription drug abuse in Kentucky:

- Past-year nonmedical use of opioids was highest among transition-age youth (18-25 years old), with approximately 15.4% reporting use compared to 11.9% nationally (National Survey on Drug Use and Health (NSDUH), 2008-2009).

Further, heroin has now become the drug of choice for many individuals across the nation and Kentucky. The larger metropolitan areas of Lexington, Louisville and Northern Kentucky have been especially hard hit by this epidemic. A growing number of youth and young adults previously abusing expensive prescription drugs are now using heroin, which is cheaper and easier to buy. This is taking a deadly toll on Kentucky's transition-age youth. Heroin overdose deaths increased 650% between 2011 and 2012, from twenty-two (22) cases in 2011 to 143 in

2012. In 2011, the percentage of heroin overdose deaths was 3.22%. In 2012, it had jumped to almost 20% of all overdose deaths.

Results of the 2010-11 NSDUH reveals further distressing statistics for Kentucky's youth and young adults. As noted in Table 1, the dramatic increase in the use of drugs, alcohol and tobacco between those who are 12-17 years old and 18-25 years old is startling, furthering illustrating the need for intervention at earlier ages and the urgent need for treatment and recovery supports for transitional age youth.

Table 1: 2010-2011 National Survey on Drug Use and Health - Kentucky		
ITEM	12 – 17 Years	18 – 25 Years
Past Month Illicit Drug Use	29	82
Past Year Marijuana Use	41	109
Past Year Non-Medical Pain Reliever Use	22	50
Past Month Alcohol Use	43	235
Past Month Binge Alcohol Use	26	174
Alcohol Dependence or Abuse	12	52
Needing But Not Receiving Treatment For Alcohol Use	12	48
Past Month Tobacco Product Use	50	232
Past Month Cigarette Use	39	195
Had at least one major depressive episode in the past year	30	36
Serious thoughts of suicide in the past year	Not reported	30

As noted previously, the KYT initiative proposes to include military personnel of transition age and military-connected youth as special populations of focus. The recognition of the needs of this special population have become ever-more apparent in the results of the most recent Kentucky Incentives for Prevention (KIP) survey (2014), a school-administered survey that assesses the extent of alcohol, drug, and tobacco use among 11 to 18 year olds throughout Kentucky. Table 2 depicts the prevalence of prescription drug use and mental health correlates among 10th graders from military-connected families. For any prescription drug use as well as the three main prescription drug classes, 10th graders from military-connected families consistently had higher 30-day rates of prescription drug use. Military-connected youth also had higher rates of mental distress as indicated by self-harm, suicidal ideation, suicide plans, and suicide attempts.

Table 2. Prevalence of Prescription Drug Use and Mental Health Correlates among 10th Graders from Military-Connected Families (KIP, 2014)			
Family Member on Active Duty or Veteran			
	No/DK N (%)	Yes N (%)	Yes More than 1 N (%)
30-Day Prescription Drug Use			
Any prescription	522 (3.3)	184 (3.7)	263 (3.9)
Opioids	619 (4.0)	200 (4.1)	359 (5.3)
Tranquilizers	216 (1.4)	62 (1.3)	119 (1.8)
Stimulants	261 (1.7)	91 (1.8)	138 (2.0)
Mental Health			
Symptoms Psychological Distress	2,663 (17.0)	883 (17.8)	1,382 (20.4)
Self-harm	2,732 (18.8)	921 (20.0)	1,506 (23.8)
Suicide ideation	2,190 (13.9)	769 (15.4)	1,261 (18.5)
Suicide plan	1,764 (11.2)	624 (12.6)	1,038 (15.3)
Suicide attempt	1,136 (7.2)	412 (8.3)	677 (9.9)

Goals for SFY 2016/2017:

- Encourage the statewide use (especially the CMHCs) of an evidence based screening and assessment tool for initial screening/assessment process (i.e. GAIN Family of instruments). All CMHCs should conduct standard screening and assessment for trauma and substance use for all youth who enter the door.
- Continue to implement school based screening for behavioral health needs in middle and high schools using the GAIN SS.
- Continue to work with AOC, DJJ, CMHCs, and communities across the state to implement system change and engage behavioral health providers and the community to work together to help adolescents who may have substance use disorders/co-occurring mental health and substance use disorders, and their families, in accessing less restrictive community services versus more restrictive placements such as out of home or detention services
- Continue to support infrastructure in using evidence based treatment and assessment by offering an adolescent track at the annual Kentucky School for Alcohol and Drug Studies. CMHC Plan and Budget documents will be reviewed to identify needed topics for adolescent treatment providers.
- 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.
- Support each CMHC in developing at least one (1) Intensive Outpatient Program for adolescents with substance use and/or co-occurring disorders and the ability to provide this level of treatment with confidence.
- Provide support and coaching for the development of co-occurring capable programming in at least six (6) sites in the state by utilizing the Dual Diagnosis Capability in Youth Treatment (DDCYT) tool to assess current co-occurring capability and evaluate strengths and weaknesses and provide feedback to programs. This would include training DDCYT assessors within the CMHC system.
- Use intake and follow-up data from providers to strengthen clinical workforce regarding adolescent behavioral health treatment, and to assist providers and policymakers in better understanding characteristics/needs of adolescents entering treatment.
- Restructure funding to support more treatment and aftercare of adolescents in need of behavioral health services.
- Strengthen the use of data in guiding treatment efforts and in comparing outcomes for adolescents with those of adults.
- Continue to assist with the ongoing work of the Kentucky Adolescent Substance Abuse Consortium (KASAC).
- Continue to work with Substance Abuse Treatment – Education and Dissemination (SAT-ED) cooperative agreement to provide financial mapping of behavioral health services for adolescents and their families, to identify service gaps and offer ideas to expand the continuum of services and supports.
- Continue to collaborate with KASAC regarding state standards for endorsement of treatment providers for adolescents with behavioral health disorders and their family.

Data Sources Used:

- Centers for Disease Control and Prevention (CDC). (2010). *Behavioral Risk Factor Surveillance System Survey Data*. (BRFSS) Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.
- Centers for Disease Control and Prevention (CDC).*Youth Risk Behavior Surveillance*. Available at http://www.cdc.gov/HealthyYouth/yrbs/index.htm
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Environmental Factors and Plans

2) Health Disparities

*In accordance with the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[52], **Healthy People, 2020**[53], **National Stakeholder Strategy for Achieving Health Equity**[54], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, and people living with HIV/AIDS or other chronic diseases/impairments) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS standards).[55]*

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The top Secretarial priority in the Action Plan is to "[a]ssess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[56]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, in accordance with section 4302 of the Affordable Care Act, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status.[57] This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations.[58] In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the population they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. *Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?*
2. *Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.*
3. *Are linguistic disparities/language barriers identified, monitored, and addressed?*
4. *Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.*
5. *Is there state support for cultural and linguistic competency training for providers?*

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

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

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

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

[55] http://www.ThinkCulturalHealth.hhs.gov

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

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

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

There are no federally recognized tribes in Kentucky, nor is it a designated state for HIV/AIDS or TB. There are, however, subpopulations that experience significant disparity in service use, access and outcomes: those who are deaf and hard of hearing; active military and veterans; racial minorities; and individuals who are homeless. It is estimated that Kentucky has 737,000 persons who are Deaf or Hard of Hearing, with 6% of those expected to meet the designation of SMI. In SFY 2014, the 14 CMHCs collectively served 4,690 unduplicated adults and children who are deaf and hard of hearing. The majority (88%) of these individuals are served in the five selected proposed CCBHC regions. In an effort to support the 14 regional CMHCs in providing linguistically-sensitive services, all CMHCs are compensated for interpreter services through either the MCOs or DBHDID. DBHDID also funds two therapists employed by two of the proposed CCBHCs that offer services in ASL or use other assistive devices.

There are two military installations in Kentucky, and while not located in the proposed CCBHC regions, there are citizens serving in the military and National Guard who live across the Commonwealth. There are an estimated 23.4 million veterans in the US, and about 2.2 million military service members and 3.1 million immediate family members. Kentucky's Veteran population is 330,599, including approximately 9,000 who are under the age of 25. As of September 2012 there were 24,493 women Veterans, a number that is rapidly trending upwards. Between 2004 and 2006, SAMHSA estimates that over 7% of Veterans met the criteria for a

SUD and in the years from 2005-2009, 1,100 members of the Armed Forces took their own lives, equating to one suicide every 36 hours. During SFY 2014, the 14 CMHCs reported providing services to 769 active duty service members and 2301 Veterans (increase of 1% from SFY 2012). For the 5 CMHCs selected, there were 240 Active Duty and 830 Veterans served. The Military and Veterans Administration Hospitals are under Presidential Order to increase the services and manpower needed to treat Service members and Veterans. They have made great strides toward this goal but there continues to be unmet need of Service members, Veterans and their families in Kentucky. There are currently four Veteran Drug Treatment Courts in Kentucky and two are located in the proposed regions (Lexington and Louisville). DBHDID has identified 20 veterans that wish to become certified peer specialists with the intent to establish a Veteran/Military Peer Support Network. For several years, CMHCs have been contractually obligated to designate Military Behavioral Health Coordinators (MBHCs). MBHCs have received training by a team of experts from the U.S. Department of Veterans Affairs, Kentucky National Guard, Kentucky Department for Veteran Affairs, and the DHBDID and are charged to coordinate care and enable access to services for those eligible for federal and/or state programs.

Kentucky's citizenry is comprised of 86.3% Non-Hispanic Whites, 8% African Americans/Non-Hispanic, 2% American Indian/Alaska Native/Non-Hispanic, 1% Asian/Non-Hispanic, 1% of two or more races/Non-Hispanic and only 4000 additional citizens of races designated as Other. Comparatively, of all mental health clients served the 14 CMHCs, 82% were Non-Hispanic Whites. Of the five proposed CCBHCs, there was wide variance in client composition by race, from Non-Hispanic Whites being 53% of the total mental health population served in one region, to 99% in another. All regions struggle to ensure that the staffing ratios with regard to race and ethnicity are comparable.

DBHDID recognizes the importance of system coordination among the numerous agencies and programs involved with services to individuals with behavioral health disorders and who are homeless. At the state level, DBHDID participates in the Kentucky Interagency Council on Homelessness (KICH), a group of state and local providers, consumers and government officials. The Council drafted a Homelessness Prevention Plan and Kentucky's Ten-Year Plan to End Homelessness. The 14 CMHCs consider individuals who are homeless and mentally ill as a priority population and have specialized programming to address their unique needs. Many CMHCs provide consultation to local shelters, regularly visit homeless shelters and do other "street" outreach. Seven of the 14 CMHCs receive PATH funds, including all five of the CMHCs proposed to pursue certification.

Kentucky Institute for Excellence in Behavioral Health

Building Effective Behavioral Health Service Delivery Systems

An Institute for Excellence is an organization or group of partnering organizations whose primary role is to support systems level reform efforts that are using evidence-based and promising practices as a core strategy.

Background

Kentucky's behavioral health service delivery system is undergoing monumental change. With the implementation of health care reform efforts, Kentucky's behavioral health care system is serving more individuals, offers a broader array of services and supports, and has more providers. However, increased access to care does not necessarily translate to quality care. These changes have significant implications for ensuring publically-funded providers are equipped to implement effective behavioral health services, and ultimately improve the health and well-being of the citizens of Kentucky.

Since the evidence-based practices movement ensued in the early 2000s, state and local governments have given greater attention to building the necessary core infrastructure to support effective implementation of new approaches to care. Good outcomes are based not merely on the availability and utilization of evidence-based practices but are critically dependent on the quality of implementation planning, effective delivery of practices, stakeholder involvement, and community level buy-in.

To date, Kentucky has been able to support implementation of a limited number of evidence-based practices in specific geographic regions with select providers. In fact, reports by external consultants have identified Kentucky's dire need for a more coordinated and systematic approach to support evidence-based policy and practice implementation in behavioral health.

A growing number of state behavioral health authorities have established partnerships with universities, nonprofits, and other entities to create Institutes for Excellence/Centers of Excellence as one strategy to support providers to deliver evidence-based services and supports. A review of publically available information as well as interviews with selected Institutes and Centers was conducted. Utilizing this information, the development of an Institute to support excellence in behavioral health service delivery in Kentucky is proposed.

Mission

While the exact wording of the mission for the proposed Institute will be determined by an advisory board, the primary purpose is to support publically-funded providers to implement evidence-based behavioral health services and supports, including promotion of positive well-being, prevention of mental health and substance use problems, and interventions to address mental health and substance use difficulties.

Structure and Governance

The majority of the existing Institutes/Centers identified through the review are affiliated with a university. Other settings include divisions of state government and nonprofits. Within university-affiliated entities, two types of organizational structure are apparent. Some centers operate as stand-alone entities, in that they are not directly affiliated with a specific university department or college, e.g., the Center for Innovative Practices (Kent State University). These entities report that this type of structure allows for enhanced ability to create multi-disciplinary collaborations across departments as well as increased flexibility to focus on its specific mission, apart from academically– valued endeavors such as teaching, research, grants, and publications. Other centers are embedded within a specific school or college, such as the Center for Excellence in Community Mental Health, housed in the Department of Psychiatry at the University of North Carolina. These entities suggest that the Center must have some degree of autonomy so that university rules do become a barrier.

It is recommended that Kentucky's Institute be housed within the Training Resource Center at Eastern Kentucky University (EKU) in Richmond, Kentucky. While housed within the Training Resource Center, Institute staff will work in partnership with the State Behavioral Health Agency and create a network of formal and informal partnerships with other departments at EKU as well as other universities and colleges, such as psychology, social work, nursing, public health, public policy, psychiatry, medicine, education, criminal justice, and occupational and physical therapy. Likewise, the Institute will establish partnerships with behavioral health advocacy organizations, state agencies, and other entities that provide training and technical assistance in behavioral health.

The Institute will operate with an advisory board comprised of state agency representatives, university representatives, consumer and family representatives, providers, and other public stakeholders. The advisory board will be responsible for strategic planning and ensuring that the Institute addresses the needs of its stakeholders.

Core Functions

The Annie E. Casey Foundation convened a Learning Community to support new and existing Institutes and Centers of Excellence. One component of this work involved a description of the core services rendered by existing Centers and Institutes across the nation. Figure 1 illustrates the five most common core functions.

Kentucky 's Institute will provide each of these core functions to varying degrees, depending upon the needs of its stakeholders.

- **Selection & Implementation Support**—One of the key activities of the Institute will include assisting provider agencies in the selection and implementation of evidence-based models. This will include capacity assessments, service array development, implementation planning, and CQI development and facilitation.
- **Workforce Development**—The Institute will also support providers in the adoption, installation, implementation, and sustainability of evidence-based and promising practice approaches. This will include providing training and ongoing coaching and technical assistance in selected evidence-based and promising practice models , either directly or through contracts with purveyors, as well as assisting in the creation of infrastructure to assisting in sustaining ongoing implementation, such as developing training-of-trainers models to save money by eliminating the need for ongoing training by external entities. Because current research on evidence-based programming demonstrates a critical link between high fidelity implementation and anticipated positive outcomes, the presence of a mechanism to monitor ongoing fidelity of implementation efforts will be a critical function of the Institute. The Institute will focus on cross-system workforce development needs for evidence-based and promising approaches by working collaboratively with all providers in the system. For example, both child welfare and juvenile justice may share an interest in enhancing the workforce's ability to provide trauma-informed care and may find benefit in collaborative training and coaching endeavors. Further, the Institute will work with institutes of higher education to ensure the graduating workforce is competent in selected evidence-based and promising practice models of care.

Figure 1. Core Functions
Adapted from The Institute for Innovation & Implementation (The Institute) at the University of Maryland School of Social Work in partnership with The Center for Innovative Practices at Case Western Reserve University.

Core Functions (continued)

- **Policy & Finance**— The Institute will provide policy and financing support primarily by assisting state agencies in researching and formulating policy option briefs and recommendations for financing approaches. The Institute will also support entities in systems design and change management strategies as well as strategic planning. Finally, grant writing will be a key function of the Institute.
- **Partnership Engagement and Collaboration**— To support cross-agency collaboration and coordination, the Institute will serve to identify and link agencies who are interested in adopting similar evidence-based and promising practice models by creating supporting cross-agency training initiatives, the establishment of learning collaboratives, and assisting in the development of state and local implementation teams. Further, the Institute will be available to provide support to existing bodies to strengthen their collaborative efforts through processes such as stakeholder analysis, assessing current collaborative functioning, and network analysis.
- **Research, Evaluation, and Data Linking**— The Institute will collect, analyze, and disseminate data and information that can be used by policymakers, funders, provider organizations, and families and youth. Assisting agencies in cross-agency data linking will be a core function. The Institute will assist implementation teams to enhance data literacy to support CQI design, data collection and linking, analysis, and reporting to support implementation of evidence-based and promising practices.

Financing

Most Institutes/Centers of Excellence are not reliant on a single funding source but rather operate with a variety of funding sources, such as revenue from contracts; federal, state, and local grants; and foundation grants and donations. It is recommend that financing of Institute include both "hard" money devoted to key infrastructure and "soft" money funding directed at specific projects. To ensure consistent base funding, the Institute could be funded through a legislative appropriation and/or through contributions by state agencies and organizations, such as Managed Care Organizations, who have a vested interest in ensuring that high quality behavioral health services are rendered. Additionally, contracts with state agencies, federal grants, and foundation grants could provide additional support. The Institute should have the flexibility to maintain its core infrastructure and staffing while allowing for expansion and reduction depending on current activities. The Institute must have a diverse but manageable portfolio of activities.

Conclusions

The Kentucky Institute for Excellence in Behavioral Health seeks to ensure that Kentucky citizens have immediate access to evidence-based and promising practice models of care, robust support services, and community partnerships that have proven to produce better health outcomes.

Environmental Factors and Plan

16. Recovery

Narrative Question: The implementation of recovery-based approaches is imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.

Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of health (access to quality health and behavioral health treatment), home (housing with needed supports), purpose (education, employment, and other pursuits), and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes of recurrence of symptoms associated with an individual's mental or substance use disorder. This includes the use of psychotropic or other medications for mental illnesses or addictions to assist in the diminishing or elimination of symptoms as needed. Further, the use of psychiatric advance directives is encouraged to provide an individual to opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly. Resolution of symptoms through acute care treatment contributes to the stability necessary for individuals to pursue their ongoing recovery and to make use of SAMHSA encouraged recovery resources.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders: Recovery is a process of change through which an individual improves their health and wellness, lives a self-directed life and strives to reach their full potential. In addition, SAMHSA identified 10 guiding principles of recovery: Recovery emerges from hope; Recovery is person driven; Recovery occurs via many pathways; Recovery is holistic; Recovery is supported by peers and allies; Recovery is supported through relationship and social networks; Recovery is culturally based and influenced; Recovery is supported by addressing trauma; Recovery involves individuals, families, community strengths, and responsibility; and Recovery is based on respect.

States are strongly encouraged to consider ways to incorporate recovery support services, including peer delivered services, into their continuum of care. Examples of evidence based and emerging practices in peer recovery support services include, but are not limited to, the following: Drop in centers; Peer delivered motivational interviewing; Peer specialist; Promotoras; Self -directed care; Supportive housing models; Recovery community centers; WRAP, Supported employment; Family navigators/parent support partners/providers; Peer health navigators; Peer wellness coaching; Recovery coaching; Shared decision making; Telephone recovery checkups; Warm lines; Whole Health Action Management; Mutual aid groups for individuals with MH/SA disorders or CODs; Peer run respite services; person centered planning; self-care and wellness approaches; Peer run crisis diversion services; and Wellness based community campaign.

SAMHSA encourages states to take proactive steps to implement recovery support services, and is seeking input from states to address this position. To accomplish this goal and support the wide scale adoption of recovery supports in the area of health, home, purpose and community, SAMHSA has launched Bridging Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS); BRSS TACS assists states and others to promote adoption of recovery oriented supports, services and systems for people in recovery from substance use and/or mental disorders.

Recovery is based on the involvement of consumers/peers and their family members. States should work to support and help strengthen existing consumer, family and youth networks, recovery organizations, and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. States should describe their efforts to

engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system.

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:
1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person centered planning and self-direction and participant directed care, variety of recovery services and supports (i.e. peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?
2. How are treatment and recovery support services coordinated for any individual served by block grant funds?
3. Does the state's plan include peer delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
4. Does the state provide or support training for the professional workforce on recovery principles and recovery oriented practices and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer run services?
5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery oriented approaches and services within the state's behavioral health system?
6. Describe how individuals in recovery and family members are involved in the planning, delivery and evaluation of behavioral health services (e.g. meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).
7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks and recovery oriented services?
8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.
9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.
10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?
11. Describe how the state is supporting the employment and educational needs of individuals served.

Kentucky's DBHDID has long supported the provision of recovery oriented services and supports to all individuals served by the public behavioral health system. The strategic plan for DBHDID includes Mission and Vision statements that include "…..facilitating recovery….", "….administration and delivery of evidence based services and supports that are individually focused….", and organizational values including choice and self-determination, excellence and respect. Strategic DBHDID goals include: Promote inclusion in community-based settings for individuals with disabilities; and Promote resiliency, recovery and inclusion in community living.

For many years, DBHDID has partnered with statewide advocacy organizations that represent individuals in recovery from behavioral health disorders and their family members. These partnerships have resulted in countless training opportunities, implementation of various initiatives, promotion of recovery oriented services and supports, and more awareness of the need and benefits of such services and supports.

Currently DBHDID formally partners with four (4) statewide advocacy organizations: People Advocating Recovery (PAR), an advocacy group governed by and supporting individuals in

recovery from substance use disorders; Kentucky System Transformation: Advocating Recovery Supports (KYSTARS), a training and technical assistance center that is governed by and supporting individuals in recovery from behavioral health disorders, family members, and providers; Kentucky Partnership for Families and Children (KPFC), an organization that is governed by and supporting children and youth in recovery from behavioral health disorders and their family members; and the National Alliance on Mental Illness (NAMI) Kentucky Chapter, an organization governed by and supporting family members of individuals in recovery from behavioral health disorders.

DBHDID also has less formal partnerships with other advocacy organizations including Mental Health Coalition, Mental Health America (both of Kentucky and of Northern Kentucky and Southwestern Ohio), and Kentucky Chapter of the Psychiatric Rehabilitation Association (KyPRA).

In 2004, the Department merged two divisions to create the Division of Mental Health and Substance Abuse, in an effort to integrate statewide efforts. During SFY 2009, the Department renamed the Division, Division of Behavioral Health, and made further efforts at statewide integration. In 2011, DBHDID hired a Recovery Services Coordinator, a self-identified individual in recovery from behavioral health disorders, to work within the Division to further integrate statewide efforts and to assist with implementing recovery principles across all service arrays.

One initiative that has been led by the Recovery Services Coordinator is the implementation of adult peer run programs across the state. During SFY 2013, a request for application (RFA) was initiated, utilizing some Mental Health Block Grant funds to contract with CMHCs to develop adult peer run programming. These RFAs included a requirement to follow the SAMHSA toolkit for Consumer Operated Services (COS) and create a steering committee or advisory board including a majority of individuals in recovery and their family members. DBHDID provided start-up funding and technical assistance for this programming. The partnership with KYSTARS included technical assistance and training opportunities for this initiative. At this point, DBHDID has assisted with funding of eight (8) programs, in seven (7) CMHC regions.

For SFY 2016, DBHDID is anticipating providing start-up funds in a similar manner for drop in centers for youth and young adults, similar to "Youth Move Oregon" programming. DBHDID was provided impetus for providing this initiative through the awarding of some grant opportunities, including the 5% set aside of Mental Health Block Grant funding for developing early interventions for first episode of psychosis.

Since 2006, DBHDID has provided training for adult and family peer support specialists. Although peer support was not yet a Medicaid billable service, a few CMHCs and at least one (1) state psychiatric hospital hired adult and family peers. In 2008, a DBH regulation was passed into law, guiding implementation efforts. However, the regulation specified adult peer support only for individuals with serious mental illness or a co-occurring disorder. During SFY 2013, DBH formed a peer support workgroup, including peers and stakeholders from both mental health and substance use disorder programming, both inside DBH and from CMHCs. This workgroup focused on integrating the peer support specialist training curriculum to include both mental health and substance use disorders. The result was a thirty (30) hour training curriculum, provided by individuals in recovery that would be provided for all adults in recovery from behavioral health disorders (mental health and substance use). SAMHSA's working definition of behavioral health recovery, including the four (4) dimensions and the ten (10) principles, were integrated into this training curriculum. Since 2013, adult peer support specialist trainings have been completed in an integrated fashion, including all individuals, regardless of

diagnoses. Peer specialists who were certified then began working in various types of programming across the state, including substance use disorder programs. In addition, the workgroup made suggestions of necessary changes to the current DBH adult peer support regulation, to be inclusive of all individuals. When peer support became a Medicaid billable service in January of 2014, more revisions were necessary to the regulation. During SFY 2015, the revised peer support regulations were finalized. Kentucky now has three (3) types of peer support that are billable through Medicaid: Adult Peer Support; Youth Peer Support; and Family/Parent Peer Support. Each service is available through both mental health and substance use disorder programming. Also, beginning in SFY 2015, DBH added language to CMHC contracts requiring the hiring of at least 2.0 FTE adult peer support specialists to work with individuals moving out of personal care homes and other institutions. All CMHCs began to hire peers. At present, all CMHCs have hired at least one (1) adult peer specialist, and most have hired several. CMHCs have had to rewrite hiring policies, supervision policies and overcome other obstacles that have traditionally made hiring peers difficult. As of May of 2015, approximately eighty-six (86) adult peer specialists were working in the CMHCs, most of them on a part-time basis. One (1) state psychiatric facility had hired an adult peer specialist, and another state psychiatric facility contracts with an organization to provide several peer specialists to work with individuals hospitalized at their facility, and their family members. CMHCs have long employed Family Liaisons in their targeted case management program utilizing Wraparound. Many of these individuals are now providing billable peer support services. A few CMHCs recently have hired youth peer specialists. In the SFY 2016 CMHC contracts, there is a new requirement to hire at least 2.0 FTE adult peer support specialists for substance use disorder programming. Peer support is expected to grow in all areas across the state.

Assertive Community Treatment (ACT) also became a Medicaid billable service in January 2014. DBH required CMHCs to include peer specialists on their ACT teams, in an effort to enhance the focus on the recovery of the individual being served. Although Supported Employment and Supportive Housing were not part of the new Medicaid State Plan Amendment, and therefore not Medicaid billable services for Kentucky, DBH also provided some guidance around these evidence based practices and their promotion of recovery. Beginning in SFY 2015, each CMHC was required by contract to provide Supported Employment through the Individual Placement and Support (IPS) Dartmouth model and Supported Housing through the Permanent Supportive Housing (PSH) SAMHSA model. As of April 2015, all CMHCs had Supported Employment programming for adults with SMI and most had a housing coordinator and were working toward PSH model.

DBHDID worked collaboratively with Kentucky Medicaid to submit the State Plan Amendment that was approved by CMS in January of 2014. DBH contributed some recovery oriented language and some person centered planning requirements were included in service descriptions. In addition, DBH developed a service standards workgroup and many standards, designed to guide delivery of services in a recovery oriented manner, were incorporated into contracts and practices.

DBH has embraced SAMHSAs working definition of recovery in its programming and has made efforts to incorporate these recovery oriented ideals across the state. Some efforts made by DBH to promote recovery principles and recovery oriented practice for the state workforce includes the following:

- Advancing Recovery Conference in March of 2014 in collaboration with KyPRA. Offered national speakers, Darby Penney of the "Suitcase Exhibit" and Stephen LeMaster, person centered planning. Also included a panel discussion with a team of stakeholders

from various state agencies and a peer who had moved to independent housing from a personal care home. Targeted all staff, including peer specialists, who were working with individuals wanting to move from institutions into independent housing;

- Webinar hosted by DBH in February of 2014 for all CMHC and other contracted entities who supervised adult peer specialists. Discussed recovery principles, issues related to hiring and supervising peers;
- Workshops on Developing Readiness for Change, hosted by DBH in collaboration with KyPRA. Provided by team consisting of a professional and a peer, discussing the importance of individualized care and recovery orientation;
- Workshop in June of 2014, on Crisis Planning, specifically for individuals with SMI, providing by DBH in collaboration with KyPRA. Provided by a team of a professional and a peer. Focused on importance of utilizing peer support and other available supports to enhance recovery;
- Webinar hosted by DBH in April 2014 for all CMHC and other contracted entities who supervised adult peer specialists. Discussed continued issues related to hiring and supervising peers and promoting recovery;
- Series of Webinars hosted by DBH in fall of 2013 and spring of 2014 related to implementation of the Interim Settlement Agreement. Focused on education of stakeholders, including a variety of state agencies and CMHCs on the principles of recovery and the importance of individualized care; and
- Statewide Targeted Case Management Conference in March 2015. Had workshops taught by peers that focused on the definition of recovery, the principles of recovery, ethics related to recovery oriented services, and the dimensions of recovery.

DBH has also been dedicated to the implementation of person centered planning across the state. In SFY 2015, all CMHC contracts included a requirement for the provision of person centered planning for all adults with SMI. DBH partnered with two (2) national consultants on person centered planning, Janis Tondora, PsyD., from Yale University and Diane Grieder, M.Ed., from Alipar, Inc. Beginning in SFY 2015, the following efforts were made regarding person centered planning and shared decision making:

- Two (2) day workshop on person centered planning in Morehead, Kentucky, by Janis Tondora and Diane Grieder. Focused on individuals working at CMHCs and other contracted entities as part of the Interim Settlement Agreement. Focused on an overview of recovery principles and shared decision making, stages of recovery/stages of change, and hands on implementation of a strengths based assessment and treatment planning process;
- A series of technical assistance phone calls/webinars, hosted by DBH, provided by Janis Tondora and Diane Grieder, to assist regional staff with honing person centered skills in a medical necessity environment;
- Two (2) day workshop on person centered planning in Hopkinsville, Kentucky, by Janis Tondora and Diane Grieder. Focused on individuals working at CMHCs and other contracted entities as part of the Interim Settlement Agreement. Focusing on an overview of recovery principles and shared decision making, stages of recovery/stages of change, and hand on implementation of a strengths based assessment and treatment planning process;
- Webinars for targeted state agencies on the process of person centered planning and shared decision making hosted by DBH and provided by Janis Tondora and Diane Grieder;

- A series of technical assistance coaching calls to CMHCs and other contracted entities to discuss and guide training for implementation of the person centered planning model in various agencies;
- Development of a recovery oriented indicators tool, by Janis Tondora and Diane Grieder, to further guide implementation and monitoring of the initiative; and
- Key note speaker at the statewide Targeted Case Management Conference in March 2015 was Janis Tondora, discussing person centered planning and shared decision making for all individuals.

Since 1989, DBH has supported the Oxford House model for individuals in recovery from substance use disorders. DBH has been partnering with organizations such as Kentucky Housing Corporation (KHC) to support housing that fits the Oxford House model. Partnerships also include the Department for Veteran's Affairs to provide additional funding for the establishment of Veteran Oxford Houses. The Oxford House model is evidence based and provides support for six (6) to twelve (12) individuals in recovery from substance use disorders to live in a recovery oriented environment of their choice, paying their own rent and utilities, and establish common housing guidelines in a democratic manner with other residents.

In February 2014, Kentucky's governor announced the kyhealthnow initiative, an effort to improve the health and wellness of Kentucky's citizens. This initiative outlined seven (7) key health goals for Kentucky to work toward during the next five (5) years. These initiatives include:

- Reduce Kentucky's rate of uninsured individuals to less than 5%;
- Reduce Kentucky's smoking rate by 10%;
- Reduce the rate of obesity among Kentuckians by 10%;
- Reduce Kentucky cancer deaths by 10%;
- Reduce cardiovascular deaths by 10%;
- Reduce the percentage of children with untreated dental decay by 25% and increase adult dental visits by 10%; and
- Reduce deaths from drug overdose by 25% and reduce by 25% the average number of poor mental health days of Kentuckians.

An executive order following, establishing an oversight team to provide oversight of the efforts to meet these goals. This team includes several departments within the Cabinet for Health and Family Services including the Department of Public Health and DBHDID, as well as the Office of Health Policy. The governor also executed an order to expand the prohibition of all tobacco products and e-cigarettes in executive branch buildings in Kentucky. This order took effect November 20, 2014. This order impacts 33,000 state workers, 2,888 state owned building and hundreds of thousands of visitors.

During SFY 2013, CMHC contracts included the requirement to designate a staff person to coordinate Veteran's services. DBH also designated a program administrator to focus on coordinating services to satisfy statewide behavioral health needs for the Veteran population. Kentucky has two (2) Veteran's Medical Centers, two (2) military bases, and a variety of other service related resources. However, CMHCs serve many Veterans across the state for behavioral health issues for a variety of reasons. Currently, DBH is working to develop a peer support network for Veterans who receive services through the public behavioral health system. Many Veterans in recovery from behavioral health issues have been certified as peer support specialists. Some of those are working in the veteran's medical centers and others are working in CMHCs or for private providers.

On May 1, 2015, DBH convened a meeting of recovery staff across programs, to discuss peer support/recovery planning. This meeting resulted in a consensus statement on peer support from DBH which included the following:

- DBH promote SAMHSAs principles of recovery and believes that all individuals can recovery, leaders will find value in this framework and DBH has a role in changing attitudes;
- DBH adopts SAMHSAs working definition of adult behavioral health recovery and the ten (10) guiding principles of recovery;
- DBH adopts a working definition of system of care for children with emotional disorders, including accompanying guiding principles;
- DBH has a vital role to ensure peer support is embedded in the public behavioral health system and that:
    - Peer support is essential to recovery
    - DBH is obligated to provide strong leadership in this area
    - DBH is obligated to lead in development of a strong workforce that can deliver high quality services (Pillars of Peer Support)
    - DBH should set standards around Kentucky peer support
    - Formal and informal peer support has value
    - Peers have a valued role in a variety of service settings
    - Lived experience is a key feature of the peer support role
    - Programs and services should incorporate a recovery approach and fully involve people with lived experience in program/services design, development, implementation and evaluation
    - Peers should have a defined role and this role should be clearly communicated and understood by all staff
    - DBH should incorporate best practices in the delivery of peer support
    - Supervisors have a key role in raising awareness and in supporting growth and development of peer support
    - DBH needs to partner with individuals in recovery, youth and family members, supervisors, staff, agency leadership, and community stakeholders in raising awareness and promoting their principles and values

Lastly, DBHDID has an Olmstead Plan to address the needs of individuals in restrictive environments and their rights to reside in communities of their choice. (See Environmental Factors and Plan #17). In addition, the Cabinet entered into an Interim Settlement Agreement in August of 2013 with Kentucky Protection and Advocacy, to move individuals with SMI out of personal care homes and into communities of their choice. (See Environmental Factors and Plan #17)

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead

Narrative Question:
The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in Olmstead v. L.C., 527 U.S.581 (1999) provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated arrangement appropriate and prohibit needless institutionalization and segregation in work, living and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to Section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office of Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including us of traditional institutions and other residences that have institutional characteristics to house persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services and employment services.
2. How are individuals transitioned from hospital to community settings?
3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?
4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved.

Kentucky has an Olmstead Compliance Plan in response to the landmark civil rights case of Olmstead in 1999, when the Supreme Court held that it is discriminatory and unlawful for governments to keep persons with disabilities in segregated settings when they are capable and desire to reside in the community. Kentucky's first Olmstead Compliance Plan was in 2002. The Cabinet established a committee to continually review and update progress on Olmstead goals. Kentucky's current Olmstead Plan consists of nine (9) goals:

1. All persons with any disability will experience meaningful, inclusive and integrated lives in their community supported by an array of services, in a setting of which they choose, according to individual need, with input from their families and legal guardians as required.
2. Education/Outreach to prevent facility placement, with input from his/her family and legal guardian, as required.
3. Assure that persons with disabilities are not incarcerated for minor offenses that are a result of their disability. Assure persons with disabilities who leave correctional

institutions or other institutions are able to access needed community based services with family and legal guardian input, as required.

4. All transition age youth (14-25 years old) will have a seamless transition to adulthood through the effective and efficient use of evidence based programs and practices that are developmentally appropriate, according to individual choice and need with family and guardian input, as required.
5. Increase available, accessible, quality, and affordable community housing.
6. Ensure a safe and appropriate transition from an institution to a community setting.
7. Kentuckians with disabilities will have choices for competitive, meaningful, and sustainable employment in the most integrated setting, according to individual choice and need, with input from families and guardians, as required.
8. Individuals with disabilities will have access to reliable, cost-effective, and accessible transportation choices that support the essential elements of life such as employment, housing, education, and social connections.
9. Ensure allocation of quantifiable, measurable tasks in regard to the elements of the Olmstead plan, including regular updates in order to ensure that the Commonwealth progresses toward the vision of protecting the rights of persons with disabilities. In order to do so, the Commonwealth will sustain a Cabinet level Olmstead Committee, measure progress on strategies, and update the Olmstead plan on a minimum of twice a year.

In the process of implementing the first Olmstead Compliance Plan, DBHDID developed more supports for individuals with serious mental illness. Behavioral health funding is made available specifically for individuals in institutions who meet the Olmstead criteria. Each of four (4) state psychiatric hospital catchment areas receives $200,000 each year to serve individuals in their area. Regional Olmstead committees were formed, consisting of DBH representatives and staff from CMHCs, state psychiatric hospitals, and other community stakeholders. Currently these committees meet monthly, at each state psychiatric facility to discuss individual needs and resources specific to each catchment area. In addition, a statewide quarterly Olmstead committee was developed and is hosted by DBH, and includes representatives from DBH, CMHCs, state psychiatric facilities, state nursing facilities, specialized personal care homes, National Alliance on Mental Illness (NAMI) and other community partners. This quarterly meeting allows a structure to discuss systemic issues and possible barriers to implementation of necessary community services.

Housing services are essential in this process. DBH provides funding to the Kentucky Housing Corporation (KHC) specifically for Olmstead Housing Initiative (OHI) vouchers. These vouchers are to serve the Olmstead population and can be used in a variety of ways including for rent, security deposits, furniture, utility deposits, etc. These vouchers are often the flexible funding needed to make a transition successful. At present, DBH provides $386,000 per year for OHI vouchers. In addition, DBH provides funding to the Louisville Metro Housing Authority that provides fifty (50) OHI vouchers for individuals who meet Olmstead criteria in Jefferson County.

In August 2013, the Cabinet for Health and Family Services entered into an Interim Settlement Agreement (ISA) with Kentucky Protection and Advocacy, to avoid litigation concerning the institutionalization of adults with SMI who resided in personal care homes in Kentucky. Estimates of persons impacted under this agreement range as high as 2,300 individuals, with an original list of 130 individuals with SMI who expressed a desire to move out of personal care homes and into housing in the community. The agreement was to move at least six hundred (600) individuals with SMI out of personal care homes within a three (3) year period. As a result of ISA, efforts were made by DBH to create a new and expanded system of care for these individuals. DBH contracted with CMHCs to provide Direct Intervention: Very Early Response

Treatment System (DIVERTS) services across the state to individuals with SMI who expressed a desire to live in the community. Kentucky's new Medicaid State Plan Amendment was approved by CMS a few months later, in January of 2014, making the new service system more sustainable.

DIVERTS services consists of the following evidence based services and supports for individuals with SMI:

- Assertive Community Treatment (ACT);
- Peer Support;
- Supported Employment;
- Supportive Housing;
- Targeted Case Management; and
- Crisis Services.

CMHC contracts were rewritten and required provision of DIVERTS services for individuals moving out of personal care homes and for individuals at risk of readmission to a personal care home, hospital or other institution. DBHDID provided approximately $7 Million of funding for the first year and approximately $6 Million of funding for the next two (2) years for the ISA. These funds were made available partially from state psychiatric facility budgets, thus "rebalancing" some behavioral health funding into the community. CMHCs developed new services and began providing in reach to individuals with SMI in personal care homes and other institutions. DBH program administrators were reorganized in an effort to assist with program development and the terms of the ISA. An entirely new web-based data system was created to track ISA data and milestones.

The desired outcomes of the ISA are as follows:

- Individuals with a serious mental illness, who reside in the Commonwealth of Kentucky, are afforded the opportunity for safe, productive and fully integrated lives within their chosen communities;
- The Kentucky Cabinet for Health and Family Services ensures resources and the delivery of supports to individuals; via policy implementation, oversight, funding, and provision of technical expertise for related Community Mental Health Center activities; and
- Terms identified within the Interim Settlement Agreement are met or exceeded; with progress and quality measured by defined formal reports and established processes.

Due to the ISA, several collaborative efforts have resulted in positive changes in the service system. For example, collaboration with the Department for Medicaid Services and the Department for Community Based Services resulted in a change in the traditional state supplement for individuals with SMI living in personal care homes. The program is now called Community Integration Supplement (CIS) and can now be effective for these individuals as an effort to prevent institutionalization, not just available when they are in an institution. Another example is the collaboration with the Department for Aging and Independent Living (DAIL) and their state guardianship office. State guardians are collaborating with service providers in securing community housing for their individuals with SMI. In addition, because of ISA, $1 Million in additional funding was made available in SFY 2016 to KHC specifically for OHI vouchers targeting individuals served under ISA.

DBH is currently working on several issues related to Olmstead and ISA, including leveraging a Transformation Transfer Initiative (TTI) grant award to assist with developing peer bridging

services through state psychiatric facilities. Also, funding from the 5% set aside for Early Interventions for First Episode of Psychosis is being leveraged to positively affect these initiatives as well. DBH is working with CMHCs to provide technical assistance to strengthen the new service system and work toward full Medicaid sustainability for all relevant necessary services. DBH is currently working toward a strategic plan for ISA in hopes to continue and strengthen efforts for this vulnerable population. In the future, DBH hopes to focus more on outcomes vs infrastructure.

Lastly, DBH has a long term goal of preventing unnecessary admission into institutions, including personal care homes and psychiatric hospitals, and assisting individuals with SMI to move toward their paths to recovery as early as possible and with individualized, quality supports and services.

Environmental Factors and Plans

22. State Behavioral Health Planning and Advisory Council and Input on the Mental Health and Substance Abuse Block Grant Application

1. *How was the Council actively involved in the State Plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).*

The Kentucky Behavioral Health Planning and Advisory Council's Finance and Data Committee held a meeting on April 16, 2015. Members were provided with copies of the SFY 2015 and the proposed SFY 2016 SABG and MHBG allocations for direct services through the community mental health centers, statewide projects, miscellaneous initiatives (e.g., data collection and advocacy organization deliverables), and audit reserves. Staff reviewed the documents and committee members were encouraged to provide feedback on the allocations.

Following that discussion, members were provided with an overview of projects to potentially fund with reserve block grant funds. Finance Committee members voted to support the following initiatives:

- ☐ Peer Support
- ☐ First Episode Psychosis
- ☐ Oxford House Model

The minutes from the April 16, 2015 Finance and Data Committee meeting are attached at the end of this document.

Traditionally DBHDID would hold a Public Forum to receive feedback on the state plan and hold it the day before the Planning Council meeting. The same staff would present the same PowerPoint presentation and the public were provided with opportunities to provide verbal and written feedback. Usually only a few individuals would attend the Public Forum despite advertising in two paper newspapers, one online newspaper, on the DBHDID home page, multiple email distributions to a wide variety of listservs, and at meetings. As it did not appear to be mandatory to hold a Public Forum this year in addition to a public Council meeting, DBHIDID chose to focus on increasing public attendance at the Council meeting, held August 13, 2015. This also served as an opportunity to educate guests about the Planning Council and make membership applications available.

This year, Department staff drafted the state plan and Council members and the public were invited to provide comments. The draft of the plan was placed as a Hot Topic on our Department website. The website also contains a document that lists opportunities to provide written and/or verbal feedback on the draft of the current state plan or on any of the approved state plans or implementation reports that are archived on the Council website. The public was invited to provide comments on the draft. Council members and the public were invited to the quarterly meeting of Council as one opportunity to provide verbal or written feedback. To give members time to review the document, staff provided the plan fifteen days prior to the quarterly meeting. As is customary with all Council meetings, members are offered travel reimbursement and a stipend to support their attendance. Staff provided a brief presentation on the state plan. Time was given on the agenda for comments on the plan. The Council created a letter confirming their participation and opportunity to review and provide feedback on it. At the Council meeting, staff encouraged the public and members to continue to submit feedback and provided information about how to submit comments via mail, fax, email, and telephone. Comments were encouraged up to the

submission date. Comments are included in the final document. An archive of past Block Grant reports is available for members to review at the Planning Council website. A copy of the August 13, 2015 minutes are attached at the end of this document.

Per KRS 45.351, the Department provides a draft of the Plan to the Legislative Research Commission (LRC) 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. The public is made aware of these hearings by the LRC's weekly The Legislative Calendar and email notification by statewide advocacy organizations. Video streaming of Interim Joint Committee meetings is occasionally available through Kentucky Educational Television (KET).

Kentucky's current Plans and Behavioral Health Reports as well as Plans and Reports from previous years are posted on the website of the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID). The status of each document is indicated beside it (draft, submitted or approved). A Plan or Report which indicates "draft" means the document is being made public to solicit comments and has not been submitted to SAMHSA. A Plan or Report that indicates "submitted" means that the document has been submitted to SAMHSA for approval. Once the document is submitted, SAMHSA has the opportunity to request BHDID make revisions on sections of the document. A Plan or Report that indicates "approved" means that the document has been reviewed by SAMHSA's staff and met eligibility for approval. BHDID welcomes and encourages the public to provide comments on Plans and Reports of any status.

2. *What planning mechanism does the state use to plan and implement substance abuse services?*

The Department has been sponsoring an annual substance abuse prevention and treatment conference called the Kentucky School of Alcohol and Other Drug Studies for forty-two years. This conference is planned by and attended by many individuals in recovery and their family members. It is attended by individuals in who work in the field in corrections, juvenile justice, homeless services, child welfare, behavioral health, independent providers, court services, and more. During this conference, staff receive vital feedback on the system of care, particularly related to service gaps and workforce needs. Videos and discussions are in the evenings and this is a particularly rich opportunity.

Department staff also solicits input from the regional substance abuse treatment directors and regional substance abuse prevention directors at quarterly peer group meetings.

3. *Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?*

The Kentucky Behavioral Health Planning and Advisory Council is actively transitioning toward becoming an integrated council. The following is a timeline of integration initiatives:

- **August 2009** – The Division of Mental Health and Substance Abuse holds a joint Public Forum for public comment on the SAPT and MH block grants.
- **January 2011** – The Membership Committee was provided with an update on changes proposed by SAMHSA and discussed the potential impact on membership and Council proceedings.
- **February 2011** – The Council was provided with an update on changes proposed by SAMHSA to combine the MHBG and SAPT block grants, revise report submission dates, Eight Strategic

Initiatives to incorporate into the application, and planning and outreach to additional vulnerable populations.

- **July 2011** – Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities decided to prepare and submit a Unified Block Grant Application on September 1. Staff were educated on new reporting requirements.
- **September 2011** - KDBHDID submitted a Unified Block Grant application for FY 2012.
- **October 2011** – The Council Membership application was revised to parallel membership categories referenced in the FY 2013 Block Grant Application guidance:

Former Membership Category	Current Membership Category
Adult Consumer of Mental Health Services	Individual in Recovery from a Mental Health and/or Substance Use Disorder
Family Member of An Adult with SMI	Family Member of an Individual in Recovery from a Mental Health and/or Substance Use Disorder
Parent of a Child with SED	Parent of a Child with Behavioral Health Challenges
Young Adult Consumer	Young Adult in Recovery from a Mental Health and/or Substance Use Disorder

- **November 2011** – Member categories were revised on selected print and electronic materials, such as name tents, membership roster, and website. Also, the Council asked that the Membership Application be revised to include the following statement: "Recovery is an on-going, non-linear process that may include relapse."
- **January 2012** – Membership Committee made a recommendation to the Bylaws Committee to add a statewide advocacy organization for individuals in recovery from a substance use disorder to the Council membership.
- **February 2012** – Staff reviewed the Consensus Statement on State MHAs and SSAs. The Council recommended forming an ad hoc committee to plan changes for Council transformation. To date, this committee has not convened due to competing priorities (e.g., implementation of Medicaid managed care on November 1, 2011 and January 1, 2013).
- **May 2012** – The Council received a prevention overview – prevention goals, prevention strategies, and Kentucky data.
- **May 2012** – The Council received a substance abuse treatment overview – services, priority populations, importance of integrated treatment and trauma-informed care, and data.
- **November 2012** – The Council adopted the name Kentucky Behavioral Health Planning and Advisory Council.
- **November 2012** – The Council added a membership seat for a statewide advocacy organization for individuals in recovery from substance use disorders.
- **January 2013** – The Executive Committee discussed the State Planning Council Application for Intensive Technical Assistance opportunity and made a recommendation to prepare and submit an application.

- **February 2013** – The Council submitted a State Planning Council Application for Intensive Technical Assistance to the Advocates for Human Potential, Inc.
- **March 2013** – The Council is awarded targeted technical assistance to integrate substance abuse prevention and treatment onto the Council.
- **July 2013** – The Council holds a special meeting with TA Consultant Fredrick Sandoval. It develops a list of prospective members, communication outlets, and two new committees.
- **August 2013** – The Council developed 2 Committees (Advocacy & Policy Committee and Services Committee) and a new committee structure of 5-7 committee members who are more active administratively, less reliant on staff and who use technology to meet on a more regular basis, possibly monthly. The new structure will be less expensive and more productive. Committees are still open meetings per Kentucky's Open Meeting Law.
- **September 2013** – The Membership Committee voted to recommend a representative on the Council from the Regional Prevention Center.
- **January 2014** – The Membership Committee recommended strengthening the marketing of the Council in order to increase integration and diversity of the Council.
- **April 2014** – The Membership Committee holds a conference call to begin drafting a Member Handbook and to revise the Council's brochure.
- **June 2014** – The Advocacy and Policy Committee submitted their inaugural set of Legislative Priorities to the Council. Members approved the Legislative Priorities and encouraged one another to use the information to engage their representatives in a dialogue.

4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?

Diversity is important to the Kentucky Behavioral Health Planning and Advisory Council. When choosing new members, the Membership Committee pays particular attention to ways each applicant will increase the diversity of voices and experiences on the Council.

In October 2007, the Membership Committee chose to emphasize the importance of diversity by including a diversity statement on the membership application. The statement reads as follows:

> The Kentucky Mental Health Planning and Advisory Council has an ongoing commitment to advancing diversity within its membership. We acknowledge that diversity includes any aspect of an individual that makes him or her unique. Our Council values and actively promotes diverse and inclusive participation by its officers, members, and staff. We recognize that diversity is vital to all elements of our mission.

In July 2008, the Membership Committee decided to include space on the membership application for applicants to include information about how they would contribute to the diversity of the Council. The current membership application includes the above language plus the following additional sentence:

> At your option, you may state how you would contribute to the diversity of the Council.

All applicants (100 percent of applicants reviewed in January 2015) chose to answer this question and Committee members find the information valuable as they consider membership. The diversity responses

are usually the most influential to Committee members because members learn where an applicant can truly fill a gap or provide a voice on the Council.

One tool that the Membership Committee uses to ensure geographic diversity is a state map with the residences of current members indicated. The Committee gives greater consideration to applicants who would represent an area of the state that is not currently represented. The Council experiences difficulty recruiting members from the western portion of the state. A different time zone and distance are barriers. Contrary to the roads and interstates approaching Frankfort from the east, north and south, the interstate from the western portion of the state has long stretches where there are no exits, gas stations, restaurants or rest areas. Joyce Soularie, our June 2014 CMHS Monitoring Visit Peer Reviewer from Arkansas, compared it to frontier territory. The Council plans to strengthen marketing efforts in the West by widely distributing the revised Council brochure in that area.

In 2011 the Membership Committee revised its Member Orientation and included Cultural Awareness as a topic. That section was prepared by a Council member using resources from the NAMI Multicultural Action Center. This material is presented annually by a Council member during the Member Orientation. The Membership Committee plans to review and update the material in the near future.

5. *Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI and SED.*

The Planning Council is comprised of the following adults in recovery, parents, and family members who all bring their diverse experiences and the input of those they collaborate with to the Council:

- Six adults in recovery from mental health disorders and/or substance use disorders;
- Six parents/grandparents/guardians/foster parents who have custody of a child (birth through age 20) with behavioral health challenges;
- Six family members of an adult in recovery from behavioral health disorders;
- One young adult in recovery from behavioral health disorders (age 18-25);
- One organization for individuals in recovery from substance use disorders;
- One organization for individuals in recovery from mental health disorders and/or co-occurring substance use disorders;
- One organization for family members of adults in recovery from mental health disorders and/or substance use disorders; and
- One organization for youth and family members of youth with significant behavioral health challenges.

Each of the advocacy organizations are connected with thousands of members and contacts. They are a valuable resource for sharing Council information across the state via email. One advocacy organization has been very successful at gathering meaningful information about system of care strengths and gaps through the use of online surveys and its vast following of contacts on its email distribution list. Over the next two years the Council will use this successful idea and build on it in the following ways:

1. The Finance and Data Committee will establish workgroups to develop surveys individualized to the target population of each of the four statewide advocacy organizations;
2. A report of each survey will be created;
3. The results of the surveys will be reviewed by the Finance and Data Committee and recommendations submitted to the Council; and

4. The Council will submit recommendations to the Commissioner of the Department for Behavioral Health, Developmental and Intellectual Disabilities.

The following is an excerpt from the Bylaws of the Council duties:

Duties: The Council shall do all of the following:

- Report directly to the Commissioner of the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (BHDID).
- Assist BHDID in designing a comprehensive, recovery-oriented system of care.
- Advise BHDID on the use of Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funds and Mental Health Block Grant (MHBG) funds and on the quality of statewide, recovery-oriented behavioral health services.
- Review the biennial combined SAPTBG and MHBG Application and annual Implementation Report pursuant to Public Law 102-321, Section 1915 (a) and to submit recommendations to BHDID, prior to the April 1 and December 1 due dates, respectively.
- Advocate for individuals in recovery, children and youth with behavioral health challenges, and family members.
- Monitor, review, and evaluate, not less than once a year, the allocation and quality of statewide, recovery-oriented behavioral health services.

In February 2013, Kentucky submitted an application for the State Planning Council Intensive Technical Assistance Grant and was awarded targeted technical assistance to integrate substance abuse prevention and treatment onto the Council. Fredrick Sandoval was selected as the consultant to Kentucky. Mr. Sandoval spent two and a half days working with the Council and staff in July 2013. As a result of that work, the Policy and Advocacy Committee was created with Cathy Epperson as its Chair. For the last two legislative sessions, the Policy and Advocacy Committee has drafted documents titled, *Kentucky Behavioral Health Planning and Advisory Council: Legislative Goals 2014,* and this year, *2015*. This year the Committee is advocating for the following three goals:

1. Increase access to effective mental health, substance use, prevention, treatment and recovery.
2. Promote integration of mental health, substance use and physical health care.
3. Provide housing for transition age youth and adult individuals living with co-occurring disorders.

Kentucky Behavioral Health Planning and Advisory Council
Finance Committee Meeting Summary
April 16, 2015 10:00am to 2:00pm
KY Transportation Cabinet, 200 Mero Street, 1st Floor, Conference Room C118, Frankfort, Kentucky

Members Present: Betty Jo Moss, Mary Singleton, Gayla Lockhart, Maggie Krueger, Sherry Sexton, Becky Clark, Becky Burton, LeeAnn Kelley, Brandon Kelley, Yayo Radder (KDE)
Staff Present: Michele Blevins, Missy Runyon, Christie Penn

Topic	Discussion	Next Steps
Call to Order & Introductions	Betty Jo Moss, Committee Chair, called the meeting to order at 10:04 AM. Committee members and staff introduced themselves.	
Overview of CMHCs	Michele Blevins reviewed the DBHDID SFY 2016 Budget for the CMHCs.	
Review of Kentucky's 2015-2016 Biennium Budget	Michele Blevins provided an informational overview of the Kentucky's 2015-16 Biennium Budget providing copies of the SFY 15 & 16 SA & MH Block Grant Allocations. Members reviewed the information and Michele answered questions.	
Block Grant Drafted Budgets for 2016	Committee members reviewed the SFY 2015 MHBG & SABG allocations. Members reviewed the information and Michele answered questions. Janice Johnston provided an overview of the 5% set aside for first episode psychosis grant. Summarized plans for the first year and long term goal over the following 6 years.	
Discussion and Recommendations	• Janice Johnston provided an overview of the TAYLRD grant. • Member stated - SA Budget is 3X the MH budget. "Is this because so many people are using drugs?" and "When looking at SA Treatment, do they look at those who are self-medicating? • One member stated, "It looks like we are being more specific on how we are spending our money." • Seven Counties reports that it costs $350,000/year to operate its Crisis line. • ACT, SE, SH, PS, TCM = DIVERTS to address the needs of individuals with mental health conditions who are coming out of Personal Care Homes (PCHs) or hospitals or at risk of going into PCH or hospital.	
Fund requests	• Homeless Prevention Project – Adanta requested $19,300 in additional funding for SFY 2016 (Current Funds: $96,500. MHBG) for the Homeless Prevention Project aimed at assisting individuals with mental health issues exiting institutions who do not have a home to go to. ** No members were opposed. • DBH staff requested $10,000. Of Substance Abuse Treatment funds to support the Oxford House Model. ** Members supported it. • Request was made to provide $60-65,000 MHBG funds for First Episode of Psychosis (in excess of 5% set aside for First Episode of Psychosis) to allow $200,000 for each chosen implementation site. ** Members supported it. Members were also in support of spending additional SAPT BG funds for Peer Support (SA) although a specific funding request was not shared.	
Adjournment	Mary Singleton made a motion to adjourn the meeting, Lee Ann Kelley seconded and **Motion passed.** The meeting adjourned at 2:17 PM.	Next Meeting April 21, 2016 10:00 AM - 2:00 PM Location TBD

At the 4/17/14 Finance Committee Mtg. of the KY BHPAC members were asked to provide feedback and recommendations to the BHDID staff regarding MH Block Grant Allocations for SFY 2015.

Recommended Priorities

With the implementation of ACA, SAMHSA has directed states that Block Grant funds should be directed toward four (4) purposes, including:

(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.

1. SAMHSA's 6 Strategic Initiatives

- Prevention
- Health Care and Health Systems Integration
- Trauma and Justice **(1)**
- Recovery Support **(1)**
- Health Information Technology
- Workforce

2. Services

- Suicide Prevention **(2)**
- Supported Employment **(1)**
- Peer Support **(1)**
- Supported Housing **(2)**
- Transition Services for Young Adults **(2)**
- Consumer Operated Peer Services **(3)**
- Other (please specify): **(1)**
  - Adolescent recovery Groups – SAFE ones
  - Quality safe child care for parents in treatment at consumer run centers

3. Populations

- Adults with SMI **(2)**
- Children with SED **(3)**
- Military, Veterans, and Family Members **(2)**
- Individuals with Substance Use Disorders **(1)**
- Individuals with Co-occurring Disorders **(2)**
- Transition-Age Youth **(3)**
- Individuals Who Are LGBTQ **(1)**
- Individuals Who Are a Racial or Ethnic Minority **(2)**
- Individuals Who Are Homeless **(1)**
- Individuals Residing in Rural Areas **(2)**
- Other (please specify): **(1)**
  - Mental Health Support Groups in Schools

Additional Comments:

"Increase this knowledge of how 'assistance' gets out to the individuals with substance use disorders & the employment occupational support system. (Increase outreach.)"

"Address the (???) w/ some mental health services."

"Need more awareness for transition services for young adults."

"More money for consumer operated peer services."

"Awareness & Education for military, veterans and family members, individuals who are LGBTQ, individuals who are a racial or ethnic minority, individuals residing in rural areas. Need for knowledge & transportation."

"extra for our ones with a passion for living that comes from a group that has hope of there dream of a future of living on there own in this time of there life a hand up will be welcomed." [sic]

"I absolutely believe training & implementation of TRAUMA AWARE approach to treatment is necessary. Current evidenced based therapies being used @ trauma treatment centers need to be included w/ substance abuse recovery & prevention treatment. The two are inextricably linked & the trauma piece actually is considered biological by some insurance. If the consumer cannot learn to cope w/ past/current trauma, they will have a hard time recovering."

- Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[97]

Additionally, **Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51)** applicable to the SABG and the MHBG, requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.

For MHBG and integrated BHPC; States must include documentation that they shared their application and implementation report with the Planning Council; please also describe the steps the state took to make the public aware of the plan and allow for public comment.

SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).
2. What mechanism does the state use to plan and implement substance abuse services?
3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[98]

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[97] **http://beta.samhsa.gov/grants/block-grants/resources**

[98] There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Kentucky Behavioral Health Planning & Advisory Council

Mary Singleton, Chair • Vacant, Vice Chair • Gayla Hayes, Secretary
275 East Main Street, Frankfort, Kentucky 40601

August 13, 2015

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, MD 20857

Dear Ms. Simmons:

I am writing on behalf of Kentucky's Behavioral Health Planning & Advisory Council to confirm that Council members have reviewed Kentucky's drafted FY 2016-2017 Combined Behavioral Health Assessment and Plan. 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 2015.

Our Council has met quarterly over the past year. Committees have met to carry out their work and members have been diligent as we continue to build a solid Council that guide the development of Kentucky's behavioral health system of care. Recent activities of the Council include the following:

- The Council Bylaws have been revised to reflect the expanded scope of the Council and to include a prevention representative as a voting member;
- The Policy and Advocacy Committee recommended legislative priorities, which the Council adopted and members used to advocate with legislators;
- Finance Committee members reviewed Block Grant appropriations and made recommendations for reserve funds;
- The Membership Committee has revised its Member Orientation and Council brochure to reflect the expanded scope of the Council and has created a Member Handbook;
- The Department has recently been awarded several SAMHSA grants and has asked the Council to serve in an advisory capacity as these are implemented. We look forward to these opportunities and the benefit they promise for our citizens.

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

Sincerely,

Mary Singleton

Mary Singleton
Chair, Kentucky Behavioral Health Planning & Advisory Council

Cc: Mary Begley, Commissioner, Department for Behavioral Health, Developmental & Intellectual Disabilities
Natalie Kelly, Director, Division of Behavioral Health