

# Kentucky

## UNIFORM APPLICATION

FY 2020/2021 Block Grant Application

SUBSTANCE ABUSE PREVENTION AND TREATMENT

and

COMMUNITY MENTAL HEALTH SERVICES

BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022  
(generated on 03/03/2020 10.49.38 AM)

Center for Substance Abuse Prevention

Division of State Programs

Center for Substance Abuse Treatment

Division of State and Community Assistance

and

Center for Mental Health Services

Division of State and Community Systems Development

## State Information

### State Information

#### Plan Year

Start Year 2020

End Year 2021

#### State SAPT DUNS Number

Number 927049767

Expiration Date

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

Agency Name Cabinet for Health and Family Services

Organizational Unit Department for Behavioral Health, Developmental and Intellectual Disabilities

Mailing Address 275 East Main Street 4 W-G

City Frankfort

Zip Code 40621

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

First Name Michele

Last Name Blevins

Agency Name Cabinet for Health and Family Services

Mailing Address 275 East Main Street 4W-G

City Frankfort

Zip Code 40621

Telephone 502-782-6150

Fax 502-564-4826

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 40621

#### 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 502-564-6150

Fax 502-564-4826

Email Address michele.blevins@ky.gov

### III. Third Party Administrator of Mental Health Services

Do you have a third party administrator?  Yes  No

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

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

From

To

### V. Date Submitted

Submission Date 9/3/2019 4:00:56 PM

Revision Date 3/3/2020 10:48:22 AM

### VI. Contact Person Responsible for Application Submission

First Name Michele

Last Name Blevins

Telephone 502-782-6150

Fax 502-564-4826

Email Address michele.blevins@ky.gov

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

**Footnotes:**

# State Information

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

Fiscal Year 2020

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

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

Section 1943	Additional Requirements	<a href="#">42 USC § 300x-53</a>
Section 1946	Prohibition Regarding Receipt of Funds	<a href="#">42 USC § 300x-56</a>
Section 1947	Nondiscrimination	<a href="#">42 USC § 300x-57</a>
Section 1953	Continuation of Certain Programs	<a href="#">42 USC § 300x-63</a>
Section 1955	Services Provided by Nongovernmental Organizations	<a href="#">42 USC § 300x-65</a>
Section 1956	Services for Individuals with Co-Occurring Disorders	<a href="#">42 USC § 300x-66</a>

## ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

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

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

## LIST of CERTIFICATIONS

### 1. Certification Regarding Debarment and Suspension

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

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

### 2. Certification Regarding Drug-Free Workplace Requirements

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

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

### 3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs.

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

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

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

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

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

#### **5. Certification Regarding Environmental Tobacco Smoke**

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

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

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

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

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

### **HHS Assurances of Compliance (HHS 690)**

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

State: \_\_\_\_\_

Name of Chief Executive Officer (CEO) or Designee: Adam Meier \_\_\_\_\_

Signature of CEO or Designee<sup>1</sup>: \_\_\_\_\_

Title: Cabinet Secretary \_\_\_\_\_

Date Signed: \_\_\_\_\_

mm/dd/yyyy

\_\_\_\_\_ <sup>1</sup>If the agreement is signed by an authorized designee, a copy of the designation must be attached.

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

**Footnotes:**

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

State: Kentucky

Name of Chief Executive Officer (CEO) or Designee: Adam Meier

Signature of CEO or Designee: 

Title: Cabinet Secretary

Date Signed: 8-26-19  
mm/dd/yyyy

<sup>1</sup>If the agreement is signed by an authorized designee, a copy of the designation must be attached.

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

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to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §57401 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).

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## LIST of CERTIFICATIONS

### 1. Certification Regarding Debarment and Suspension

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

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

### 2. Certification Regarding Drug-Free Workplace Requirements

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

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

### 3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs.

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

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

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

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

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

#### **5. Certification Regarding Environmental Tobacco Smoke**

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

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

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

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

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

**HHS Assurances of Compliance (HHS 690)**

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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



COMMONWEALTH OF KENTUCKY  
OFFICE OF THE GOVERNOR

MATTHEW G. BEVIN  
GOVERNOR

700 CAPITOL AVENUE  
SUITE 100  
FRANKFORT, KY 40601  
(502) 564-2611  
FAX: (502) 564-2517

August 16, 2017

Grants Management Officer  
Office of Financial Resources, Division of Grants Management  
Substance Abuse and Mental Health Services Administration  
5600 Fisher Lane, Rm 17E20  
Rockville, MD 20857

To Whom It May Concern:

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

Please contact Michele Blevins, Assistant Director within the Division of Behavioral Health, if you have any questions. You may reach Ms. Blevins electronically at [Michele.Blevins@ky.gov](mailto:Michele.Blevins@ky.gov) or by phone at (502) 782-6150.

Sincerely,

A handwritten signature in black ink, appearing to read "Matthew G. Bevin".

Matthew G. Bevin  
Governor





**CABINET FOR HEALTH AND FAMILY SERVICES  
OFFICE OF THE SECRETARY**

**Matthew G. Bevin**  
Governor

275 East Main Street, 5W-A  
Frankfort, KY 40621  
502-564-7042  
502-564-7091  
www.chfs.ky.gov

**Adam M. Meier**  
Secretary

October 21, 2019

Wendy Pang  
SAMHSA  
Center for Mental Health Services  
5600 Fishers Lane  
Room 17E21C  
Rockville, MD 20857

Dear Ms. Pang,

This letter serves as an attestation to certify that the grantee organization/recipient, State, and all sub-recipients of the grant entitled **KY SUBSTANCE ABUSE PREVENTION & TREATMENT BLOCK GRANT (6B08T1010021-19M001)** will comply with the following NoA language:

*"Grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. See, e.g., 45 C.F.R. § 75.300(a) (requiring HHS to "ensure that Federal funding is expended . . . in full accordance with U.S. statutory . . . requirements."); 21 U.S.C. §§ 812(c)(10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the DEA and under an FDA-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under federal law."*

Correspondence containing attestation statements from award sub-recipients are appended to this letter. Thank you for your prompt attention to this matter.

Sincerely,

Adam M. Meier  
Secretary, Cabinet for Health and Family Services

Cc: Michele Blevins, Principal Investigator





**CABINET FOR HEALTH AND FAMILY SERVICES  
OFFICE OF THE SECRETARY**

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Secretary, Cabinet for Health and Family Services

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## State Information

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

#### Fiscal Year 2020

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

<b>Title XIX, Part B, Subpart II of the Public Health Service Act</b>		
Section	Title	Chapter
Section 1911	Formula Grants to States	<a href="#">42 USC § 300x</a>
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	<a href="#">42 USC § 300x-1</a>
Section 1913	Certain Agreements	<a href="#">42 USC § 300x-2</a>
Section 1914	State Mental Health Planning Council	<a href="#">42 USC § 300x-3</a>
Section 1915	Additional Provisions	<a href="#">42 USC § 300x-4</a>
Section 1916	Restrictions on Use of Payments	<a href="#">42 USC § 300x-5</a>
Section 1917	Application for Grant	<a href="#">42 USC § 300x-6</a>
<b>Title XIX, Part B, Subpart III of the Public Health Service Act</b>		
Section 1941	Opportunity for Public Comment on State Plans	<a href="#">42 USC § 300x-51</a>
Section 1942	Requirement of Reports and Audits by States	<a href="#">42 USC § 300x-52</a>
Section 1943	Additional Requirements	<a href="#">42 USC § 300x-53</a>
Section 1946	Prohibition Regarding Receipt of Funds	<a href="#">42 USC § 300x-56</a>
Section 1947	Nondiscrimination	<a href="#">42 USC § 300x-57</a>
Section 1953	Continuation of Certain Programs	<a href="#">42 USC § 300x-63</a>
Section 1955	Services Provided by Nongovernmental Organizations	<a href="#">42 USC § 300x-65</a>
Section 1956	Services for Individuals with Co-Occurring Disorders	<a href="#">42 USC § 300x-66</a>

## ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

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

State (Clear Air) Implementation Plans under Section 176(c) of the 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).

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17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

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  - a. Checking the Exclusion Extract located on the System for Award Management (SAM) at <http://sam.gov>
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The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

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

### 3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs.

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

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

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

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

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

#### **5. Certification Regarding Environmental Tobacco Smoke**

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

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

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

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

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

### **HHS Assurances of Compliance (HHS 690)**

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

Name of Chief Executive Officer (CEO) or Designee: Adam Meier

Signature of CEO or Designee<sup>1</sup>: \_\_\_\_\_

Title: Cabinet Secretary

Date Signed: \_\_\_\_\_

mm/dd/yyyy

<sup>1</sup>If the agreement is signed by an authorized designee, a copy of the designation must be attached.

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

**Footnotes:**

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: Adam Meier

Signature of CEO or Designee<sup>1</sup>: 

Title: Cabinet Secretary

Date Signed: 8-26-19  
mm/dd/yyyy

<sup>1</sup>If the agreement is signed by an authorized designee, a copy of the designation must be attached.

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

**Footnotes:**

# State Information

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

Fiscal Year 2020

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

## ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §5794), 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 Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §57401 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. §52131 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. §54801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

## LIST of CERTIFICATIONS

### 1. Certification Regarding Debarment and Suspension

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

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

### 2. Certification Regarding Drug-Free Workplace Requirements

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

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

### 3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs.

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1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
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By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

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

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
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4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
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The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

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



COMMONWEALTH OF KENTUCKY  
OFFICE OF THE GOVERNOR

MATTHEW G. BEVIN  
GOVERNOR

August 25, 2017

700 CAPITOL AVENUE  
SUITE 100  
FRANKFORT, KY 40601  
(502) 564-2611  
FAX (502) 564-2517

Grants Management Officer  
Office of Financial Resources, Division of Grants Management  
Substance Abuse and Mental Health Services Administration  
5600 Fisher Lane, Rm 17E20  
Rockville, MD 20857

To Whom It May Concern:

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

Please contact Michele Blevins, Assistant Director within the Division of Behavioral Health, if you have any questions. You may reach Ms. Blevins electronically at [Michele.Blevins@ky.gov](mailto:Michele.Blevins@ky.gov) or by phone at (502) 782-6150.

Sincerely,

A handwritten signature in black ink, appearing to read "Matthew G. Bevin".

Matthew G. Bevin  
Governor



**CABINET FOR HEALTH AND FAMILY SERVICES  
OFFICE OF THE SECRETARY**

**Matthew G. Bevin**  
Governor

275 East Main Street, 5W-A  
Frankfort, KY 40621  
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www.chfs.ky.gov

**Adam M. Meier**  
Secretary

October 21, 2019

Wendy Pang  
SAMHSA  
Center for Mental Health Services  
5600 Fishers Lane  
Room 17E21C  
Rockville, MD 20857

Dear Ms. Pang,

This letter serves as an attestation to certify that the grantee organization/recipient, State, and all sub-recipients of the grant entitled **COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT (3B09SM010021-19S4)** will comply with the following NoA language:

*"Grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. See, e.g., 45 C.F.R. § 75.300(a) (requiring HHS to "ensure that Federal funding is expended . . . in full accordance with U.S. statutory . . . requirements."); 21 U.S.C. §§ 812(c)(10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the DEA and under an FDA-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under federal law."*

Correspondence containing attestation statements from award sub-recipients are appended to this letter. Thank you for your prompt attention to this matter.

Sincerely,

Adam M. Meier  
Secretary, Cabinet for Health and Family Services

Cc: Michele Blevins, Principal Investigator



**CABINET FOR HEALTH AND FAMILY SERVICES  
OFFICE OF THE SECRETARY**

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## 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

Adam Meier

Title

Cabinet Secretary

Organization

Kentucky Cabinet for Health and Family Services

---

Signature:

Date:

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

**Footnotes:**

N/A for the State of Kentucky

## State Information

### Disclosure of Lobbying Activities

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

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Name

Adam Meier

Title

Cabinet Secretary

Organization

Kentucky Cabinet for Health and Family Services

---

Signature:



Date:

8-26-19

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

**Footnotes:**

## Planning Steps

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

Narrative Question:

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

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

**Footnotes:**

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

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

The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) administers a comprehensive, community-based system of behavioral health care for adults with serious mental illness (SMI), children with severe emotional disabilities (SED), and their families, and adults and youth with substance use disorders. DBHDID is building a statewide network of early intervention services and supports to address first episode psychosis. With guidance from SAMHSA's *Strategic Plan: FY2019 - FY2023*, 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.

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 Department 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 to achieve its service and quality goals.

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

- Office of the Secretary;
- Office of Health Data & Analytics (including KY Health Information Exchange and KY Health Benefit Exchange);
- Office of the Inspector General (Certificates of Need, Licensing and Regulation Authority);
- Office of Public Affairs;
- Office of the Ombudsman;
- Office for Children with Special Health Care Needs
- Department for Public Health (Local and State Public Health Programs);
- Department for Medicaid Services (Medicaid Authority);
- Department for Aging and Independent Living (Aging, Guardianship, Long-term Care Services);
- Department for Community-Based Services (Adult and Child Protection, Child Welfare);
- Department for Income Support (Disability Determinations, Child Support Enforcement); and
- Department for Family Resource Centers and Volunteer Services.

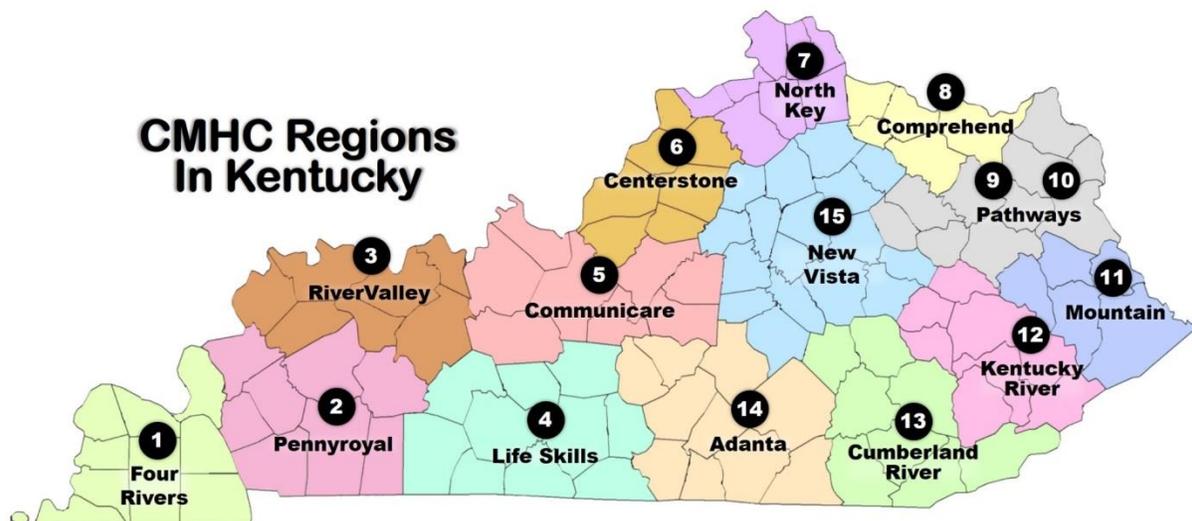
<http://chfs.ky.gov/agencies/pages/default.aspx>

Within DBHDID, there are four Divisions, including: Administration and Financial Management; Developmental and Intellectual Disabilities; Program Integrity and Behavioral Health. The Division of Behavioral Health is a product of the merger of the Division of Substance Abuse and the Division of Mental Health in July 2004. With an increased focus on the treatment needs of individuals with co-occurring disorders (mental health and substance use) at the national, state and local level, the Division is aimed at ensuring an integrated, seamless service system.

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

- *Behavioral Health Prevention and Promotion Branch* – Oversees the programs associated with the prevention of the abuse of alcohol, tobacco and other drugs in Kentucky, as well as Suicide Prevention and Zero Tolerance (under age 21 driving under the influence) programs. The Branch is also responsible for completing the Annual Synar Report;
- *Adult Substance Abuse Treatment and Recovery Services Branch* – Oversees the administration of the community based, outpatient and residential services, including those for men, women, pregnant women and women with dependent children. The Branch also houses the Driving Under the Influence (DUI) Program;
- *Children's Behavioral Health and Recovery Services Branch* - Oversees the services and supports for children and youth who have or are at-risk of developing behavioral health concerns (including both mental health and substance use) and their families. The branch also leads Kentucky's efforts to address first episode psychosis; and
- *Adult Mental Health Services and Recovery Branch* - Oversees the planning and implementation of mental health services for adults with serious mental illness. The branch facilitates implementation teams for Assertive Community Treatment, Peer Support, Person Centered Recovery Planning, Supported Employment (utilizing the Individual Placement and Support –IPS model, and Supportive Housing.

Kentucky is divided into fourteen (14) geographic regions for the purposes of planning and providing publicly funded community mental health, substance use and prevention services. A Regional Board has been established pursuant to KRS 210.370-210.480 (<http://www.lrc.ky.gov/KRS/210-00/370.PDF>) as the planning authority for behavioral health programs in each region and these generally align with the Area Development Districts (ADD) throughout the Commonwealth. County and municipal governments generally do not provide community behavioral health services. A Regional Board is an independent, non-profit organization that is governed by a volunteer board of directors that broadly represents stakeholders (including consumers and family members) and counties in the region. These fourteen agencies are 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 1 - 15.

KRS 210.410 authorizes the Secretary of the CHFS to make state grants and other funding allocations to Regional Boards to provide, at a minimum, the following behavioral health services: Inpatient Services; Outpatient Services; Partial Hospitalization or Psychosocial Rehabilitation Services; Emergency Services; Consultation and Education Services; and Services for Individuals with an Intellectual Disability. Behavioral health services, including mental health services for adults and children, substance abuse services for adults and adolescents, and services for individuals with co-occurring disorders are provided in county level clinics and a number of services may also be provided off-site in homes, school and in other community locations. In addition to the clinics, there are 14 Regional Prevention Centers established to provide technical assistance and training on evidence-based prevention strategies. While the main focus is aimed at Primary Prevention for substance abuse, they also support some selective and indicated prevention strategies (using funds other than those set aside for Primary Prevention) when those activities directly support the Primary Prevention goals for each region identified through a comprehensive needs assessment. With its available resources of state general funds, block grant/other federal funds, and awarded agency funds, DBHDID contracts with the 14 private, not-for-profit CMHCs to provide services to citizens in all 120 counties of the state. These funds are awarded annually and contracts may be modified throughout the year. The fiscal year of operation is July 1 through June 30. CMHCs are required to specifically describe their current systems of care for adults and children, including crisis care, and are required to report their plans for development regarding key system components, within an *Annual Plan & Budget* process. DBHDID is committed to working collaboratively with CMHCs to continuously enhance continuity of care, implementation of evidence based practices and service effectiveness and accountability. DBHDID contracts with several CMHCs and a few other community-based, non-profit, entities to provide additional targeted services. Examples of these include programming for Supported Employment, Supportive Housing, and specialized residential treatment for men, women, pregnant women and parents with dependent children, youth, and individuals with substance use disorders and individuals who are homeless.

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

- Fourteen community mental health centers;
- Two state-operated psychiatric hospitals;
- Two state-contracted psychiatric hospitals;
- Four intermediate care facilities for individuals with intellectual disability; and
- Two non-profit agencies contracted to provide specialized services to individuals with substance use disorders.

Kentucky is not a very diverse state racially and there are no designated tribes but it is considered very diverse in culture from one area of the state to the other and there are great differences in income/wealth among residents across the state. The population of Kentucky is 88% White alone, 8.4% Black or African American alone, 1.6% Asian alone, .5% Native Hawaiian or Other Pacific Islander alone, 2% Other or Mixed Race, .3% American Indian and Alaska Native. The percent of the population that is Hispanic or Latino is increasing and is currently around 3.8%. The median income in Kentucky is \$46,535/year.

CHFS and DBHDID are committed to addressing health disparities, particularly access to quality behavioral health services for all citizens. DBHDID is a member of the Juvenile Justice Oversight Council, Juvenile Justice Advisory Board/subcommittee for Equity and Justice for All Youth, Differential Treatment Workgroup and the Disproportionality and Disparities standing committee of the State Interagency Council. The Treatment workgroup is currently analyzing statewide and

regional program performance data, disaggregated by race, ethnicity, gender and disability to determine if there are differences in access, use and outcomes. Providers are responsible for ensuring all staff participate in cultural awareness and sensitivity training regularly and that their policies and procedures do not discriminate but rather encourage inclusion of all citizens. Many CMHCs also focus on cultural competency and racial, ethnic and sexual gender awareness in employee performance evaluation efforts and provide specific and detailed goals and objectives whenever deficits are identified. Additionally, the State Epidemiological Outcomes Workgroup analyzes the KIP survey data, and other state and local-level consequence and consumption data to determine where health disparities exist in order to guide primary prevention intervention delivery.

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 majority of care in these facilities is provided with state general funds. Three of the four are IMD designated facilities.

State Hospital/Location Operation	ADC* SFY 2016	ADC* SFY 2017	ADC* SFY 2018	ADC* SFY 2019
Western State Hospital/ Hopkinsville State Operated	126	113	115	114
Central State Hospital/ Louisville State Operated	47	57	58	54
Eastern State Hospital/ Lexington Contracted	115	130	127	102
Appalachian Regional Hospital (ARH) Psychiatric Center/Hazard Contracted	74	56	54	102
<b>TOTAL</b>	<b>362</b>	<b>356</b>	<b>354</b>	<b>372</b>

\*ADC = Average Daily Census

Data Source: Client Event Data/Report ID: FIS\_ADC\_YR

Kentucky Correctional Psychiatric Center (KCPC) is an inpatient psychiatric hospital, located within a correctional system complex, but operated by DBHDID. It primarily provides court-ordered inpatient evaluation and treatment to restore competency to persons charged with a felony offense. When inpatient evaluation is unnecessary, KCPC facilitates outpatient competency evaluations through contracts for professional services with CMHCs. The facility's average daily census in SFY 2018 was 62 people.

Kentucky does not operate any state funded inpatient facilities for children/youth under 18 years of age. There are currently 596 available child psychiatric beds located in 13 hospitals that are geographically located in 9 of the 14 regions. Other residential care for children includes Psychiatric Residential Treatment Facilities (PRTFs), Private Child Care (PCCs) facilities and Therapeutic Foster Care (TFC) contracted by the Department for Community Based Services, Kentucky's child welfare agency.

**Psychiatric Inpatient Utilization - Statewide - Children and Adolescents 0-17 Years of Age**

Calendar Year	Number of Hospitals	Total # Licensed Child/Adolescent Beds	Total # Child/Adolescent Beds in Operation	Total # Admissions	Total # Inpatient Days	Average Daily Census (ADC)	Average Length of Stay (ALOS)	Occupancy %
2014	13	611	608	11,989	116,274	319	9.68	52.14%
2015	13	627	595	11,287	121,630	333	10.49	53.15%
2016	13	712	609	10,609	123,612	338	11.90	47.44%
2017	13	699	596	11,473	131,449	360	11.15	51.52%
2018	13	700	596	11,098	124,190	340	11.52	48.61%

Data Source: Kentucky Office of Health Data & Analytics: [Annual Hospital Utilization and Services Reports](#)

The Office of Inspector General, an agency within CHFS, is the regulatory agency for licensing all health care facilities, day cares, long-term care facilities, and child adoption/child-placing agencies in the Commonwealth. The child welfare and juvenile justice agencies are the only state agencies authorized to take custody of children. Neither provider licensing, or “care, custody and control” of children are a function of the Kentucky Department for Medicaid Services (DMS) or DBHDID.

Kentucky has been applauded over the years for making a small amount of funding go a long way but ultimately the behavioral health system in Kentucky has been underfunded and unbalanced between community based services and inpatient/institutional care. Over the last decade, progress has been made to give more funding from the residential/facilities side of the equation and increased access to much needed services in the community. However, both remain at the bottom of state spending as rankings range from 45<sup>th</sup> to 47<sup>th</sup> among several sources, in recent years. Current year data was not readily available.

[www.governing.com/gov-data/health/mental-health-spending-by-state.html](http://www.governing.com/gov-data/health/mental-health-spending-by-state.html)

<http://www.pewtrusts.org/en/archived-projects/state-health-care-spending>

<https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/State-Mental-Health-Legislation-2015/NAMI-StateMentalHealthLegislation2015.pdf>

The availability and funding of behavioral health services in Kentucky has seen some significant changes in recent years due to a variety of factors. Since the time of deinstitutionalization in the 1960s, Kentucky’s publicly funded services system for community based, non-residential, mental health and substance use has relied, almost solely, on a network of fourteen 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 history of recent changes.

In November 2011, Kentucky transitioned its Medicaid program to managed care by initiating 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, 2017, 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, Aetna, Anthem and Passport Health Plan. There is currently a *Request for Proposals* posted and new MCO contracts will be awarded in January 2020.

In May 2013, the decision to expand Medicaid eligibility in Kentucky pursuant to the Affordable Care Act was announced, allowing individuals and families earning up to 138 percent of the federal poverty line to enroll in an insurance plan. Kentucky created Kynect, an on-line health insurance marketplace to allow citizens to learn about and select health insurance plans. The system allowed Medicaid eligible individuals to sign up for coverage through the marketplace. Medicaid coverage for the expansion population began Jan. 1, 2014. Over 450,000 Kentuckians enrolled in health coverage under Medicaid expansion and an additional 105,877 enrolled in coverage through a Qualified Health Plan.

The current Administration believes that Kentucky's Medicaid program is not financially sustainable. On August 24, 2016, Kentucky submitted an application for a section 1115(a) demonstration entitled, "Helping to Engage and Achieve Long Term Health (HEALTH)." It is aimed at encouraging Kentuckians to get healthier and to transition to the commercial health insurance market to become independent of the government program. Currently, an implementation date is uncertain. On January 24, 2019 another lawsuit was filed in federal district court to challenge CMS's re-approval of the waiver and on March 27, 2019, the federal district court ruled to block CMS's re-approval of the waiver. On April 10, 2019, the Trump administration filed a notice of appeal to challenge the federal district court's ruling.

The Kentucky Department for Medicaid Services has had State Plan Amendments (SPAs) approved in recent years and this has resulted in the expansion of Medicaid benefits for clinic, rehabilitation and targeted case management services. Perhaps the most significant is the addition of coverage for services for substance use disorders. Historically, Kentucky was in the minority of states that did not have a Medicaid benefit for substance use treatment, except for pregnant women. Along with developing new behavioral health services through the Medicaid SPAs, the decision was made to expand the eligibility of professionals and organizations that are eligible to apply for and become Medicaid providers. Today the number of behavioral health providers who are able to seek reimbursement for Medicaid payment, through the MCOs, is growing steadily. There are a greater number of licensed professionals who may apply to become Medicaid providers including, Licensed Clinical Social Workers, Licensed Marriage and Family Therapists, Licensed Professional Clinical Counselors, Licensed Psychologists, Licensed Art Therapists, Certified Behavioral Analysts, and Licensed Alcohol and Drug Counselors. Several new licensure categories have been created including, Behavioral Health Services Organizations (BHSOs) and Multi-Specialty Groups (MSGs). A few services are limited 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 regulations has ensued.

Another catalyst for new legislation and regulatory changes has been the escalation of the misuse of prescription drugs and other opioid use in Kentucky. All age groups have been effected by this epidemic and efforts are currently underway to address the increase in opioid overdose deaths, substance exposed infants, children placed in out-of-home care due to the death, incarceration or drug use by parents. Kentucky's efforts related to the nation's opioid epidemic has been widespread, seeking to stem the number of overdose deaths, create an effective pathway for individuals to engage in accessible treatment once an overdose has occurred/been reversed with medication and engage in robust universal, selective and indicated prevention efforts. The Kentucky Opioid Response Effort (KORE) focuses its efforts across the continuum of need, including prevention, treatment and recovery support services.

The Kentucky Incentives for Prevention (KIP) Survey is the primary data source used to set SAPT block grant priorities and to track outcomes for prevention. The KIP survey, conducted in 151 of Kentucky's 173 school districts, provides data at the county or school district level for grades 6,8,10, and 12. The KIP survey, implemented in even numbered years, is modeled after the national *Monitoring the Future* survey. Data indicates that 128,759 students participated in the KIP survey in 2018. In addition to the KIP survey, Kentucky also tracks usage rates through the National Survey on Drug Use and Health (NSDUH), which is implemented annually among randomly selected youth aged 12 and older and the Youth Risk Behavioral Survey System (YRBSS). The NSDUH data allows us to track general usage rates among youth ages 12 – 17 on an annual basis. NSDUH also provides much needed adult data which is used to set priorities for the over 17 population. YRBSS is implemented every two years in odd numbered years and provides state level consumption data. With this broad approach to data collection, plus additional local surveys and data, Kentucky's substance use Preventionists complete thorough needs assessments to guide their community-level efforts.

## Planning Steps

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

#### Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system. 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 the unmet service needs and gaps.

A data-driven process must support the state's priorities and goals. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data sets including, but not limited to, the [National Survey on Drug Use and Health](#) (NSDUH), the [Treatment Episode Data Set](#) (TEDS), the [National Facilities Surveys on Drug Abuse and Mental Health Services](#), and the [Uniform Reporting System](#) (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorder prevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

In addition to in-state data, SAMHSA has identified several [other data sets](#) that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the [Healthy People Initiative](#)<sup>16</sup> HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

<sup>16</sup> <http://www.healthypeople.gov/2020/default.aspx>

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

#### Footnotes:

## II. Planning Steps

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

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

- Analyzing data reports for performance indicators and deliverables in provider contracts;
- Communicating data trends to providers in various forums;
- Children's system of care development & child welfare reform;
- Readiness assessment conducted for competitive grant applications;
- 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:

- The implementation of the Affordable Care Act and Medicaid Expansion in Kentucky;
- The 1115 Medicaid Waiver request to CMS to transform Kentucky's Medicaid program, by the current Administration;

- The 21<sup>st</sup> Century Cures Act and the subsequent award of substantial federal funding for the Kentucky Opioid Response Effort (KORE);
- The increasingly large network of Medicaid/MCO enrolled behavioral health providers that are working to implement an array of behavioral health services;
- The continued work on implementation of additional rehabilitation and targeted case management services as outlined in the amended Medicaid state plan, especially services for substance use disorder services, crisis services and evidence based practices for adults with SMI;
- The continued promulgation new/amended regulations, in collaboration with the Departments for Medicaid, Aging and Independent Living, Community Based Services, Corrections and the Administrative Office of the Courts, in order to adequately outline all available services and supports;
- The full implementation of performance based contracting, by DBHDID;
- The reduction in state general funds allocated to DBHDID as a result of anticipated savings with more services being Medicaid billable and more individuals receiving Medicaid funded behavioral health benefits (\$21 Million in SFY 2015; \$30 Million in SFY 2016);
- The ten percent (10%) funding cut imposed as a result of state revenues not meeting the State Budget Director's office's expectations in SFY 2017;
- The *Second Amended Settlement Agreement* between the Cabinet of Health and Family Services and Kentucky Protection and Advocacy (signed October 2019);
- The rebalancing of DBHDID facility funds to community funds for *Direct Intervention Very Early Response Treatment System (DIVERTS)* services to support individuals identified through the Amended Settlement Agreement;
- The transition, by the Kentucky Department for Medicaid Services (DMS), to managed care oversight for all of health, including behavioral health care, services. There are currently five MCOs contracted to serve Kentucky and each has its unique, required processes for prior authorizations, billing and monitoring activities, etc.;
- The recent legislative actions (including unfunded mandates);
- The influx of returning Service Members, Veterans and their Families (SMVF) with behavioral health needs;
- The continued workforce issues and shortages, especially in rural areas;
- The current Administration's priorities; and
- The underfunded state pension system and the increased retirement contributions required by the majority of the CMHCs.

Priorities identified by the Kentucky Behavioral Health Planning and Advisory Council (BHPAC) include the following, as discussed at the Finance and Data Committee meeting of the BHPAC in April 2019:

- Transitional Housing, including individuals in recovery from substance use disorders with dependent children;
- Oxford Houses, an evidence based practice for supported housing for individuals in recovery from substance use disorders;
- Diversion programming from criminal justice or juvenile justice settings;
- Early Interventions for First Episode Psychosis;
- Supported Employment and Supportive Housing programs;
- Behavioral health treatment for Service Members, Veterans and Families (SMVF); and
- Emergency preparedness planning.

The following DBHDID priorities have been identified by DBHDID leadership:

- Preserve and enhance the behavioral health safety network to ensure access to meaningful services for at-risk and underserved populations;

- Develop and expand a recovery oriented system of care to address the opioid crisis and other substance use disorders, including administration of the SAMHSA funded, KORE initiatives;
- Support and promote the behavioral health and wellness of children and families involved with or at risk of involvement with child welfare;
- Promote employment and fully implement supported employment and supported education statewide;
- Decriminalization of behavioral health disorders;
- Continuing full implementation of electronic medical records (EMRs) at each of the DBHDID facilities; and
- Comprehensive assessment of the capacity of facilities, operated by DBHDID, to ensure the most effective/efficient use of state resources.

### **Kentucky Priority Populations**

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

#### **Adults with SMI**

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

Kentucky’s statutory definition of SMI is more aligned with the federal SPMI definition. See Environmental Factor #9 for additional detail. The following denotes the adult population in Kentucky and the estimated number of adults with a serious mental illness (SMI) and thus percentage served.

Adult Census (2010) – 3,315,996

Estimated Number of Adults with SMI (2.6% of Kentucky’s adult population) – 86,216

Kentucky SMI Adults Served in SFY 2018 – 43,358 or 50% (of the 2.6% SMI population)

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

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

During SFY 2017, Kentucky System Transformation Advocating Recovery Supports (KYSTARS), through a contract with DBHDID, conducted fidelity assessments with consumer run programs across the state. This assessment gathered information regarding six (6) primary areas:

- Structure

- Environment
- Belief Systems
- Peer Support
- Education
- Advocacy

These programs were funded by DBH and developed based on the SAMHSA Consumer Operated Services Program (COSP) toolkit. These programs were designed to serve primarily adults with SMI. A KYSTARS review team interviewed leadership and participants of each consumer run program funded by DBH at that time (e.g. eight (8) programs). For the three (3) initial programs funded in SFY 2014, a full fidelity review utilizing the Fidelity Assessment Common Ingredients Tool (FACIT) was performed. For the five (5) additional programs, funded at a later date, the programs each performed a self-assessment based on the FACIT and then the results were authenticated/collaborated by KYSTARS staff during the fidelity visit. KYSTARS found that all programs were performing at or above national benchmarks on all six (6) primary areas, but would benefit from additional training in various program areas. Gaps discovered across programs included:

- Issues with staff turnover;
- Knowledge related to purpose behind the domains measuring on the FACIT (e.g. not just see the item on the fidelity tool, but embrace the true meaning of what the item is truly measuring); and
- Knowledge of recovery principles and how to incorporate the principles into programming.

A Gap Analysis was calculated by DBHDID based on 2010 Census numbers and certified 2013 KY MIS Client/Event data. This data was based on prevalence data regarding adults with SMI. It was noted at that time that about 45% of adults with SMI in Kentucky receive services from the Regional Boards, and about 9.5% of adults with SMI served by the Regional Boards received targeted case management services. Looking at this data again utilizing certified 2018 KY MIS Client/Event data, approximately 50% of adults with SMI in Kentucky received serves from the Regional Boards, and about 7.5% of them received targeted case management services. While the number of adults with SMI served by the Regional Boards seems to rise, the number of those individuals receiving targeted case management services has not kept pace. DBH considers targeted case management for this population a critical need.

An additional need discovered by reviewing available data gathered in Client/Event Data Set as well as through the CMHC contract monitoring process, is increasing the utilization of crisis stabilization programs and other crisis services as alternatives to psychiatric hospitalization for this population.

***Addressing the Need:***

Due in part to the impetus of fulfilling the terms of the Settlement Agreement, DBHDID has been working to enhance the community-based behavioral health system in Kentucky for adults with SMI. Several community evidence-based services are now available, including assertive community treatment (ACT), individual placement and support (IPS) supported employment, and peer support. ACT fidelity reviews show that twelve (12) CMHCs meet “fair implementation” of the model, with two CMHCs meeting “good implementation”. IPS Supported Employment fidelity reviews show that four regions meet exemplary fidelity, five meet good fidelity, and four meet fair fidelity. Each of these services are available to adults with SMI in most CMHC service regions, however, they are not available in every county in Kentucky. In addition, access to peer support services for adults with SMI has been progressively expanding, but the process of transformation of a service system has been slow.

To address some of the issues related to housing assistance, during SFY 2017, DBHDID made \$500,000 of additional funding available, through a contract with Kentucky Housing Corporation (KHC), specifically

for housing vouchers for individuals served through the Settlement Agreement. An additional \$400,000 was allocated during SFY 2018.

KYSTARS used the findings from COSP fidelity reviews to design beneficial workshops at their annual conference for peers and providers in May 2017. An entire conference track was dedicated to peers working in consumer run programs. KYSTARS will continue to work with these programs, offering fidelity reviews and training and technical assistance, via contracting with DBH.

DBH continues participating in quarterly meetings with each of five (5) Managed Care Organizations (MCOs), which began during SFY 2017. These meetings provide an opportunity for dialogue and data sharing between DBHDID, Kentucky Department for Medicaid Services, and the MCOs, and are attended by the DBHDID Medical Director and Deputy Commissioner. A variety of topics, including authorization for services, are regularly discussed.

DBH continues work towards full implementation of community based, evidence based practices in Kentucky. While DBHDID continues to work collaboratively with MCOs and Medicaid on many issues, including reimbursement rates, other efforts for sustainability continue. Such efforts include training for agencies who hire Peer Support Specialists, specifically in how to recruit, retain and supervise these individuals. Historically, most agencies have not hired peers but many had a few peer volunteers. Thus, training includes information about defining roles and incorporating the peer as a part of the continuum of care for individuals with SMI. DBH also continues to provide training and technical assistance around ACT, including guidance on team building and engagement. An implementation team oversees and guides all aspects of the delivery of IPS Supported Employment. The team is comprised of DBH staff, Office of Vocational Rehabilitation staff, and trainers/coaches and fidelity reviewers (contracted through two universities).

DBH also has been working towards implementation of *Person Centered Recovery Planning* for all adults with SMI who receive behavioral health services at CMHCs. This initiative involves the best practices of shared decision-making and person centered planning, in a stage wise format, along with the mechanics of adequate documentation of medical necessity.

**Data Sources Used:**

- Kentucky MIS Client/Event Data Set
- Kentucky State Data Center/US Census Bureau 2010
- U.S. Census Bureau's Decennial Census and National Center for Health Statistics, processed by Kentucky Population Research at the University of Louisville Urban Studies Institute.
- KYSTARS FACIT review data
- University of Kentucky Human Development Institute (HDI) IPS site data
- Interim Settlement Agreement (signed August 2013)
- Amended Settlement Agreement (signed October 2015)
- Second Amended Settlement Agreement (signed October 2018)

**Early Serious Mental Illness**

***Demographic and Prevalence Data for this population (transition age youth between 16-25 years old):***

<b>2017 Census Estimates (KSDC)*</b>	<b>KY</b>
Total population	4,454,189
Total # between 16-25 years old*	598,309

% of population between 16-25 years old*	13%
<b>By % Race/Ethnicity/Language (15-24 year olds**)</b>	
Black	10%
Native Hawaiian and Other Pacific Islander	0.1%
Asian	2%
White (non-Hispanic)	80%
Hispanic	5%
American Indian and Alaska Native	0.3%
Other	3%
2 or more Races	1.9%
Language other than English spoken at home	5.2%
<b>By Gender (2017 census estimate % of total number of 16-25 year olds***)</b>	
Female	48%
Male	52%
<b>By Socioeconomic characteristics*</b>	
% of persons 16+ years of age in workforce	59%
% of persons in poverty	17%
Estimate # of Veterans between 18-34 years old*+	23,794
<b>16-25 year olds served within the CMHC SFY 2017^</b>	
Total: all clients served at CMHC	179,178
Total: 16-25 year olds served	32,099
Penetration rate total #16-25 yr olds served (%)	5.4%
Total 16-25 served with a Substance Use Disorder	3,362
Total served with SED/SMI	8,990
Penetration rate SED/SMI (%)	1.5%
*2017 census estimates Kentucky State Data Center (KSDC)**2017 estimates of race/ethnicity in age groups only (15-19 years old and 20-24 years old) KSDC/***Kentucky does not collect transgender data/*+Housing Assistance Council/Veterans Data Central/^KY Cabinet for Health and Family Services	

**Unmet Needs and Critical Gaps:**

The demographic and prevalence data above indicates several areas of unmet needs and critical gaps in services for transition age youth with or at risk of developing early serious mental illness. While research shows that at least 20% of individuals will experience a behavioral health issue in their lifetime and these behavioral health issues most often surface by the time a person is 24 years old, the CMHCs are serving 5.4% of the total population of 16-25 year olds. Also, while research shows that between 5-10% of a population will experience a serious behavioral health issue, Kentucky's CMHCs are only serving 1.5% of the 16-25 year olds who may have SED/SMI.

**Addressing the Need:**

Kentucky was recently awarded a second 2019 Healthy Transitions Grant through SAMHSA in order to continue identifying these critical gaps. The grant assists in continuing the work to better identify and treat youth and young adults with early serious mental illness. The Healthy Transitions Grant funding along with the with the 10% set aside first episode psychosis funding further affords programming to coordinate services across the continuum. Specific programming to address first episode psychosis services and supports, including early serious mental illness, includes the following:

- 1) DBH requires, via contract, each CMHC to assign at least one (1) key contact for youth or young adults experiencing their first episode of psychosis from the children's service system and at least one (1) key contact for youth or young adults experiencing their first episode of psychosis from the adult service system. This encourages collaborative between systems of care for this vulnerable population. In addition, the DBH has two (2) program administrators assigned to coordinate the statewide effort for this population, one (1) program administrator from the children's mental health services branch and one (1) program administrator from the adult mental health services branch.
- 2) Key contacts from across the state are targeted for training opportunities, and technical assistance through the Early Assessment and Support Alliance (EASA), including trainings on the Structured Interview for DSM-5, differential diagnoses, and cognitive behavioral therapy. EASA also provides monthly consultation calls and various webinars on pertinent topics to key contacts and Kentucky's programs addressing first episode psychosis (iHOPE). A statewide education and technical assistance meeting, coordinated by DBH, is held two (2) times per year and provides an opportunity to education the workforce on issues related to early psychosis and assist with coordinating evidence based practices for this population.
- 3) Kentucky continues to make other training opportunities available that benefit this population including a Motivational Interviewing learning collaborative, Applied Suicide Intervention Skills Training (ASIST), Mental Health First Aid (MHFA) Youth and Adult, Assessing and Managing Suicide Risk (AMSR), Wellness Recovery Action Plan (WRAP), and person centered planning (PCRPP), as well as training in numerous screening and assessment tool

### **Children with SED**

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

Using 2010 census data and the state's agreed upon prevalence rate estimate of five (5) percent, Regional Boards are aware of the number of children in potential need of services. The Boards also rely heavily on indicators and recommendations from the local communities, parent networks and Regional Interagency Councils. Kentucky Kids Count, the annual report distributed by Kentucky Youth Advocates is also helpful for program planning. ([www.kyyouth.org](http://www.kyyouth.org).)

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

Estimated 2010 Child Census – 1,023,371

Estimated Number of Children with SED (5% of Kentucky's child population) – 51,169

Kentucky SED Children Served SFY 2017 – 20,588 or 40% (of the 5% SED population)

Kentucky SED Children Served SFY 2018 – 23,675 or 46% (of the 5% SED population)

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

Kentucky's estimated prevalence rate falls in the low range of estimates derived from local studies and cited in "Prevalence of Severe Emotional Disturbance in Children and Adolescence" (Friedman et al, 1996). This study acknowledges the lack of epidemiological data and concludes that regardless of the

estimated prevalence rate that may be used, children with severe emotional disabilities are greatly underserved, a conclusion Kentucky planners share.

A Gap Analysis calculated by DBHDID based on 2010 Census numbers and utilizing certified 2018 KY MIS Client/Event data, approximately 46% of children with SED were served by Regional Boards and approximately 15% of them received targeted case management services. DBHDID believes that targeted case management services for this population are critical for ensuring that children and youth are able to remain in their own homes, schools and communities. Notably, there is a very large gap between the children with SED being served and those receiving targeted case management.

***Addressing the Need:***

DBH staff participated in quarterly meetings with each of five (5) Managed Care Organizations (MCOs) during SFY 2017 in an effort to increase dialogue and data sharing between DBHDID, DMS, and the MCOs. These meetings are attended by the DBHDID Medical Director and Deputy Commissioner, along with a number of program staff. A variety of topics, including authorization for services, delayed payment to providers and target populations are regularly discussed. While these meetings occurred less frequently in SFY 2018, dialog among and between partners continued. Additionally, DBHDID provided training and technical assistance to CMHC staff regarding eligibility for, provision of, and documentation pertaining to targeted case management. Eligibility checklists were disseminated to staff to improve identification of clients who meet the criteria for SED and SMI. DBHDID staff recommended changes to its Targeted Case Management regulation in order to clarify staff education, training, and supervision requirements to decrease burden on the workforce. Finally, DBH will offer its *Creating Community Connections* conference in October 2019. This conference provides workshops aimed specifically at those who provide Targeted Case Management, Peer Support, and Community Support services and their supervisors to ensure relevant, high quality continuing education opportunities for these non-clinical behavioral health professionals.

***Data Sources Used:***

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

**Co-occurring Disorders**

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

During SFY 2018, 11,878 individuals over the age of eighteen and 359 under the age of eighteen, diagnosed with co-occurring mental health and substance use disorders were served by the Regional Boards. The number of adults has increased over the last few years, due in part to the new Medicaid state plan amendment approved by CMS in January 2014 that included Medicaid reimbursement for substance use disorder treatment. Until then, individuals in Kentucky who were diagnosed with substance use disorders were required to provide payment through other insurance, self-pay, or by providers who were funded through state general funds and other grants. Many individuals did not receive treatment/adequate length of treatment, and many were not diagnosed appropriately due to fear of not being reimbursed if substance use was mentioned in a medical record.

In addition, data gathered through quarterly Assertive Community Treatment (ACT) team leader meetings identified that many of the individuals served on these teams were diagnosed with co-occurring serious mental illness and substance use disorder. Reviews show that few ACT staff has expertise in treating individuals with co-occurring disorders. Between SFY 2015 and SFY 2017, DBHDID contracted with Case Western Reserve University to provide training in Integrated Dual Diagnosis Treatment (IDDT), an evidence-based practice that has been renamed Integrated Treatment for Co-Occurring Disorders by SAMHSA, to staff working on ACT teams in Kentucky. Due to staff turnover in these programs, DBHDID is considering offering these trainings again.

Children and youth with substance use disorders and co-occurring mental health and substance use disorders are also more readily being identified and served since the Medicaid state plan was amended to include coverage for substance use. Kentucky has also been awarded several grants over the past decade to address adolescent substance use and co-occurring conditions.

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

As a result of several years of fidelity assessments, utilizing the Dual Diagnosis Capability in Addiction Treatment (DDCAT) and Dual Diagnosis Capability in Mental Health Treatment (DDMHT) tools, it became clear that there was a gap in essential support groups for individuals with co-occurring disorders. These fidelity assessments occurred through a team of integration specialists developed by DBHDID, through work with a national consultant and a Transformation Transfer Initiative (TTI) grant. In addition, fidelity self-assessments were made a requirement for individual contracted agencies.

It also became apparent that Kentucky had workforce development needs for the behavioral health service system that provides services to individuals with co-occurring disorders. Both the service system traditionally serving adults with serious mental illness and children with severe emotional disturbances, as well as the service system traditionally serving those with substance use disorders, have gaps in skills related to training, technical assistance and coaching on integrated treatment. For example, ACT teams in Kentucky need to fully implement integrated principles of co-occurring disorder treatment into their service package. Individuals being served by ACT teams have very intense treatment needs and many require integrated treatment in order to be successful.

There is also a gap regarding intensive outpatient treatment for individuals with co-occurring disorders in Kentucky. There are several intensive outpatient treatment programs offered for individuals with substance use disorders across the state. There are a few intensive outpatient treatment programs for individuals with mental health disorders. However, it is unclear how either of these programs serves individuals who have co-occurring disorders. Either program, should be able to serve individuals with co-occurring disorders and ensure quality outcomes.

Kentucky has been training peer support specialists since 2006. However, initially, peers were only trained who were in recovery from mental health or co-occurring disorders. During the last few years, the DBHDID has been training peers in recovery from substance use disorders as well. When the 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 and available across the behavioral health service system in Kentucky. More work needs to be done in this area to ensure proper training, adequate numbers of peer support specialists to work with all populations, and adequate support and supervision.

***Addressing the Need:***

To address the identified needs and gaps, Kentucky DBHDID has done, or is planning to do, the following:

- Contract with Case Western Reserve University to provide IDDT training to ACT teams in Kentucky;
- Work with peers in recovery, advocacy groups, and others across the state, to spread the development of Double Trouble in Recovery (DTR) support groups. DTR is an evidence based model for peer led group support for individuals with co-occurring mental health and substance use disorders. Peer support through mutual support and mutual aid groups is one of SAMHSA's ten (10) guiding principles of recovery. At present, the Veteran's Administration in Kentucky, and at least nine (9) regions provide DTR as a support for individuals. More DTR availability is occurring with continued support from DBHDID;
- Provide workshops at Kentucky School for Alcohol and Other Drug Studies (which has traditionally been designed for substance use disorders only) that focus on co-occurring topics and integrated treatment;
- Include contract requirements for CMHCs to include hiring at least 2.0 FTE peer support specialists with lived experience in substance use disorders and/or co-occurring disorders, and for agencies to provide fidelity self-assessments of co-occurring capability by utilizing the DDCAT/DDMHT tools;
- Include administrative staff in traditional "mental health" branches in DBH who have experience in administering substance use and co-occurring programs; and
- Restructure the plan and budget statutory process to include plans for all treatment, including integrated treatment.

Providers serving children and youth have received training and technical assistance from DBHDID to effectively screen, assess and provide treatment for youth with co-occurring mental health and substance use disorders. A number of evidence based programs have been implemented across the Commonwealth including the use of the GAIN, Sources of Strength and Seven Challenges. Enhancing the knowledge and skills of professionals serving youth in behavioral health settings as well as school, child welfare and juvenile justice has been a strong focus of DBHDID's efforts to address the increasing needs of children and youth with co-occurring disorders.

**Data Sources Used:**

- Kentucky MIS Client/Event Data Set
- DBHDID SFY 2017/2018 Plan and Budget Documents
- Institute of Pharmaceutical Outcomes and Policy (IPOP) Data
- DBHDID/CMHC SFY 2017/2018 contracts
- <http://media.samhsa.gov/co-occurring/news-and-features/integrated-treatment.aspx> (Toolkit for Integrated Treatment for Co-Occurring Disorders)
- <https://www.centerforebp.case.edu/resources/tools/best-of-samhsa-resources-for-ddcat-and-ddcmht> (DDCAT/DDMHT information)
- <http://www.hazelden.org/web/go/dtr> (Double Trouble in Recovery)
- <http://www.samhsa.gov/recovery>

**Service Members, Veterans and their Families in Kentucky**

The Division of Behavioral Health is striving to meet the behavioral health needs of the Service Members, Veterans and their Families (SMVF) in Kentucky. The Substance Abuse and Mental Health Services Administration (SAMHSA) through its Service Members, Veterans, and their Families (SMVF) Training and Technical Assistance Center has held Policy Academies to help states and territories strengthen the behavioral health service systems supporting the SMVF population. Since 2012, Kentucky has been selected to participate and highlight their efforts at multiple SMVF Policy Academies including Behavioral

Health, Suicide Prevention, and most recently, Substance Use Disorders. Kentucky is very fortunate to have a strong representation of stakeholders for planning purposes, including Military leaders, the federal and state Departments of Veterans Affairs, statewide service organizations, higher education representatives, and the backing of military leadership.

Kentucky has a strong military history and presence. Approximately 7% of the 4.4 million Kentuckians are Veterans, compared to less than 1% that serves our military nationwide. According to the U.S. Department of Veterans Affairs (VA) 298,860 military Veterans, reside in Kentucky of which 24,084 are female and 274,776 are male.

As of July 2017, there were a total number of 24,084 women Veterans in Kentucky, which is slightly down by 409 from the 24,493 reported from the previous data in September 2014. Unfortunately, some women Veterans are not aggressive in seeking services, as some do not consider themselves a "Veteran". Hopefully, with the current awareness campaigns and events encouraging individuals with prior military service to register with the Veterans Administration, male and female Veterans will begin to receive the care they so richly deserve.

There are approximately 42,995 current military personnel, predominately Army (including the Reserve and National Guard), with two large army military installations located within our borders - Ft. Campbell and Ft. Knox. Kentucky currently ranks twelfth highest among the fifty states with 34,595 active duty military personnel stationed in the Commonwealth, and sixteenth in the number of total military personnel (including civilian workers, reservists, and National Guard). Kentucky has the fourth highest number of active-duty Army personnel following Texas, Georgia and North Carolina.

The Kentucky National Guard is comprised of approximately 8,400 Soldiers and Airmen in the Army National Guard and the Air National Guard. The Kentucky National Guard has mobilized and deployed more than 16,000 Soldiers and Airmen in support of the Global War on Terror. More than two-thirds of those military connected individuals live within our communities and access community resources for behavioral health needs.

According to the most recent report from 2015, the Department of Veterans Affairs estimated that there are 103,073 Veteran households with children and youth (ages 0 to 18) residing in Kentucky. Military families and Veterans in Kentucky are recognized as underserved populations as it pertains to physical and behavioral health needs.

Service Members and Veterans from the Kentucky National Guard are scattered across Kentucky's 120 counties and it is difficult for them to get behavioral health treatment when and where they need it. Most individuals are typically not located near a military base or a Veterans Hospital Administration (VHA). However, nineteen VHA Community Based Outpatient Clinics (CBOCs) in Kentucky provide mental health services. These clinics suffer from workforce shortages at times. Service Members and Veterans in Kentucky are also seeking services at the Community Mental Health Centers (CMHCs) and private behavioral health providers in an effort to keep the diagnosis and treatment information out of their military records. If Service Members/Veterans live near a bordering state, they may leave the state for treatment or they may seek treatment in Kentucky or hide their affiliation with the military while seeking treatment. This is occurring, in part, because of the fear of stigma and the fear of hindering career advancement of the Service Member. Often the individual is paying out of pocket and in cash for confidentiality purposes.

Kentucky communities and behavioral health providers have recognized an increase in the number of Service Members returning from Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn with undiagnosed Traumatic Brain Injury (TBI) and Post Traumatic Stress Disorder (PTSD). As people become more aware of the resources, the assumption is that they will use the resources and get treatment. Resources can become more fragmented which can decrease the service quality. Without

new funding, resources and additional behavioral health staff in place to assist the Service Members and Veterans as they return home, our Heroes and their families will suffer.

**Prevalence Data for this Population:**

- Approximately 7% of Kentucky’s 4.4 million residents have served in the military
- Kentucky currently has a Veteran population of 298,860 in 2016
- In the Commonwealth, there are:
  - 24,084 Female Veterans
  - 274,776 Male Veterans
  - 103,073 Veteran Households With Children
  - 194,654 Veteran Households Without Children
  - 34,595 Active Duty Military Personnel
  - 8,400 Soldiers & Airmen in the Army National Guard & the Air National Guard
  - 42,995 Total Military Personnel

<b>Veteran and Active Duty Personnel Served by CMHCs by State Fiscal Year</b>						
<b>CMHC</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
01 - Four Rivers Behavioral Health	248	233	188	283	311	335
02 - Pennyroyal Regional Center	326	412	525	519	526	378
03 - River Valley Behavioral Health	86	104	82	69	58	51
04 - LifeSkills	280	103	188	212	125	159
05 - Communicare	155	159	144	323	353	272
06 - Centerstone	356	387	311	337	354	363
07 - NorthKey	210	179	158	194	225	194
08 - Comprehend, Inc.	106	133	166	125	108	116
10 - Pathways, Inc.	330	355	331	313	297	320
11 - Mountain Comprehensive Care	155	135	170	145	162	219
12 - Kentucky River Community Care	72	181	212	218	202	152
13 - Cumberland River	175	179	19	15	37	117
14 - Adanta	252	206	173	186	213	254
15 - Bluegrass	456	398	380	330	338	208
Total Unduplicated Count	3,189	3,148	3,032	3,250	3,288	3,098

Active Duty Personnel Served by CMHCs by State Fiscal Year						
CMHC	2011	2012	2013	2014	2015	2016
01 - Four Rivers Behavioral Health	58	51	37	39	33	53
02 - Pennyroyal Regional Center	104	100	105	116	132	81
03 - River Valley Behavioral Health	47	54	30	35	32	29
04 - LifeSkills	255	42	78	88	49	42
05 - Communicare	14	18	15	85	97	80
06 - Centerstone	75	79	66	84	82	83
07 - NorthKey	56	53	44	41	47	48
08 - Comprehend, Inc.	47	52	47	39	46	42
10 - Pathways, Inc.	49	63	54	48	62	49
11 - Mountain Comprehensive Care	93	72	96	55	60	78
12 - Kentucky River Community Care	32	105	121	114	110	71
13 - Cumberland River	1	4	6	6	11	40
14 - Adanta	51	37	30	39	48	58
15 - Bluegrass	85	79	83	81	77	52
<b>Total Unduplicated Count</b>	964	808	811	870	886	806

Certified TEDS Data for SFY 2016

Veterans Served by CMHCs								
Center			2011	2012	2013	2014	2015	2016
01 - Four Rivers Behavioral Health			192	183	151	247	278	286
02 - Pennyroyal Regional Center			223	316	421	407	395	298

03 - River Valley Behavioral Health			39	50	52	34	26	22
04 - LifeSkills			186	61	112	130	77	117
05 - Communicare			141	142	129	238	256	192
06 - Centerstone			287	319	250	259	282	280
07 - NorthKey			160	130	117	158	182	149
08 - Comprehend, Inc.			59	82	119	86	67	77
10 - Pathways, Inc.			283	292	279	265	236	271
11 - Mountain Comprehensive Care			63	64	74	91	102	141
12 - Kentucky River Community Care			40	76	91	105	92	81
13 - Cumberland River			174	175	13	9	26	78
14 - Adanta			204	172	143	149	168	197
15 - Bluegrass			373	328	301	262	265	156
Total Unduplicated Count			2,416	2,383	2,244	2,431	2,441	2,318
Certified TEDS Data for SFY 2016								

**Unmet Needs/Critical Service Gaps:**

- Increased access to effective Behavioral Health services for SMVF population
- Increase help-seeking behavior for SMVF population
- Reduce access to potentially lethal means for SMVF population
- Effective leadership, structure, and sustainability for SMVF service system

**Addressing the Needs:**

**Military Behavioral Health Coordinators**

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

**Operation Headed Home Conferences**

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

Since 2010, DBH has hosted four (4) Operation Headed Home conferences and trained more than one thousand (1,000+) individuals at no cost to the participants. Conference participants and presenters include: Past and present Service Members, Veterans (all branches) and their families/caregivers, local, state and national leaders, subject matter experts, and those serving on the “front lines” of behavioral healthcare and supportive services. The conference addressed the following identified needs: Traumatic Brain Injuries (TBI), Post-Traumatic Stress Disorder (PTSD), suicide prevention, reintegration, family and caregiver support, available resources and benefits, transitioning to work and school, Polytrauma,

polypharmacy, substance abuse prevention and treatment, and hearing loss and tinnitus from blast injuries. Normal attendance for this event is over 300 individuals.

The intent of future conferences will be to establish a core group of individuals within each region that would be lead or guided by the MBHC to bring about awareness and support systems unique to that region for Service Members, Veterans and their Families. The resources, partnerships and funding opportunities gained after the previous conferences have helped to build relationships across the state and fill tremendous gaps. It has also laid the groundwork for future community collaboration around TBI, PTSD and suicide prevention in our state.

### ***Operation Immersion***

Operation Immersion is designed to remove barriers, ease soldier apprehension, and increase access to treatment. The Kentucky Division of Behavioral Health and the Kentucky National Guard have teamed up to present a comprehensive, four-day training in military culture and issues unique to Service Members, Veterans and their Families. This training immerses Behavioral Health Providers and Professionals in aspects of military culture and the deployment experience. Attendees will sleep in barracks, participate in early morning physical training, chores and inspection, learn about military culture/structure, experience the Field Leadership Reaction Course, electronic combat simulators unique to the military, combat missions, enjoy MREs (Meal, Ready-to-Eat), network with military personnel and resource providers. In addition, workshops are provided on TBI, PTSD, Combat Stress, Suicide Prevention, Substance Abuse Prevention and Treatment, Military Sexual Assault and Prevention Program, Comprehensive Soldier and Family Fitness (CSF2), Trauma Informed Care and current best practices to treat military clients and their families. Kentucky has held seven (7) 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. Three hundred and fifty-two (352) behavioral health professionals/providers have attended this hands-on event to learn about military culture and focus on how to help the SMVF population in Kentucky.

In the fall of 2015, Kentucky combined two (2) policy academy teams into one (1) unified team that refined goals with technical assistance from SAMHSAs SMVF Technical Assistance Center. The overarching goal of the unified team is to develop and implement a comprehensive statewide strategic plan serving the behavioral health needs of the SMVF population.

### **Addressing the Need:**

#### **1. Increased Access to Effective Behavioral Health Services**

- Encourage help-seeking behavior by increasing access in utilization of available services by SMVFs.
- Continue to train, educate and develop the workforce of professionals/providers as it relates to the SMVF population in Kentucky.

#### **Kentucky Military Provider Designation:**

- Utilizing already developed and/or endorsed programs and trainings; DBHDID is developing a Military Behavioral Health Provider Designation. This designation offers providers an opportunity to receive coordinated training efforts to increase knowledge and provide care that is more adequate to Kentucky's SMVF population. This designation targets clinical providers working in behavioral health. Prior to receiving the designation, providers will participate in Operation Immersion, complete web-based educational sessions, and receive 2-day in-depth training in suicide prevention assessment, management, and treatment. Following designation, providers

will be required to maintain designation through continued education opportunities, some of which will be provided through Operation Headed Home events. Designated providers will then be considered preferred providers for those in the SMVF population seeking behavioral health services.

**Military Preferred Provider Designation Outline: Clinical Route Only**

**Component 1:**

- Requires completion of 8 online modules and completion of Operation Immersion (OI)
- Online Modules to be completed within one year

Substance Use	Resiliency
Trauma-Informed Care – including Combat Stress and TBI	Military Families
Evidence-based Treatment Modalities	Sexual Trauma / Domestic Violence
Mental Illness – to include anger management, depression, anxiety, and suicide prevention	Help seeking and Stigma
Physical Wellness (Mind/Body Connection)	Faith-based / Spirituality
Military 101, perhaps in addition to the session provided at Operation Immersion	

\*Developing in partnership with ECU, UK and the Adanta Group

\*Utilizing current OI content and modules obtained through Defense Center of Excellence, National Council for Behavioral Health and the Center for Deployment Psychology

- **Operation Immersion** event consisting of military specific classroom and field trainings designed to offer providers an opportunity to experience a brief glimpse of what it takes to serve in the military with detailed insight into the SMVF population
  - \* Participants will receive an Associate Level Designation upon completion of OI
  - \*The individual has one year to complete this phase, either from beginning the online modules or completing Operation Immersion

**Component 2:**

<b>Clinical Focus Tract</b>
<b>Completion of Assessing and Managing Suicide Risk (AMSR) / Collaborative Assessment and Management of Suicidality (CAMS) two-day training</b> *those who have taken the AMSR training with the past six (6) years will be grandfathered and will not need to repeat until required for licensure *Currently 34 AMSR trainers operating within Kentucky
<b>Participation in a learning collaborative process post AMSR/CAMS training to ensure fidelity of implementation</b>

\*Participants will receive Full Preferred Provider Status upon completion of Component II

\* Assessment of Components I and II to occur every 3 years for the clinical tract, if not compliant with CEU requirements in Component III individual must recertify

- **Component 3:** *Can happen at any point along the continuum*

- Continuing education – approximately 10 hours annually, can be concurrent with other license trainings
  - Will be offered through future **Operation Headed Home** conference (a conference designed to increase local and statewide networking and resources, as well as provide professionals with support and innovative practices to serve the SMVF population)
  - Provide on-going Technical Support and linkage to resources
  - Learning collaborative process follows training process

### **Peer Support Phase / SMVF Targeted Case Management**

- Peer Support specialists will be afforded opportunities to participate in non-clinical pathways to increasing connections with clinical provider. The Division of Behavioral Health has identified twenty (20) veterans that desire to become certified Peer Support Specialists with the intent to establish a Veteran/Military Peer Support Network. The Peer Support Specialists will receive certification after successful completion of a weeklong training course and passing a written and oral exam. The Specialists may have the opportunity to provide peer support to clients of the fourteen (14) Community Mental Health Centers (CMHC) across Kentucky.

### **2. Increase Help-Seeking Behavior**

- Provide Technical Assistance to CMHCs, Managed Care Organizations regarding TRICARE and encourage agencies to accept and work with TRICARE for the SMVF population in Kentucky
- Create and distribute marketing information linking SMVF population to services in their area, as well as state-wide services
- Increase help-seeking behavior by raising awareness of available resources and encouraging in utilization of said services by SMVF
- Expand the Provider Directory/Database for SMVF population
  - Kentucky has collaborated with United Way of the Bluegrass to add Military and Veteran resources to their toll-free 211 – telephone information system and website directory of services
  - Determine additional mechanisms to house the resource directory of available SMVF services
  - Investigate the cost of creating and maintaining a database/resource directory
  - Regional Prevention Centers have completed a survey of available resources for their respective region
- Review the resources and capacity to create branding and marketing materials
  - Utilize/rework current available materials for distribution
  - Work with the Kentucky Broadcasting Association and Kentucky Press Association for distribution of materials and assistance
  - Request technical assistance from SMVF TA Center regarding evaluation and marketing

The DBHDID and the Kentucky National Guard are continuing to collaborate on ways to include a screening, brief intervention and referral to treatment (SBIRT) process into the Guard's annual periodic health assessment conducted among all 7,000 National Guard Members every fiscal year.

### **3. Reduce Access to Lethal Means**

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

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

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

### **4. Strengthen Leadership, Structure and Sustainability**

- A comprehensive SMVF needs assessment will be conducted as part of the Zero Suicide Initiative, including:
  - Capturing data to assist with decision making.
    - Effective July 17, 2014, there was a realignment of the military behavioral health initiative to DBHDID, with continued input from Kentucky Department of Veterans Affairs (KDVA, Kentucky Department of Military Affairs (KDMA), Kentucky Commission on Military Affairs (KCMA) and Administrative Office of the Courts (AOC) at the discretion of the Cabinet for Health and Family Services.
  - Improving the overall SMVF data collection.
    - DBHDID's Data Information System Coordinator is working to identify the best language for providers funded by DBHDID in order to identify the SMVF population seeking services. Better identification will provide the department with an improved understanding of the services needed and provided through the CMHC.
    - Providers will be encouraged to utilize the updated language to identify the SMVF clients and address their needs, especially for Veterans with less-than-honorable discharge.

#### ***Data Sources Used:***

- U.S. Department of Veterans Affairs, Veteran Data  
[https://www.va.gov/vetdata/Veteran\\_Population.asp](https://www.va.gov/vetdata/Veteran_Population.asp)  
<https://www.va.gov/vetdata/stateSummaries.asp>  
[https://www.va.gov/vetdata/docs/QuickFacts/Veteran\\_Households\\_Children.xlsx](https://www.va.gov/vetdata/docs/QuickFacts/Veteran_Households_Children.xlsx)
- The Kentucky Commission on Military Affairs  
<https://kcma.ky.gov/Documents/Final%20Report.pdf>
- Military Active-Duty Personnel, Civilians by State <http://www.governing.com/gov-data/military-civilian-active-duty-employee-workforce-numbers-by-state.html>
- DoD Personnel, Workforce Reports & Publications  
[https://www.dmdc.osd.mil/appj/dwp/dwp\\_reports.jsp](https://www.dmdc.osd.mil/appj/dwp/dwp_reports.jsp)
- The Kentucky National <http://kentuckyguard.dodlive.mil/about-us/>

### **Substance Abuse Prevention**

The Behavioral Health Prevention & Promotion Branch (Branch), within the Department for Behavioral Health, Developmental & Intellectual Disabilities (DBHDID) is responsible for the planning and implementation of data-driven, evidence-based strategies in Kentucky's 120 counties to reduce the use and misuse of substances by its citizens. The Branch uses SAMHSA's Strategic Prevention Framework (SPF) as its model for planning, implementing and evaluating the work occurring across the state. By using a comprehensive set of strategies that address all levels of the social ecology and provide strategies that approach prevention from the universal, selective and indicated Institute of Medicine (IOM) lenses, and using the six strategies required by the Center For Substance Abuse Prevention (CSAP), the Branch works through its approved providers to change the community norms and improve the collective community knowledge regarding the impacts that substances have on a person's behavioral and physical health.

As part of the Branch's SPF process, the Branch utilizes the expertise and guidance provided by the State Epidemiological Outcomes Workgroup (SEOW) to drive much of its needs assessment process. The KY-SEOW, a creation of the Kentucky DBHDID, is housed and managed by REACH of Louisville. Since its inception in 2010, the SEOW has worked 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 serve to advise the DBHDID 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 are provided by a contract with REACH of Louisville, Inc. SEOW members are responsible for attending scheduled SEOW meetings, providing relevant data pertaining to substance use and mental health, guiding the analysis and interpretation of state and community data, and providing guidance for the development of state and community profiles. Four (4) subcommittees were recently formed: The Evidence-Based Practice Subcommittee, the Evaluation Subcommittee, the Youth Suicide Prevention Data Subcommittee and the Surveillance Subcommittee.

Since the filing of the last Block Grant Report the Kentucky SEOW has produced two reports which have help to guide our prevention efforts. The First report, "Military Youth and Prescription Opioid Abuse Risk Factors," builds on the findings of our PFS 2015 Needs assessment produced in February 2018. The report's summary findings reveal that Youth connected to the military are at an increased risk for nonmedical use of prescription opioids and that this elevated risk is not mediated by personal risk perception of NMPDU, or personal, parental, or peer disapproval of NMPDU. Additional research will be conducted to explore the causal pathways putting these youth at an increased risk for NMOU.

The second report, "Early onset of substance abuse and Opioids", produced in October of 2018 show a clear correlation between age of onset of tobacco/nicotine, alcohol and marijuana and later opioid use, suicidal behavior and psychological distress. The report found that among 10th graders, after controlling for gender, race/ethnicity, free/reduced lunch, and military connection, those who began using cigarettes, alcohol, or marijuana by age 12 were 12.7 times as likely to misuse Rx opioids as their peers who had never used cigarettes, alcohol, or marijuana. Those who began using cigarettes, alcohol, or marijuana older than age 12 were 6.6 times as likely to misuse Rx opioids as their peers who had never used cigarettes, alcohol, or marijuana. In terms of behavioral health consequences, among 10th graders, after controlling for gender, race/ethnicity, free/reduced lunch, and military connection those who began using cigarettes, alcohol, or marijuana by age 12 were 5 times as likely to attempt suicide as their peers who had never used cigarettes, alcohol, or marijuana. .those who began using cigarettes, alcohol, or marijuana older than age 12 were 3.6 times as likely to attempt suicide as their peers who had never used cigarettes, alcohol, or marijuana.

Current SEOW members are:

Steve Cambron	Division of Behavioral Health (DBH)
Patti Clark	Program Manager, Prevention and Promotion Branch DBH
Phyllis Millsbaugh	Assistant Director, DBH
Van Ingram	Executive Director, Kentucky Office of Drug Control Policy
Teresa McGeeney	Epidemiologist, REACH of Louisville
Dr. Vestena Robbins	Executive Advisor, DBH
Dr. Ramona Stone	University of Kentucky
Monica Clouse	Child Fatality Review Team
Dana Quesinberry	Kentucky Injury Prevention and Research Center, Department of Public Health Policy and Program Evaluator
Jasmine Fouts	Data Systems Administrator, DBH
Jaqueline Seals	Data Analyst, Kentucky Violent Death Reporting System
Brittaney Allen	KORE Project Manager, DBH
Sara Robeson	Epidemiologist, DPH

Bob Illback	CEO, REACH of Louisville
Michelyn Bhandari	Instructor, Eastern Kentucky University
Maik Schultze	Chief Analytics Officer, KY Office of Health Data and Analytics
Angela Taylor	Coordinator, KY Office of Health Data and Analytics
Genia McKee	Coordinator, KY Safe Communities, Kentucky Injury Prevention and Research Center
Dr. Sabrina Brown	Principal Investigator, Kentucky Violent Death Reporting System
Sarojini Kanotra	Epidemiologist, Department for Public Health
Dr. Richard Wilson	Professor and Chair, Department of Health Promotion and Behavioral Sciences, School of Public Health, University of Louisville
Stephanie Bunge	School Health Consultant, Department of Education
Cathy Prothro	Suicide Prevention Enhancement Site Coordinator, DBH

## Unmet Workforce Needs

**Workforce Issues** are also identified as a significant gap in Kentucky. During SFY 2018 and SFY 2019, significant time and effort was devoted to increasing the capacity of the providers (Regional Prevention Center/Prevention Specialists) to provide technical assistance to their communities utilizing the SPF process. The Branch provided technical assistance and Prevention Solutions (formerly CAPT) was utilized to increase the capacity of the RPC staff particularly around needs assessment and strategic planning.

During this period, the Branch was understaffed and a high degree of turnover occurred within the provider networks. The Branch began hiring new staff to address the capacity gaps. During that time, five (5) of the fourteen (14) providers lost their directors. In order to ensure that providers are utilizing effective prevention strategies, contracts now stipulate that all new directors must be certified prevention specialists. This change is one way that Kentucky is addressing the push that many RPC staff members are experiencing from their host agencies (CMHCs) to move away from primary prevention and toward billable services.

These CMHCs are required to be the behavioral health planning authority for their regions. The business model used involves the necessity of bringing revenue into the host agency with its services. Treatment services are billable to various payers. Prevention services, with few exceptions, do not generate revenue with their host agency. This sets the RPCs apart from their CMHC colleagues even further than the dichotomy between treatment and prevention creates.

As the CMHCs across the state face rising costs, the RPCs are faced with pressure to prove themselves as useful, necessary and effective. These pressures result in small budgets, a culture of mistrust and a sense of fight or flight within the RPC staff. Unable to articulate succinctly the role that prevention plays within their host agency, RPCs report feeling isolated within their corporate structure. Part of the technical assistance targeted over the next two (2) years involves increasing work force skills to market their services and articulate the value of prevention in the community. A focus on collaboration, increasing involvement of youth in the prevention process, and being intentional to ensure that all efforts are focused on increasing outcomes is expected to increase the success of the state's prevention providers, in turn increasing the perception of their value within their respective agencies.

## **Addressing Unmet Needs – Workforce**

In order to address the substance use issues identified through prevalence and incidence data, as well as risk factors for substance use, Kentucky's prevention efforts over the next two years will focus on increasing the capacity of the prevention workforce with a special emphasis on training for new prevention staff. Kentucky also plans on increasing surveillance opportunities related to the identified substances of focus, especially as they affect the 18-25-year-old population in the state. Kentucky is creating a strategic plan to ensure a comprehensive delivery of interventions across the lifespan utilizing a mix of the six (6) CSAP strategies at all levels of the socio-ecological construct. Kentucky's prevention system has experienced significant turnover in experienced leadership and field staff, necessitating additional training and technical assistance to increase the capacity of current staff, and recruitment of trained and trainable providers to fill vacant positions. As part of the State Opioid Response grant, each provider has hired two (2) additional prevention specialists. This provides an opportunity to expand provider capacity, but also presents the need for intensive training for a large sector of the prevention workforce. Community-level needs assessments have been conducted across the state to focus resources and prevention efforts more effectively. Providers are currently developing strategic plans based on those needs assessments. This strategic planning process and systematic implementation of the plans will create opportunities for community-level behavior change. Addressing the capacity of the prevention system will allow for systematic focus on preventing substance use and related consequences and the ability to sustain desired outcomes.

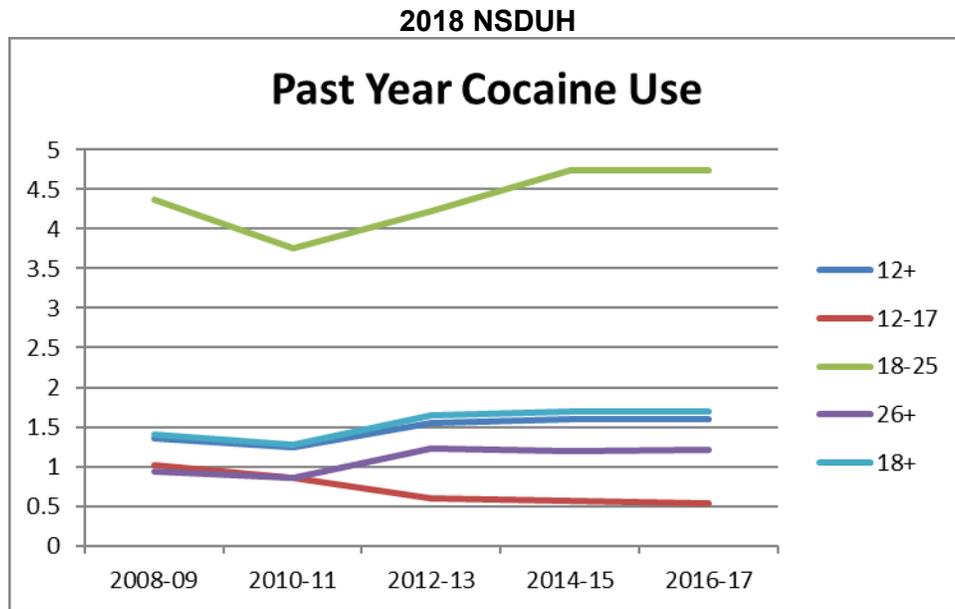
The Branch is continually providing technical assistance to the RPCs regarding timely and accurate data entry. Staff recognized that the existing data reporting system was inadequate and that similar activities were not always being reported consistently across the state. A workgroup composed of Branch staff and local-level providers revised the data entry procedures and provided training for all RPC staff. In late SFY19, a new data entry system shaped by input from local providers was introduced. Technical assistance is being provided to all local providers on utilizing the new system. The streamlined system will provide a more efficient system for RPCs to enter their strategic plans and report their efforts accurately. Issues related to RPC identity and prevention messaging are larger, systemic issues that will have to be addressed in a progressive, consistent manner. In conjunction with training and technical assistance, the strategic planning process mentioned throughout this document will be used to create a concrete set of steps to move the system toward full integration within its host agency's own set of priorities.

## **Cocaine**

Similar to marijuana, cocaine use over the last 12 years has been steady/decreasing among middle and high school students, with a gradual increase by grade level as measured by the KIP. Among 18-25-year-olds, however, use has increased 26% since 2010.

KIP data shows that about 2.2 percent of 12<sup>th</sup> graders report past year cocaine use. NSDUH data shows that 4.74% of 18- 25 year olds reported cocaine use in 2017, with a significant uptick in usage from 3.76% in 2010. Personal disapproval of cocaine – i.e. the percentage of students answering “wrong” or “very wrong” to the question, “How wrong do you think it is for someone your age to use cocaine?” - ranged from 94.1% for 12<sup>th</sup> graders to 98.1% to 6<sup>th</sup> graders. Percentage of parental disapproval to cocaine use ranged from 97.3% for 12<sup>th</sup> graders to 98.8% for 6<sup>th</sup> graders. Yet, nearly 7% of 12<sup>th</sup> graders said at least one of their four best friends had used cocaine in the last years. That percentage was 5.2 for 10<sup>th</sup> graders; 3.1 for 8<sup>th</sup> graders and 1.3 for 6<sup>th</sup> graders. Four Rivers region in far Western Kentucky had the highest rate of 10<sup>th</sup> graders reporting cocaine use (1.1%) while Kentucky River had the lowest at .1%. The overall 10<sup>th</sup> grade rate was .8%. The TEDS shows that admissions for cocaine use and medical consequences resulting from that use has remained steady over the last few years. Bridging the gap in

prevention efforts for this young adult age group is imperative in decreasing the rate of cocaine use among 18-25 years.



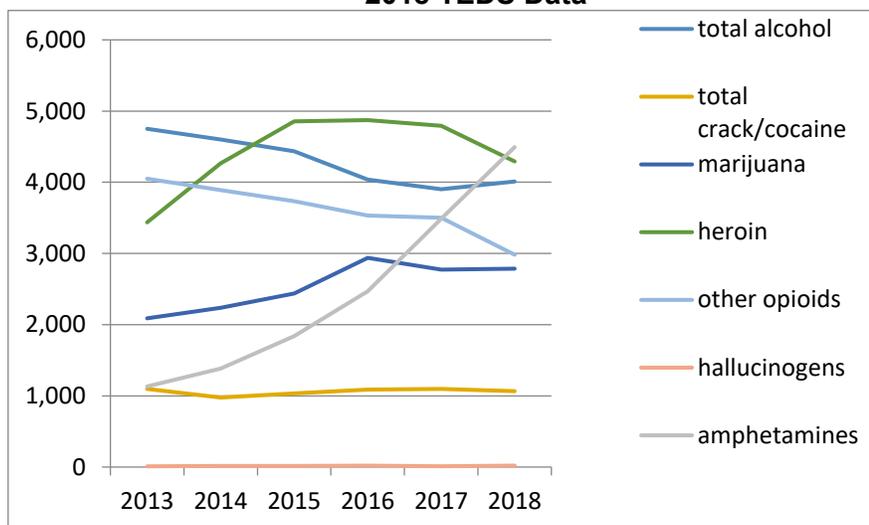
### Methamphetamines

TEDS data from 2013-2018 shows a significant increase in hospitalization for amphetamines, including methamphetamine. The increase mirrors the increase noted for heroin admissions as well. Among youth, methamphetamine use has remained steady since 2008 with an average of 1% of youth reporting past year methamphetamine use and about a half percent reporting 30-day-use. Personal disapproval of methamphetamine use is high across the grades, ranging from 96.8% among seniors to 98.1% among sixth graders. Perception of parental disapproval of meth use is even higher, ranging from 97.5% for 12<sup>th</sup> graders to 98.8% of 6<sup>th</sup> graders. In comparison, 4.1% of 12<sup>th</sup> graders said at least one of their four best friends had used the illicit substance in the past year; 1.1% of 6<sup>th</sup> graders did.

The Communicare and Pennyroyal regions in Western and west Central Kentucky have the highest rates of 10<sup>th</sup> grade methamphetamines use at .7% (compared with a statewide 10<sup>th</sup>-grade rate of .5%). The lowest rate was in the Four River region with .2% of 10<sup>th</sup> graders reporting 30-day use. The Western Kentucky regions' higher use rates coincide with anecdotal evidence from key stakeholders that methamphetamines are becoming an increasing problem in the region.

Efforts focused on **cocaine** must address the significant increase of use by those in the 18-25-age-group and should include decreasing the perception of peer use among middle and high schools as well as finding additional ways to measure the impact of use in the young adult group. Prevention strategies focused on **methamphetamine** use must first more thoroughly assess the areas in the state that are anecdotally reporting an increase in use as evidenced by the increased consequences of use. Youth use for this substance is low, but young adult use represents a significant increase.

**2018 TEDS Data**



### Inhalants

According to the Kentucky Incentives for Prevention (KIP), youth reported inhalant use at varied rates across the grade levels, ranging from 5% among 8<sup>th</sup> graders to 3.1% among 10<sup>th</sup> graders, with 2.9% of 6<sup>th</sup> graders and 1.8% of 12<sup>th</sup> graders also reporting use. Personal disapproval among middle and high school student in Kentucky ranged from 94.2% of 12<sup>th</sup> graders to 96.8% of 6<sup>th</sup> graders. Percentage of parental disapproval to inhalants use ranged from 97.4% for 12<sup>th</sup> graders to 98.2% for 6<sup>th</sup> graders. Yet, nearly 4.4% of 12<sup>th</sup> graders and 4.1% 6<sup>th</sup> graders said at least one of their four best friends had used inhalants in the last years. The Comprehend regions in Northeastern Kentucky had the highest rates of 8<sup>th</sup> grade inhalants use at 4.0% (compared with a statewide 8<sup>th</sup>-grade rate of 4.8%). The lowest rate was in the Kentucky River region with 1.4% of 8<sup>th</sup> graders reporting 30-day use.

### Steroids

According to the 2018 KIP survey, lifetime steroid youth use of steroids ranged 2.1% among 8<sup>th</sup> and 10<sup>th</sup> graders to 1.5% for 6<sup>th</sup> graders.

### Over the Counter Medications

According to 2018 KIP, past-year use of over-the-counter medications to get high ranged from 1.5% for 6<sup>th</sup> graders to 4.8% among 10<sup>th</sup> graders. 30-day use is lower, ranging from 0.9% among 6<sup>th</sup> graders to 2.4% among 10<sup>th</sup> graders.

### Unmet service needs

Data for steroid and inhalant use is limited, making it difficult to fully assess the issues related to these substances

### Data Sources Used:

- **Kentucky Incentives for Prevention (KIP) 2018** - Since 1999, the KIP Survey has been administered in Kentucky through the Substance Abuse Prevention Program in the Cabinet for Health and Family Services, through

agreements with individual school districts across the state. The intent of the survey is to anonymously assess student use of alcohol, tobacco, and other drugs (ATOD), as well as a number of factors related to potential substance abuse (e.g., peer influences, perception of risk, school safety). The survey is now conducted bi-annually in the fall in even-numbered years (2016, 2018, etc.), with 6th, 8th, 10th, and 12th graders attending school in Kentucky communities. In 2018 the total sample size for 6th, 8th, 10th, and 12th grades was 128,759. The sample includes schools from 113 out of 120 Kentucky counties, and 151 out of 173 public school districts.

- **Treatment Episode Data Set (TEDS) 2017**– The Treatment Episode Data Set is a national census data system of annual admissions to substance abuse treatment facilities. TEDS provides annual data on the number and characteristics of persons admitted to public and private substance abuse treatment programs that receive public funding. TEDS consists of data reported to state substance abuse agencies by the treatment programs, which in turn report to SAMHSA.
- **National Survey on Drug Use and Health (NSDUH)** - The National Survey on Drug Use and Health is an annual nationwide survey involving interviews with approximately 70,000 randomly selected individuals aged 12 and older. The Substance Abuse and Mental Health Services Administration (SAMHSA), which funds NSDUH, is an agency in the U.S. Department of Health and Human Services (DHHS). Data from the NSDUH provide national and state-level estimates on the use of tobacco products, alcohol, illicit drugs (including non-medical use of prescription drugs) and mental health in the United States. In keeping with past studies, these data continue to provide the drug prevention, treatment, and research communities with current, relevant information on the status of the nation's drug usage.
- **Kentucky Overdose Fatality Report 2017** – The Kentucky Overdose Fatality Report 2017 is compiled by Kentucky's Office of National Drug Control Policy and focuses on the impact of opioids on Kentucky's population. The report describes the numbers of opioid overdoses in the state as well as identifies demographic and geographic hotspots, to inform policy makes and prevention, treatment and recovery professionals in addressing the substance use issues affecting Kentucky's residents. The report utilizes information from the Kentucky Medical Examiners report, Kentucky Office of Vital Statistics, as well as other key data sources related to opioid consequences in the state.
- **Kentucky Opioid Response Effort (KORE) Needs Assessment** – The KORE Needs Assessment report was compiled in 2017 in response to the state's receipt of funding to address the opioid crisis in Kentucky. The assessment utilizes a number of key data sources, including the National Violent Death Reporting System, Kentucky Injury Prevention Research Center data collection, to outline the demographic and geographic populations of focus toward which grant efforts will be targeted. The needs assessment provides a comprehensive narrative of opioid overdoses and their impact on the state's population.
- **Prevention Data System (PDS)** – Kentucky currently has its own data collection system that its providers are required to use. Regional Prevention Centers create data-driven work plans that identify the unique challenges of their region and the evidence-based approaches they will use to address them. They prioritize by substance and develop plans that encompass all

levels of the social ecology, employ the six strategies endorsed by the Center for Substance Abuse Prevention and implement their strategies through universal, selective and indicated methodologies. It is through the PDS that the Branch is able to evaluate the work being done in each region and identify the impact and outcome results occurring at the community level. Through these data collection efforts, the Branch has been able to identify gaps related to Kentucky's prevention workforce. With dedicated staff becoming available to mine the PDS in 2017, inaccurate, missing and incomplete data rose to the top of the capacity concerns. Identified as problematic: data interpretation errors leading to poor problem statements and logic models, problem statements that did not match the needs assessment data, poor interpretation of PDS data points, gaps in data submission and inconsistency in coding. The PDS itself also created a gap in the system, as the RPCs reported finding it difficult to navigate. The Regional Prevention Centers all participated in an extensive Needs Assessment process in 2018-19 and currently report greater understanding of logic models. A new PDS web app has been created and is currently (June 2019) being used by the prevention system. It is reportedly easier to use, however, there are still glitches that need to be worked out. Changes are continually suggested, made and tested, and these efforts have improved the gaps related to data entry.

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

#### **SUBSTANCE 1: ALCOHOL**

Despite the significant gains that the Kentucky prevention system has made in reducing underage drinking, (see graph below) alcohol continues to be used by many youth. For the first time ever, it dropped into second place for youth use, behind e-cigarette use. The most recent Kentucky Incentives for Prevention (KIP) survey data (2018) reveals that 16.8% of 10th graders drank alcohol in the past 30 days, and of that number 13.2% also report having been drunk on at least one occasion in the past 30 days. Furthermore, 8.6% of 10<sup>th</sup> graders have engaged in binge drinking (defined by SAMSHA as drinking five or more alcoholic drinks on the same occasion) in the past 30 days. To put this number in perspective, roughly one out of every ten 10<sup>th</sup> graders surveyed, or 3,627 10th graders have engaged in binge drinking in the past 30 days. Even though Kentucky binge drinking data trends show positive outcomes (from 19.7% in 2004 to 8.6% in 2018) the number of Kentucky youth who engage in past 30-day drinking and binge drinking is still unacceptably high.

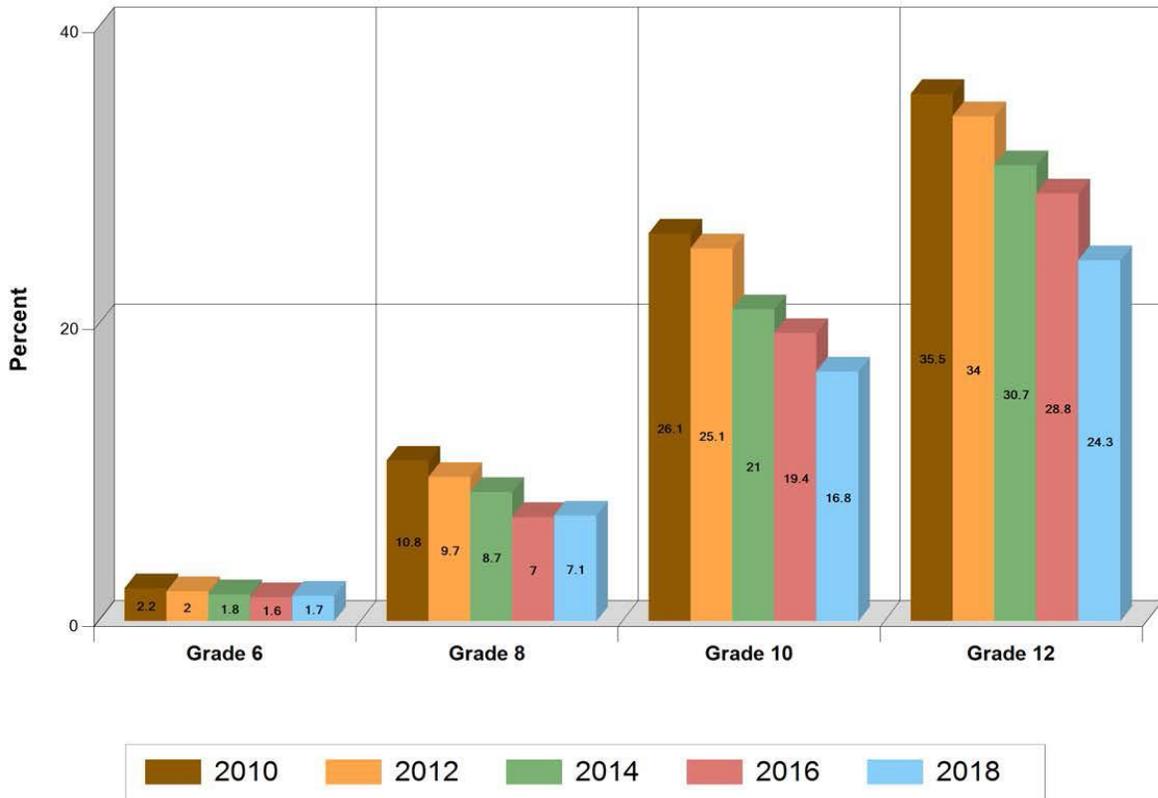
# 30 Day Alcohol Usage

Kentucky

Question 26b - On how many occasions (if any) have you had alcoholic beverages (beer, wine, or hard liquor) to drink - more than just a few sips - in the past 30 days?

Percent that answered at least 1 occasion

Grade	2010	2012	2014	2016	2018
6	2.2%	2%	1.8%	1.6%	1.7%
8	10.8%	9.7%	8.7%	7%	7.1%
10	26.1%	25.1%	21%	19.4%	16.8%
12	35.5%	34%	30.7%	28.8%	24.3%



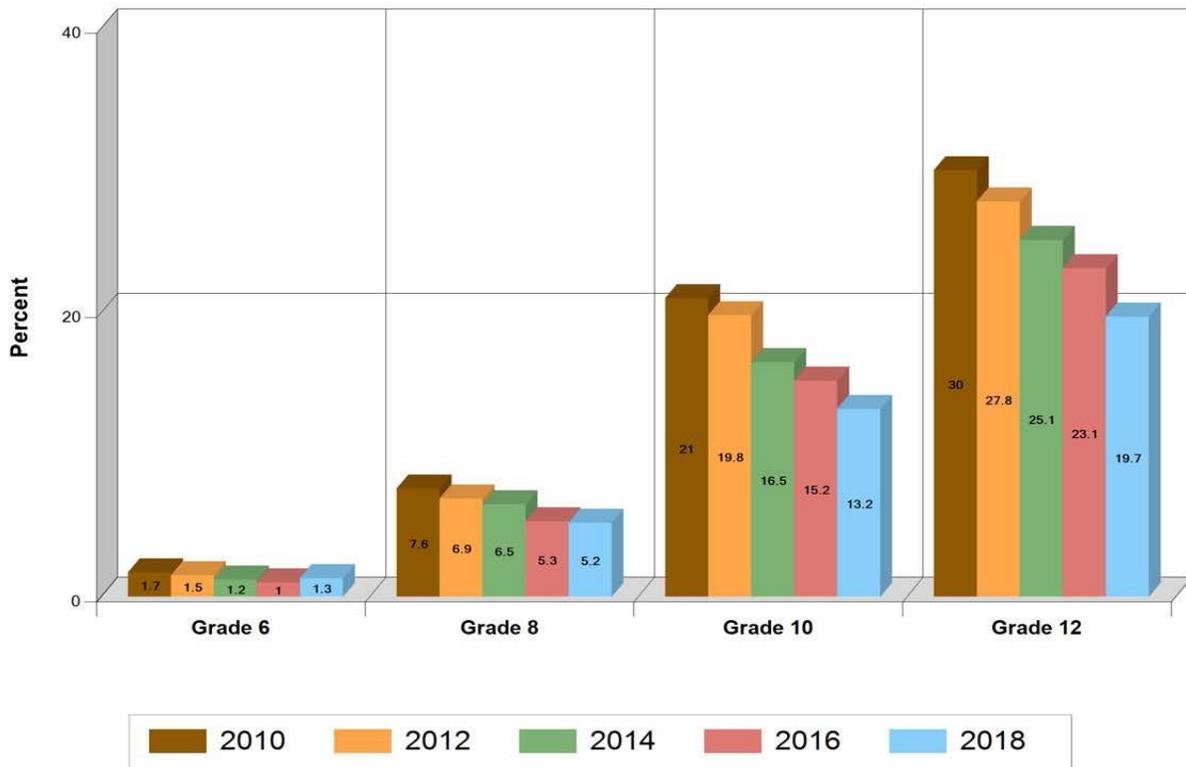
# 30 Day Drunkenness Frequency

Kentucky

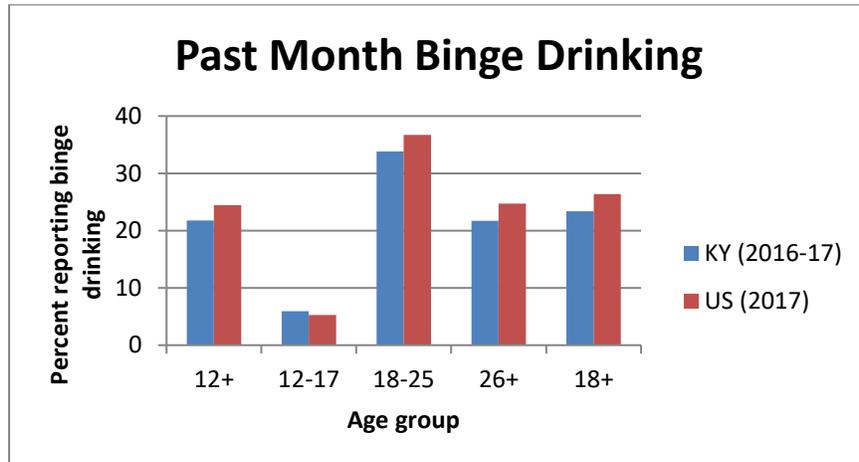
Question 27 - On how many occasions (if any) during the past 30 days have you been drunk or very high from drinking alcoholic beverages?

Percent that answered at least 1 occasion

Grade	2010	2012	2014	2016	2018
6	1.7%	1.5%	1.2%	1%	1.3%
8	7.6%	6.9%	6.5%	5.3%	5.2%
10	21%	19.8%	16.5%	15.2%	13.2%
12	30%	27.8%	25.1%	23.1%	19.7%



Adult binge drinking in Kentucky, while slightly below the national rate, remains high, with nearly a quarter of adults reporting binge drinking in the past month (23.4% in Kentucky vs. 26.4% in US, National Survey on Drug Use and Health). Of all the age groups reported, alcohol consumption is highest among 18-25-year-olds. According to NSDUH Survey data, past 30-day alcohol use among this age group remains virtually unchanged since 2008. (50.64% in 2008-9 to 49.27% in 2016-17.) 18-25 year olds are by far the most likely age group to report binge drinking, with a third of these young adults reporting binge drinking in the past month. (See graphs below.)



Similarly, based on the 2018-KIP Survey, 67.2% 10<sup>th</sup> graders who consume five or more alcoholic drinks a week feel like they are at moderate or great risk in harming themselves.

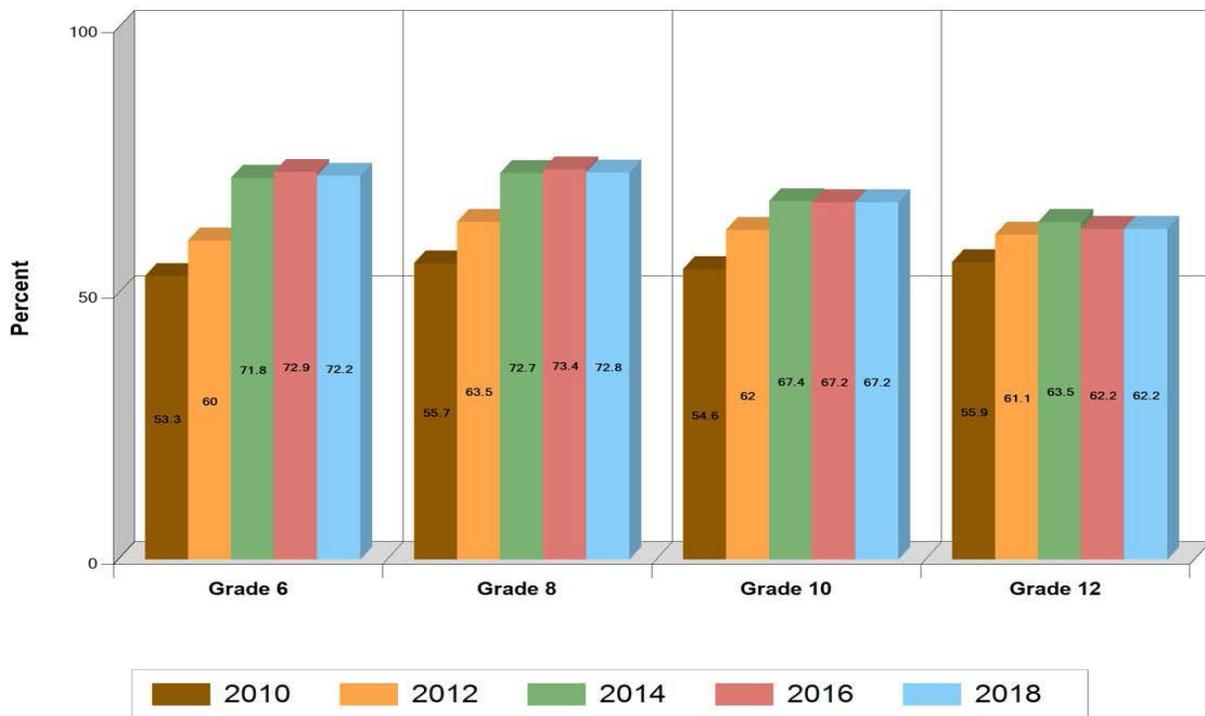
# Risk Perception: Alcohol

Kentucky

**Question 60d - How much do you think people risk harming themselves (physically or in other ways) if they have five or more drinks of an alcoholic beverage once or twice a week?**

Percent that answered 'Moderate' or 'Great' Risk'

Grade	2010	2012	2014	2016	2018
6	53.3%	60%	71.8%	72.9%	72.2%
8	55.7%	63.5%	72.7%	73.4%	72.8%
10	54.6%	62%	67.4%	67.2%	67.2%
12	55.9%	61.1%	63.5%	62.2%	62.2%



Perception of parental disapproval continues to be high with 91.5% of 10<sup>th</sup> graders believing that their parents would not approve of them having one or two alcoholic beverages nightly.(2018 KIP). That number has increased from 87.8% in 2010.

The 2018 KIP Survey also indicted that, 62.8% 10<sup>th</sup> graders believe that their peers feel it would be 'wrong' or 'very wrong' of them to have one or two drinks nearly every day. Since 2012, this number has increased almost 10% (53.2% in 2012).

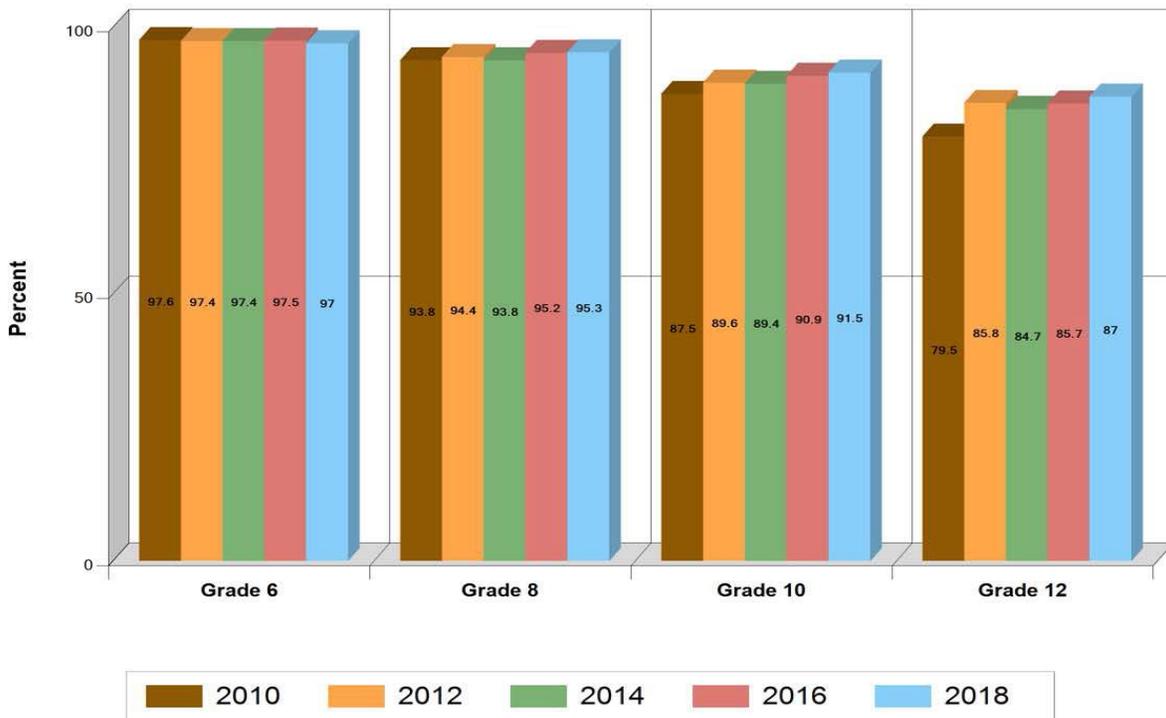
# Perception of Parental Disapproval: Alcohol

Kentucky

Question 57a - How wrong do your parents feel it would be for you to have one or two drinks of an alcoholic beverage nearly every day?

Percent that answered 'Wrong' or 'Very Wrong'

Grade	2010	2012	2014	2016	2018
6	97.6%	97.4%	97.4%	97.5%	97%
8	93.8%	94.4%	93.8%	95.2%	95.3%
10	87.5%	89.6%	89.4%	90.9%	91.5%
12	79.5%	85.8%	84.7%	85.7%	87%



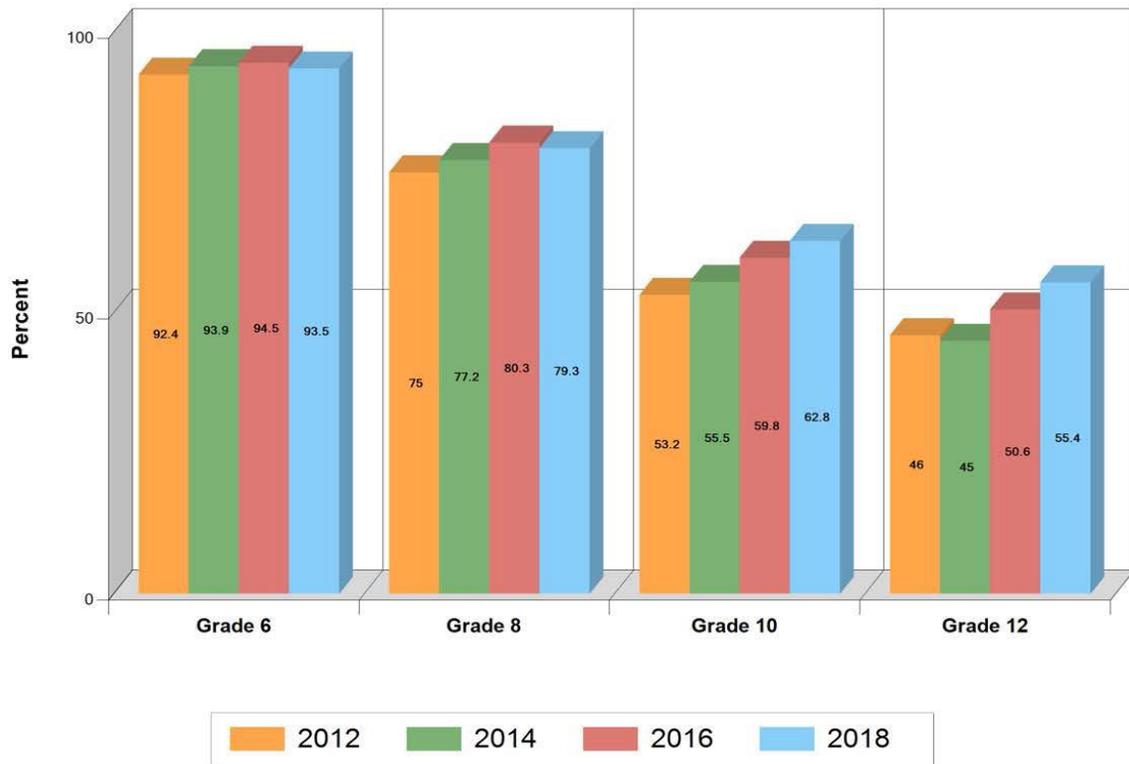
# Perception of Peer Disapproval: Alcohol

Kentucky

Question 58a - How wrong do your friends feel it would be for you to have one or two drinks of an alcoholic beverage nearly every day?

Percent that answered 'Wrong' or 'Very Wrong'

Grade	2012	2014	2016	2018
6	92.4%	93.9%	94.5%	93.5%
8	75%	77.2%	80.3%	79.3%
10	53.2%	55.5%	59.8%	62.8%
12	46%	45%	50.6%	55.4%



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

### ALCOHOL

A long recognized critical gap of Kentucky's prevention system is collecting local data on adult drinking trends and delivering prevention services to this population. The NSDUH data cited above only applies to the state. Since Kentucky has no local or even regional data, it is difficult from an epidemiological standpoint to identify areas of the state where the need for alcohol prevention services are greatest.

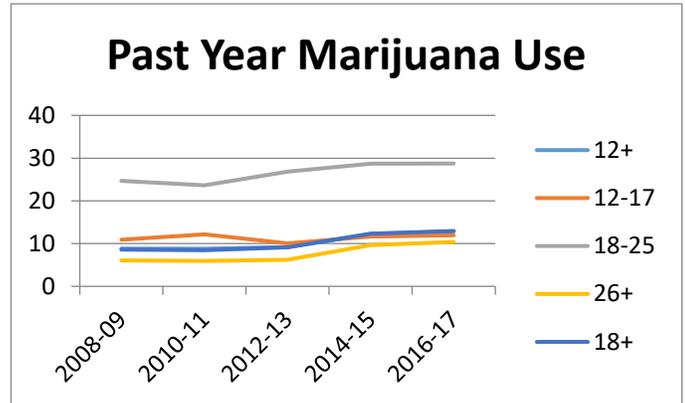
### **Addressing the Need:**

### ALCOHOL

To address underage drinking and binge drinking, each Regional Prevention Center will have an underage drinking component in the annual work plan submitted to the Branch, developed from a local, county-level needs assessment. Addressing critical gaps within the 18-25 year-olds population in Kentucky is a challenge. Kentucky proposes to engage the SEOW to analyze existing county-level data sources (admissions for alcohol treatment, DUI arrests, alcohol related traffic accidents and fatalities, rates of cirrhosis and other alcohol related health problems) to identify critical areas of need. This needs assessment will serve as the basis for future planning efforts to address alcohol use with the targeted adult population.

### **Marijuana**

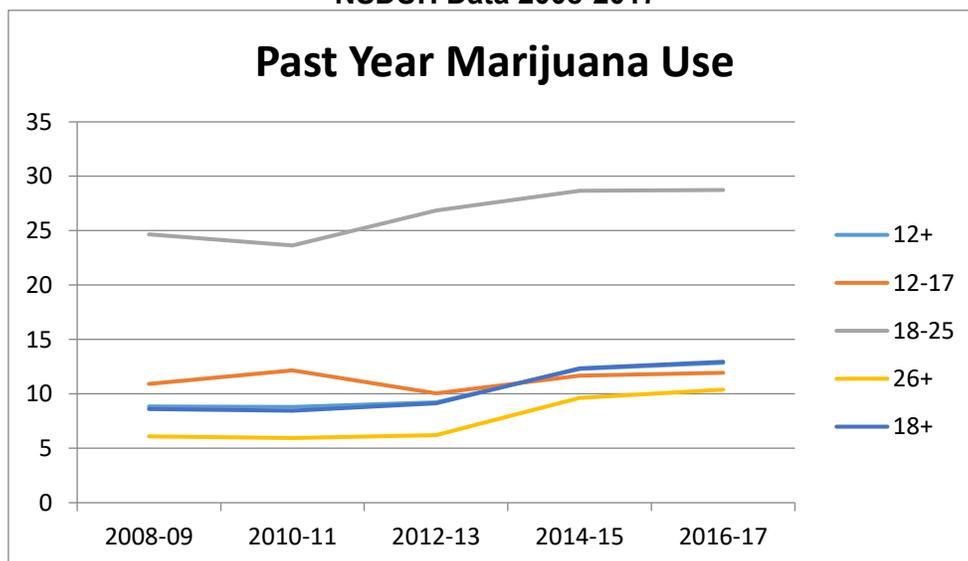
Marijuana remains the most widely used illegal substance by young people in Kentucky (KIP, 2018) despite the fact that 30-day use of marijuana by 10<sup>th</sup> grades is lower than the national rate for this age group and use among middle and high school students has been on the decline since 2010. Marijuana use among 10<sup>th</sup> graders has fluctuated on a national level over recent years. Since 2013, marijuana use among US 10<sup>th</sup> graders has steadily dropped. Kentucky mirrors these trends, and in recent years has fallen below the national average of marijuana use for 10<sup>th</sup> graders. The Four Rivers region had the highest rate of use among 10<sup>th</sup> graders with 14.5% reporting past 30-day marijuana use. The lowest rate in the state was among 10<sup>th</sup> graders in the Comprehend region in Northern Kentucky, where only 7.1% of 10<sup>th</sup> graders reported past 30-day marijuana use. Past year marijuana use rates, as measured on the (KIP survey), steadily increase from 6<sup>th</sup> through 12<sup>th</sup> grades, with 1.3% of 6<sup>th</sup> graders reporting use within the last year compared to 25.9% of 12<sup>th</sup> graders. For this age group, however, use rates have been declining since 2010, falling from a high of 30.3%. Among 10<sup>th</sup> graders in Kentucky, 4.9% report they first smoked marijuana by the age of 12. Eighth- graders were nearly as high at 5.1%, followed by 12<sup>th</sup> graders at 3.7% and 6<sup>th</sup> graders at 1.5%. While the percentage of students reporting that access to marijuana has been decreasing since 2004, 56.8% of 12<sup>th</sup> graders and nearly 42.6% of 10<sup>th</sup> graders reported that it would be "sort of easy" or "very easy" for them to access the illicit substance. Personal disapproval of marijuana use increases from 6<sup>th</sup> grader, where 96.4% of students said it was "wrong" or "very wrong" for someone to smoke marijuana to 12<sup>th</sup> graders where only 55.1% answered in the same manner. Additionally, personal disapproval ratings have been decreasing over the 10 years among 10<sup>th</sup> and 12<sup>th</sup> graders, indicating that they are perceiving it is less and less wrong for them smoke marijuana. Perception of parental disapproval of smoking marijuana has also been decreasing over the same timeframe, although nearly 16.3% of 12<sup>th</sup> graders perceive their parents would not disapprove of marijuana use. However, this is down from a high of 7.3% of 12<sup>th</sup> graders in 2004 who said that their parents would not disapprove of marijuana use, a 9% decrease in the disapproval rating. Additionally, perception of peer



disapproval of marijuana use has also decreased since 2012 (the first year the question was added to the KIP survey). The older the student the less peer disapproval they feel in regards to marijuana use. Between 2012 and 2018, peer disapproval for 6<sup>th</sup> graders was 95%. By the time those students got to 12<sup>th</sup> grade, the percentage who reported that their friends would say is was “wrong” or “very wrong” for them to smoke marijuana fell to 49.1%, a 50.9% decrease in disapproval rate from 6<sup>th</sup> to the 12<sup>th</sup> grade, reflecting the reports of increased use among 12<sup>th</sup> graders, compared to 6<sup>th</sup> graders. This number coincides with perception of peer use of marijuana, which ranges from 37.8% for 10<sup>th</sup> graders to 47.1% of 12<sup>th</sup> graders who report that at least one of their four best friends have used marijuana in the past year. While the percentage of 6<sup>th</sup> and 8<sup>th</sup> graders who report that their friends have used in the last year is much lower (3.4%, 18.7% respectively), the percentage of students perceiving that their friends are using has decreased over the last eight years. Just as disapproval ratings for marijuana use have fallen over the past decade so too have risk perception. Only 37.6% of 10<sup>th</sup> graders reported that the risk of harm was moderate or great if they tried marijuana once or twice, down from 43.9% in 2004. The perception of harm also decreases significantly from the 6<sup>th</sup> grade to the 12<sup>th</sup>. The perception of harm among 6<sup>th</sup> graders was nearly 66%, compared to 30.1 % for 12<sup>th</sup> graders. And even when the amount of marijuana used increases to once or twice a week (compared to just trying marijuana once or twice in a lifetime), the percentage of 10<sup>th</sup> graders who perceived moderate or great risk was only 50.2%. The number was 9.4% lower for 12<sup>th</sup> graders at 40.8%, compared to 72% for 6<sup>th</sup> graders.

According to NSDUH data, past year marijuana use for most age groups is trending upward, with significant gaps between use rates of the 18-25-year-olds and the rest of the population. For the 18-25 age range, NSDUH data shows that since 2010, the rate of past year marijuana use has climbed from a rate of 23.6 to 28.7. Data from the Treatment Episode Data Set (TEDS) shows that admissions for Marijuana use since 2013 has increased. Prevention efforts will focus on continuing the decrease of use among middle and high school students while also addressing the increasing use among 18-25-year-olds, as well as increased consequences of use requiring hospitalization.

**NSDUH Data 2008-2017**



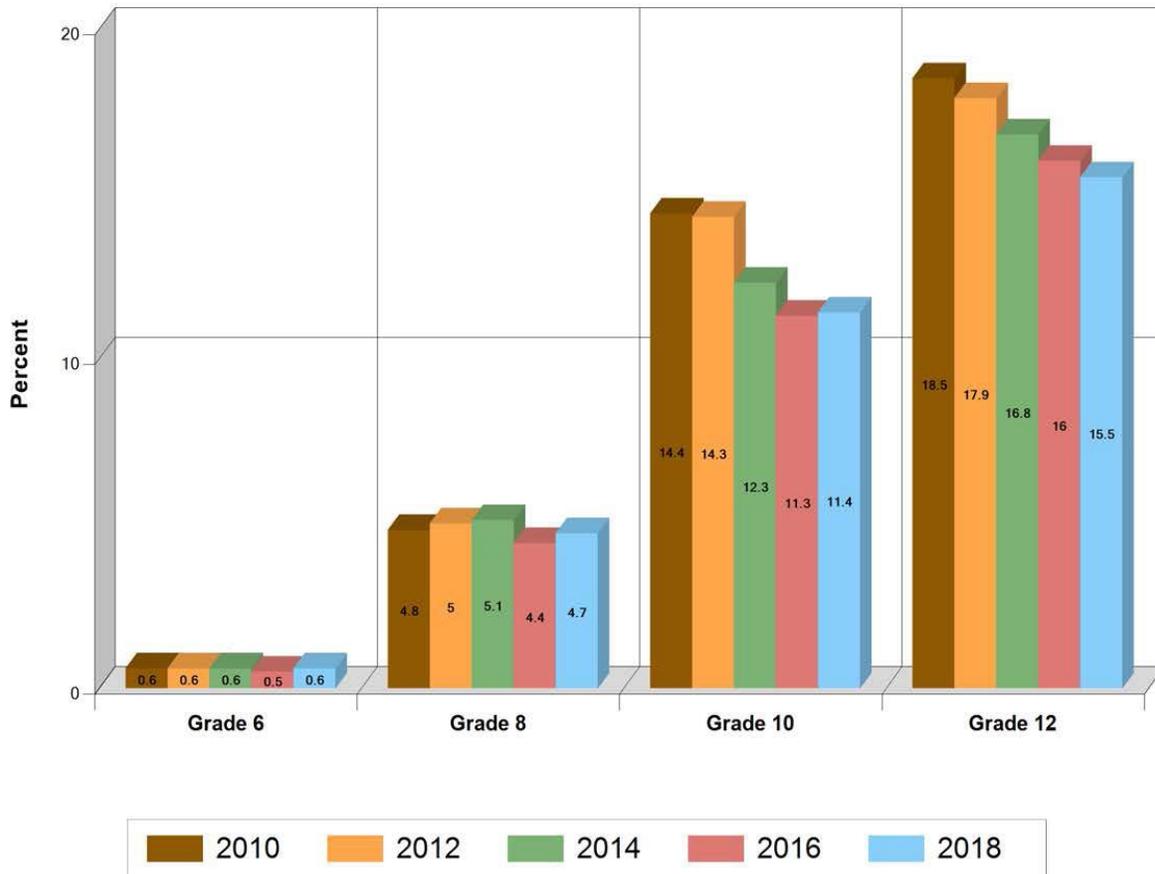
# 30 Day Marijuana Usage

Kentucky

Question 34b - On how many occasions (if any) in the past 30 days have you used marijuana?

Percent that answered at least 1 occasion

Grade	2010	2012	2014	2016	2018
6	0.6%	0.6%	0.6%	0.5%	0.6%
8	4.8%	5%	5.1%	4.4%	4.7%
10	14.4%	14.3%	12.3%	11.3%	11.4%
12	18.5%	17.9%	16.8%	16%	15.5%



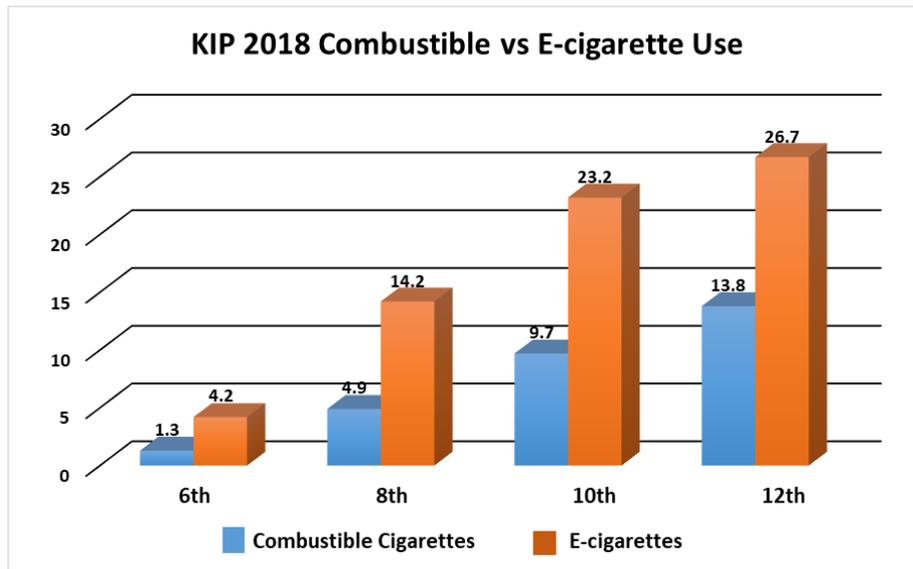
**Unmet Needs:**

Marijuana prevention efforts will focus on increasing the perception of risk of use as well as decreasing the perceived access of the drug. Additional focuses will be on decreasing early initiation of use, increasing peer and parental disapproval, and reducing use consequences that lead to hospitalization.

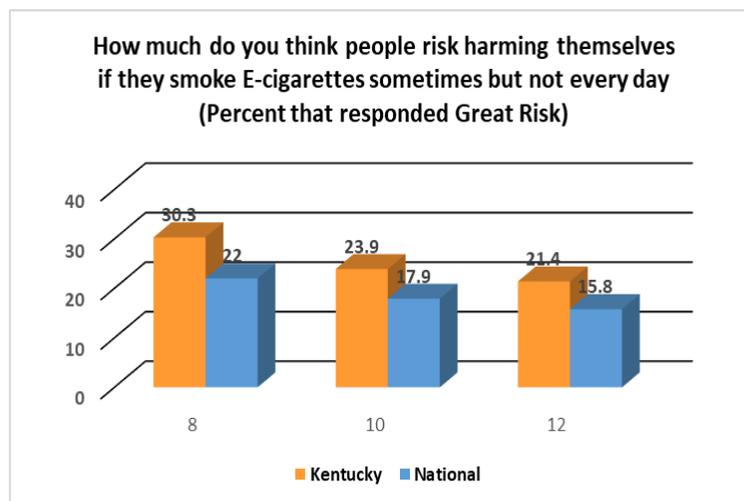
**SUBSTANCE 1: NICOTINE**

The Kentucky Prevention System has made significant progress in reducing underage tobacco use. According to the 2018 Kentucky Incentives for Prevention Survey, past thirty day use of combustible cigarettes by all grades surveyed (6, 8, 10,12) have fallen to record lows. Use among 10th graders for example has decreased by 55% from 21.7% in 2004 to 9.7% in 2018. However, these gains have been reversed by a corresponding increase in the use of e-cigarettes. (See graph.) In fact, use of e-cigarettes in Kentucky across all grades is roughly equivalent to combustible cigarette rates 15 years ago. In 2012 (the first year that e-cigarettes were included in the survey) 11% of students reported using an e-cigarette in the past 30 days. This number subsequently dropped to 8% in 2016 but then doubled to 16% in 2018. We suspect that the popularity of JUUL, a new e-cigarette that uses nicotine salts rather than a traditional liquid nicotine solution, is a contributing factor to this increase. The nicotine salt allows for a more pleasing “throat hit” and allows nicotine to enter the blood stream faster than other brands of e-cigarettes which provides the user with a dopamine rush similar to combustible cigarettes. JUUL was virtually unknown in Kentucky in 2016. Since that time, however it has become the e-cigarette brand of choice in the United States, capturing 70% of the e-cigarette market share. Our survey data also reveals that students who do not smoke combustible cigarettes are now at risk for nicotine addiction through the use of e-cigarettes. In 2014, 18.2% of students who used an e-cigarette in the last 30 days had never smoked a cigarette in their lives. In 2018, that number rose to 40%. In real numbers, using the 2018 survey results, this means that an additional 8,162 youth in Kentucky who had never smoked a cigarette have now entered the nicotine gateway.

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

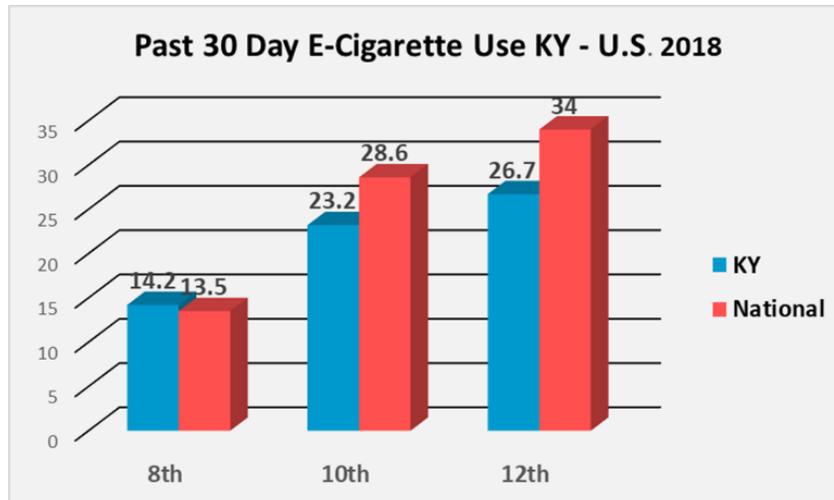


National focus group data has shown that many youths do not equate JUUL with other types of e-cigarettes and refer to their JUUL use as “JUULing” rather than vaping. It was for this reason that JUUL was specifically added to the menu of e-cigarettes in the 2018 administration of the KIP survey. This misconception, coupled with the fact that 70% of youth were not even aware that JUUL contains nicotine, are cause for great alarm. Compared to national data, Kentucky youth have a higher perception of risk of e-cigarettes than their national counterparts; however, their usage rates are only slightly below the national average. (See chart). Focus group data collected by Kentucky’s Tobacco Prevention Enhancement Site (recently renamed Nicotine Prevention Enhancement Site) reveals that peer pressure, virtually non-existent when it comes combustible cigarettes, is a significant factor in youth use of E-cigarettes. In four focus groups conducted in different areas of the state, youth routinely said that they rarely, if ever, felt pressured to smoke “regular” (combustible) cigarettes because they smelled bad and were unhealthy. But e-cigarettes were cool, easy to inhale because of the flavors and were thought to be much safer than regular cigarettes.



The KIP survey does not ask youth how youth obtain their e-cigarettes. The YRBS however, does track retail access. In 2017 YRBS, 14% of Kentucky youth who had used electronic cigarettes in the last 30 days prior to the survey reported that they bought them in a store such as a convenience store, supermarket, discount store, gas station, or vape store. We also know from the focus group data cited above that, underage youth obtain e-cigarettes from peers who sell them at school.

As far as adult use of e-cigarettes is concerned, according to the 2017 BRFSS, Kentucky adults use e-cigarettes at significantly higher rates than the national average; 6.1% compared to 4.3%. We do not know what percentage of these adults smoke only e-cigarettes and what percentage are dual users of both e-cigarettes and combustible cigarettes, however, according to national BRFSS data, 58% of adult e-cigarette users also use combustible cigarettes on a regular basis.



**Addressing the Need:**

To address underage use of electronic nicotine devices (ENDs), Kentucky will begin by realigning state resources to address capacity gaps. Kentucky’s Tobacco Prevention Enhancement Site has recently been re-organized and renamed the “Nicotine Prevention Enhancement Site” to reflect new nicotine usage patterns and delivery systems. The Nicotine Prevention Enhancement Site Specialist will work closely with the Kentucky Synar Program Coordinator and the Tobacco Prevention and Cessation Branch of the Department for Public Health to ensure analysis and translation of new data and resources to the prevention providers in the field. The Nicotine Prevention Enhancement Site Specialist will be responsible for making these new resources available to Kentucky’s fourteen Regional Prevention Centers.

The Prevention and Promotion Branch in collaboration with the Kentucky Prevention Network, the Department for Public Health and the University of Kentucky School of Nursing has launched a series of statewide e-cigarette and JUUL trainings to address stakeholder questions and misconceptions stemming from the e-cigarette industry’s narrative about 1) the health effects of and toxicity levels of e-cigarettes, 2) the effectiveness of e-cigarettes as a cessation device, 3) e-cigarettes as the gateway to nicotine addiction, and 4) effective community and school e-cigarette policies to address underage e-cigarette usage. The DBH Prevention and Promotion Branch will continue to provide e-cigarette trainings around the state as needed.

We will also work closely with our Synar Program Coordinator to increase the number of e-cigarette inspections in the Synar sample, and to monitor e-cigarette noncompliance rates relative to combustible cigarettes. E-cigarettes were added to the Synar protocol in FFY 2018. Last year Kentucky increased its number of E-cigarette inspections from 10 to 30. Among the three categories of products inspected – combustible cigarettes, e-cigarettes and smokeless tobacco -- e-cigarettes had the highest noncompliance rate at 14.3%, as opposed to 10.6% for smokeless tobacco and 8% for combustible cigarettes. DBH plans to increase the number of e-cigarette inspections for Synar 2020 to 25% of the total sample, which would place the total number of e-cigarette inspections to just over 100. This will allow the state to determine if the 2019 results are indicative of a trend. I.e. that it is easier for youth to obtain e-cigarettes than combustible cigarettes through retail sources. DBH will also collaborate with the Kentucky Attorney General’s Office to conduct environmental scans of Kentucky’s Assurance of Voluntary Compliance (AVC) participants. DBH intends to engage its statewide network of Youth Empowerment groups and adult supervisors to conduct these scans. This will enable us to measure AVC participant compliance and to suggest corrective measures in the event of non-compliance. The data gathered from the scans will also provide our prevention workforce an inventory of the types of END products being sold around the state so they can better educate community stakeholders as to what

kinds of products youth in their respective areas are using. We will also collaborate with DPH and other state-level stakeholders to design consistent messaging around e-cigarettes.

DBH will use its TRUST Compliance Check Program to further engage communities by requiring that at least 50% of their compliance checks involve e-cigarette or liquid nicotine.

DBH will also look at ways to leverage its network of Youth Empowerment Specialists, created through the SOR Grant, to gather qualitative data on youth END use and to better understand the contributing factors that need to be addressed on the local level.

## **Substance Abuse Treatment**

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

Kentucky implemented the Affordable Care Act and expanded Medicaid coverage in 2014 to a larger population. Most critical to this population is the ACA parity requirement that ensures substance use disorder (SUD) and mental health services are covered. Prior to this, Medicaid SUD services were only available to pregnant and post-partum (up to 60 days) women, including case management and prevention services.

Pregnant women are a priority population in accordance with Center for Substance Abuse Treatment (CSAT) regulations. The Community Mental Health Centers (CMHC) screen for substance use disorder at initial contact and provide care within twenty-four (24) hours. If no such facility has the capacity to admit provide treatment, interim services are be made available 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.

Kentucky has fourteen (14) substance use programs designed specifically for pregnant women that receive public funding.

- 1. KY-Moms Maternal Assistance Towards Recovery (MATR)** is a program that engages pregnant and parenting women in universal, selective, and indicated substance use prevention education services, as well as identifies, assesses, and links pregnant and postpartum women to substance use and/or mental health treatment, recovery supports, and other community resources. Engaging pregnant and parenting women in intensive case management services provides an opportunity to increase readiness for treatment, while providing support for women with a mild, moderate, or severe substance use disorder. Evidence Based Practices (EBP) used include Screening, Brief Intervention, Referral and Treatment (SBIRT), Motivational Interviewing, Prime for Life (PRI) and a Contingency Management program. KY-Moms MATR services have recently expanded and are now providing prevention and case management services in all fourteen (14) regions.
- 2. Project LINK** is an intensive case management program that engages pregnant and parenting women in the Louisville Metro area. The program offers outreach and case management services for women diagnosed with a mild, moderate, or severe substance use disorder and is designed to identify, assess, and link pregnant and postpartum women to substance use treatment, recovery supports and other community resources. Evidence Based Practices (EBP) used include Screening, Brief Intervention, Referral and Treatment (SBIRT), Motivational Interviewing, and a Contingency Management program.

3. **PRIDE Program** is an intensive case management program that engages pregnant and parenting women in the Lexington Metro area. The program offers outreach and case management services for women diagnosed with a mild, moderate, or severe substance use disorder and is designed to identify, assess, and link pregnant and postpartum women to substance use treatment, recovery supports and other community resources. Evidence Based Practices (EBP) used include Screening, Brief Intervention, Referral and Treatment (SBIRT), Motivational Interviewing, and a Contingency Management program.
4. **Independence House** provides long term residential substance use treatment, intensive outpatient, medication-assisted treatment, and targeted case management services for women during pregnancy and post-partum. Located in Southeastern Kentucky, it serves women from all over the state and allows newborns to reside with mothers during treatment.
5. **Chrysalis House** is a residential and transitional housing treatment program 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 receiving treatment. Chrysalis House partners with the UK Pathways and Beyond Birth clinics to provide obstetrics services, medication assisted treatment and healthcare referrals for pediatric services at UK hospital.
6. **Freedom House I and II** provides a holistic and comprehensive program that is designed to treat the women's substance use disorder. Their program includes residential, transitional housing, intensive outpatient and medication-assisted treatment for pregnant and parenting women. The program accommodates infants and other children to reside with the mother during treatment. A third Freedom House is planned for Eastern Kentucky to open in the Fall 2019.
7. **Serenity House:** Serenity House is an eight (8)bed residential treatment program for pregnant and parenting women with substance use disorders. Residents can stay at Serenity House up to nine (9) months during pregnancy and up to six (6) post-partum with their infant. Residents of Serenity House receive counseling for Substance Use Disorder (SUD) and co-occurring mental health disorders, Trauma informed programing, Parenting, Peer Support Services, Targeted Case Management, Hazelden Betty-Ford Comprehensive Opioid Response and 12 Step facilitation and self-help groups, and other supportive services. Residents obtain prenatal care and Medication Assisted Treatment (MAT) through partnerships with local providers as an essential part of their comprehensive treatment for opioid dependency. Serenity House offers an array of services that promote maternal bonding, recovery, health and wellness of both the mother and the infant.
8. **Centerstone:** Centerstone located in the Metro Louisville area operates The Addiction Recovery Center (ARC) for Women and The Women's Renaissance Center (WRC) in Shelbyville.

ARC, located in an urban Jefferson County, offers residential and an Intensive Outpatient program for pregnant and parenting women. WRC, located in rural Shelby County, is a residential facility (8 bed) that provides comprehensive services to pregnant and parenting women and their children. Multiple therapeutic modalities are used in both locations including the following;

- Evidence Based Mental Health and Addiction Treatment including Medication Addiction Treatment (MAT)
- Trauma Informed Care
- Child-Parent Psychotherapy, (CPP). CPP aims to support and strengthen the caregiver-child relationship through interaction and observation for trauma-exposed children ages 0-5.

- Incredible Years. Incredible Years is a training series for parents to increase parent-child connectedness and promote the child's overall well-being. Participants gain important skills for reducing difficult behaviors.
- Life skills and parenting skills for a healthy safe pregnancy for mother and child.
- Employment Supports
- Peer Support Services (PSS) for Pregnant and Parenting Women. PSS offer recovery-focused, person-centered support from individuals who are in recovery from a mental health or substance use disorder with specific training to address the needs of this population.
- Transitional housing and supportive services as individuals and families move through the continuum of care.

Their goal is to provide a warm, nurturing environment for women with a substance use disorder and their children and families.

**9. Office of Drug Control Policy Expansion Grants** to fund Neonatal Abstinence Syndrome treatment and supports:

- a. Transitions, Inc. provides residential treatment and transitional housing services for pregnant and parenting women. , The Recovery Treatment Center (RTC) has thirty (30) treatment beds for PPW. Services include; Medication Assisted Treatment, on-site healthcare and OB/GYN services, transportation, Targeted Case Management, services promoting child/parent bonding and recovery supports. Dayton Healthy Baby House is a transitional house serving women and children. Services include IOP, Outpatient, Peer support, rental assistance, recovery supports and Individual Placement Supports (IPS) Supported Employment.
- b. LifeSkills, Inc. Park Place Recovery Center for Women is a 16 bed residential facility specifically designed for pregnant and parenting women struggling with SUD. Infants remain with their mothers to promote bonding and attachment. Comprehensive services are provided for the family, including family therapy, self-help groups, trauma services, Person Centered Treatment Planning, group therapy, and aftercare services. Medication assisted treatment is also included. Transitional services are provided to assist the family
- c. Haven4Change is owned and operated by LifeSkills and is a 24 bed transitional facility for parenting women and their children. Recovery support services include continuing education, job training and placement, skill building and integration back into the community. Aftercare services include; support meetings, outpatient services through Lifeskills qualified community mental health services and Recovery Community Support groups such as Alcoholics Anonymous (AA) Narcotics Anonymous (NA) Alanon and several Faith-Based groups.
- d. Communicare: The Elizabethtown Alcohol and Substances Treatment Center (EAST) program is an eight (8)-bed recovery residence and intensive outpatient program for pregnant, post-partum and parenting women with opioid use disorder. Services include Medication Assisted treatment, individual and group therapy, peer support, case management and other comprehensive services to assist mothers and their families in recovery. Passages Eastern Care Center is an eight (8) bed transitional recovery residence (including children) offering IOP, Parent Child Interactive Therapy (PCIT) MAT, Daily Living Skills, support for continuing education, job placement, childcare partnerships and recovery supports.
- e. Kentucky River: Hollyberry House operates as transitional living apartments with intensive treatment options that provide 24-hour supports with parenting, addiction recovery, counseling for trauma or other co-occurring issues, and options for long-term linkage into effective recovery models, as well as support from early childhood specialty programs for NAS, would offer a holistic program that is sustainable with available resources. Hollyberry House is a Modified Treatment Community approach designed to assist pregnant and parenting women with substance use problems, and who lack the necessary support systems in their community to sustain recovery.

Residents are able to have 2 preschool children stay with them in an effort to support the family unit and to assist the resident in caring for her children while sustaining recovery.

**10. Plan of Safe Care Initiative:** Kentucky's Plan of Safe Care (POSC) Initiative focuses on developing a Community Safety Net for Substance Exposed Infants (SEI) and families suffering from Substance Use Disorder (SUD). The focus of this effort is to develop a collaborative community response to address the needs of the infants, mothers and their families by promoting partnerships and linkages between service providers, stakeholders, community partners and families to improve outcomes for this population. The initiative recognizes the relationship between trauma and adverse childhood experiences and substance use disorder and mental illness. It seeks to ensure services and supports are coordinated, available and accessible to this population.

There are four POSC Pilot sites, led by regional Community Mental Health Centers (CMHC) in partnership with the local Department for Community Based Services (DCBS), Child Protective Services staff, working with other community partners and stakeholders to implement this initiative in their communities. Three additional POSC Pilot sites will begin work this fiscal year covering over half of the state's CMHC regions

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

- Early identification, screening and engagement of pregnant women who are using substances
- Appropriate treatment for pregnant women, including timely access, comprehensive medication, and guidelines and standards for treatment
- Consistent hospital screening of pregnant and postpartum women and their infants.
- Consistent hospital notifications to DCBS
- Memoranda of Agreement for information sharing and monitoring infants and families across systems
- Ongoing care plans for mothers and their infants

Currently, Kentucky's statewide prevention and treatment infrastructure is growing due to the expansion of Medicaid in 2014 to the larger population and the inclusion of coverage for Substance Use Disorder (SUD) treatment services. Across the state there are approximately twenty one (21) residential treatment programs/transitional living programs and eighty-eight (88) intensive outpatient programs available (including private providers) that serve pregnant women. Fourteen (14) of the residential treatment programs/transitional living programs accept pregnant women and allow the woman's dependent children to live on-site with her during treatment.

The Pathways program at Polk Dalton Clinic in Lexington, KY (part of UK Healthcare) provides evidence based comprehensive care for opioid dependent pregnant women in a structured clinic setting that included prenatal care, substance abuse counseling (including Medication Assisted Therapy), and neonatology consultation. This program provides important comprehensive, coordinated services for this population that often have difficulty obtaining prenatal services.

Kentucky Care Integration is a five year, \$10 million SAMHSA funded grant to integrate primary care and behavioral health utilizing the chronic care model and health homes style approach. KCI is targeting adults with mental illness, adults with severe mental illness, and adults with substance use disorder, all of whom have significantly higher chances of developing chronic health conditions when compared to the general public. KCI is currently in year two and has established integrated clinics with bi-directional referral systems in Louisville, Prestonsburg, Paintsville, Pikeville, and Belfry.

The state of Kentucky currently has twenty (28) Narcotic Treatment Programs/Opioid Treatment Programs that accept pregnant women, along with approximately 1000 Buprenorphine DATA 2000 waived 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 2015 grant (PFS 2015), Kentucky All Schedule Prescription Electronic Reporting (KASPER) system, enactment of House Bill 1(HB1) and Senate Bill 192 (SB192), Medicaid expansion, Regional Prevention Centers (RPCs), KY Health Now, and implementation of the Kentucky Agency for Substance Abuse Policy (KASAP). 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.

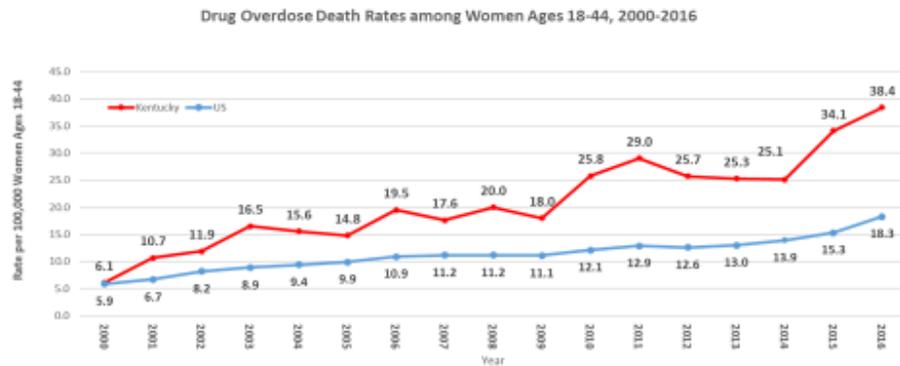
Multiple trainings have been provided across the state for behavioral health professionals, health care professionals, community based service providers, and other community agencies with specific training and information on opioid use disorder, neonatal-abstinence syndrome (NAS), trauma informed care, American Society of Addiction Medicine (ASAM), Motivational Interviewing (MI) and other Evidence-Based Practices. In an effort to address NAS, KY Department of Behavioral Health, Developmental and Intellectual Disabilities has worked in collaboration with the following agencies and organizations; the Kentucky Perinatal Association, Norton Healthcare, the University of Louisville, the University of Kentucky Division of Neonatology, and the Kentucky Chapter of ACOG.

Kentucky is working with many agencies and departments to collect data annually on substance-exposed infant births and/or substance usage during pregnancy. Kentucky data sources include, State Epidemiology Outcomes Workgroup (SEOW), Child Welfare data, and Vital Statistics data. 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 to assist in identifying potential substance exposure during pregnancy or risk of 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 creates barriers to seeking and accessing treatment.
- According to a 2018 article from the National Institute on Drug Abuse about 5% of pregnant women aged 15-44 reported to using illegal drugs and 9.4% reported using alcohol during their pregnancy.
- In Kentucky, overdose deaths in women of Childbearing age have increased dramatically over the past 10 years.

## KY Overdose Deaths in Women of Childbearing Age

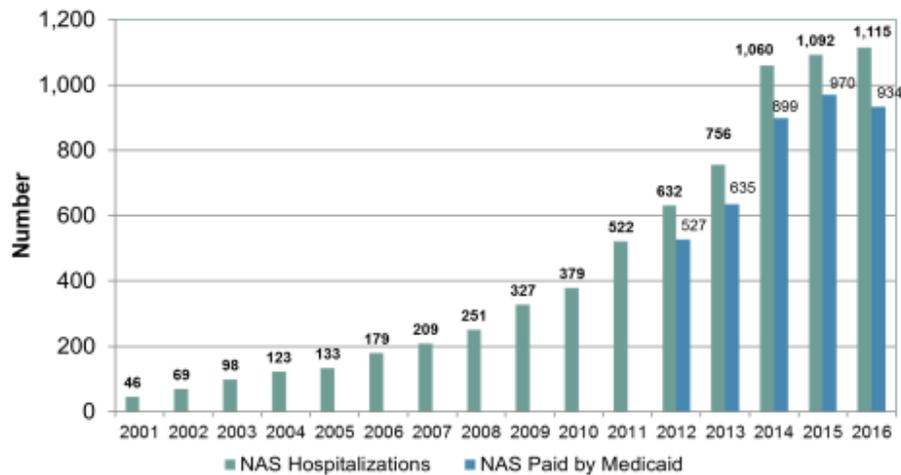


Deaths were counted under each relevant category. Produced by the Kentucky Injury Prevention and Research Center (KIPRC), a bona fide agent for the Kentucky Department for Public Health, January 2017. Data sources: Centers for Disease Control and Prevention, National Center for Health Statistics, Multiple Cause of Death 1999-2016 on CDC WONDER Online Database, released December, 2017. Data are from the Multiple Cause of Death Files, 1999-2016, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/mcd/>.



- Pregnant women, who chronically misuse prescription medications, also have a greater-than-normal risk for medical complications.  
Kentucky is primarily a rural state, which creates challenges to both identifying the need for services and providing access to services in many remote areas of the commonwealth.
- With the 2014 expansion of Medicaid services and coverage the state has struggled with the development of quality and comprehensive SUD services.
- Despite recent increase in the availability of services for pregnant and parenting women, the opioid epidemic has placed a burden on KY's system of care. There is a continued need to increase and improve services for this population.
- Kentucky lacks statewide criteria for screening pregnant women for substance use. As a result, many women are not being identified and/or referred to treatment. Early identification and treatment of pregnant women who use substances can reduce the risks of substance-exposed infants, Fetal Alcohol Disorder and NAS. 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 Neonatal Abstinence Syndrome (NAS) and screen infants appropriately.
- Stigma associated with pregnant women and substance use disorder continues to create barriers to identification and treatment of this population. In an effort to reduce stigma, ongoing training and education to professionals and community partners continues to be a crucial need.
- From 2000 to 2016, there has been a dramatic increase in the number of Kentucky infants hospitalized with Neonatal Abstinence Syndrome (NAS). In 2000, there were nineteen (19) NAS babies hospitalized in the state, by 2016, 1115 babies were reported hospitalized with NAS.

## NAS Hospitalizations of KY Newborns



- 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.

### **Addressing the Need:**

- 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; prevention, outpatient, residential services, case management, peer support, 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 safe sleep practices and reduction 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 protective services) to train front line staff on identifying substance use and misuse and treatment and on how to make appropriate referrals for treatment when working with pregnant and parenting mothers. Better identification of the role of SUD in child abuse and neglect cases and improving access to services can improve the outcome for the children and their families.
- Enhance KY-Moms: Maternal Assistance Towards Recovery prevention and case management services, focusing on the use of Evidence Based Practices and Evidence Informed Practices, 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.

- Move towards a system of care to address the concerns surrounding substance use prior to pregnancy through post-delivery and beyond. Improving intervention services during all stages of pre- and post-pregnancy can result in service provision that is interrelated and interconnected.
- Continue to collaborate with community partners on a statewide Plan of Safe Care protocol.

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- CDAR: Center for Drug and Alcohol Research, KY-Moms Annual Report for 2017
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**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 increased substance misuse and abuse from prescriptions pain medications, heroin and fentanyl along with reemergence of cocaine and methamphetamine, often laced with opioids. We know that among young children coming into Out Of Home Care (OOHC) in Kentucky; more than 74% 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 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 suggest the need for more effective and evidence based assessments and interventions to address the needs of families affected by substance abuse. The increase use and misuse of opioid medications, as well as the increase in heroin use, create additional challenges for DCBS frontline staff in providing specialized services for these families. Substance Abuse was a risk factor in approximately 70% of open child abuse and neglect cases and 75% of cases resulting in removal of the child from the home.

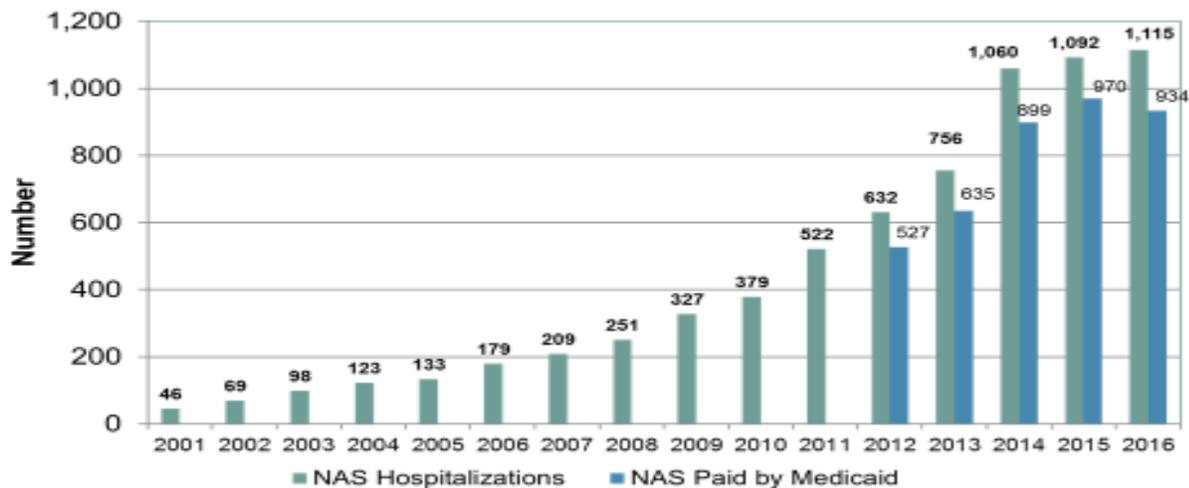
## Incidents of Substance Abuse as a Risk Factor KY 2018 (KY DCBS)

Case Status	Substance Abuse as a Risk Factor	Substance Abuse not identified as a risk factor	Total
Total Open Cases	8,494 69.4%	3,737 30.6%	12,231 100%
Open Cases Children remain in the home	6,571 68.1%	3,075 31.9%	9,646 100%
Open Cases Children removed from home	1,923 74.4%	662 25.6%	2,585 100%



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

## NAS Hospitalizations of KY Newborns



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 rates of heroin

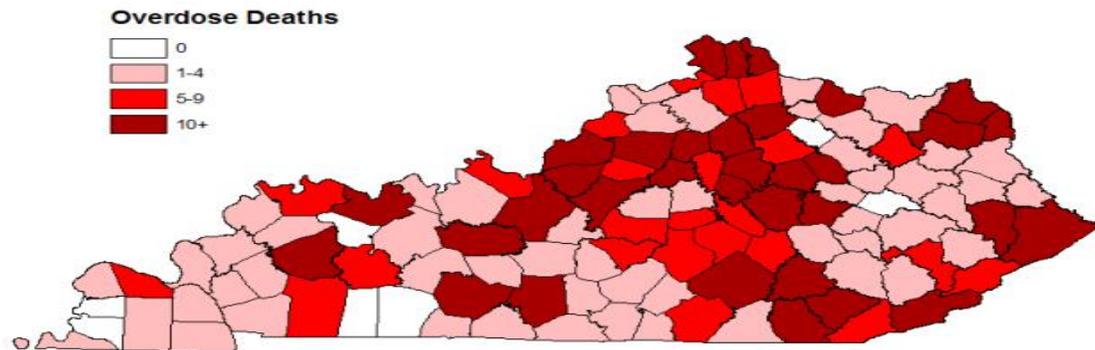
use: women, the privately insured, and people with higher incomes. Addiction to prescription painkillers is the strongest risk factor for heroin addiction (CDC Vital Signs).

- More than nine in ten people who used heroin also used at least one other drug (CDC Vital Signs)
- Among new heroin users, approximately three out of four report having misused prescription opioids prior to using heroin.
- 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)
- In 2016, there were 1,257 unduplicated cases of NAS reported to the Department for Public Health. This represents over 100 new cases of NAS each month in Kentucky (KY DPH, 2018).

Opioids drive continued increase in drug overdose deaths:

- In 2017, Kentucky ranked 5th in the nation with an overdose death rate of 37.2, compared to the national rate of 21.7 (CDC, 2018)
- Overall, there were 1,566 drug overdose deaths among Kentucky residents in 2017 . This is an increase of 10.3% from the 1,419 deaths in 2016, and marks the fourth straight year of increase in drug overdose deaths among Kentucky residents (KIPRC, 2018)
- Overdose deaths involving Heroin in Kentucky increased by approximately 19% from 2013-2017 (KIPRC, 2018).
- Fentanyl was involved in 763 Kentucky resident overdose deaths. That accounts for 52 percent of all deaths, up from 47 percent in 2016 (ODCP, n.d.).

## Counts of Drug Overdose Deaths among Kentucky Residents, 2017



Produced by the Kentucky Injury Prevention and Research Center, as bona fide agent for the Kentucky Department for Public Health. August 2018. Data source: Kentucky Death Certificate Database, Kentucky Office of Vital Statistics, Cabinet for Health and Family Services. This report was supported by Cooperative Agreement Number 6 NU17CE002732-03-04, funded by the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention or the Department of Health and Human Services.

Data are provisional and subject to change.

Numbers <5 were suppressed according to state data release policy.

Image: (NIDA, 2019)

DBHDID participated in the SAMHSA Policy Academy in 2014 on prescription drug abuse and received In Depth Technical Assistance (IDTA) provided by the National Center on Substance Abuse and Child Welfare (NCSACW) to work on developing a System of Care for Women of Child-Bearing age and Pregnant Women who are using substances. The core team involved in the project includes; DCBS, Family Drug Courts, Public Health, Office of Drug Control Policy, Medicaid, Office of Inspector General and Community Partners including Community Mental Health Centers (CMHC), Narcotic Treatment Programs, Veterans of America Freedom House, Chrysalis House and The Polk Dalton Clinic.

As a result of the work associated with the Policy Academy, KY applied for and was awarded the SAMHSA Medication Assisted Treatment-Prescription Drug and Opioid Abuse: MAT-PDOA SMARTS Grant. With this grant, KY expanded treatment services and increased capacity for evidence-based medication assisted treatment (MAT) and other recovery support services to pregnant and postpartum women with opioid use disorders, through a partnership with two Community Mental Health Centers. Although the grant funding is no longer available, the model developed through this opportunity provided the blueprint for developing comprehensive, coordinated and collaborative SUD treatment services for parents with dependent children.

Kentucky has expanded Medicaid coverage to all Medicaid recipients. Kentucky's statewide prevention and treatment infrastructure is growing due to that expansion and the inclusion of SUD services. Medicaid services for SUD had historically only been available to pregnant and post-partum women (2 months), including case management and prevention services. With Medicaid expansion, women with dependent

children, fathers, husbands, boyfriends, and significant others can have access to substance abuse treatment and support services.

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

In FY 2018 and FY 2019, The General Assembly allocated funds to the Kentucky Agency for Substance Abuse Policy (KY-ASAP) to support the development and expansion of substance use treatment and recovery support services. As in the previous years, KY-ASAP partnered with the KDBHDID to distribute funds to Community Mental Health Centers through a competitive grant application process.

In FY 18, \$4,000,000 was awarded to 10 Community Mental Health Centers and in FY 19, \$3,000,000 was awarded to nine CMHCs to aid in treatment expansion and services. Multiple programs addressing specific needs within each communities were supported with these funds. Quick Response Teams were established in six of the CMHCs regions. Multiple expansions included clinic settings for the prescribing of the FDA approved medications used in the treatment of substance use disorders. Several intensive outpatient programs were established and outreach strategies were implemented within targeted areas.

In FY 19, initiatives focused on Re-entry of persons from prison or jail back into community settings, Supported Employment Services, Individual Placement Services and Recovery Housing were a major focus of funding. Several CMHCs expanded Transitional Housing and increased Peer Support and Case Management services to support treatment and aftercare. In addition to offering these services, two CMHCs incorporated the services of a primary clinic with SUD treatment to offer a full continuum of services in behavioral health and overall wellbeing.

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

- Need for additional treatment programs that incorporate services for families with children.
- Increased need for support services specific to families with children including; childcare, supported housing, supported employment, peer support, transportation, and life skills.
- Enhance communication and collaboration between DCBS, CMHCs and other community partners.
- More training and supervision toward workforce development in EBP to ensure the provision of effective and appropriate treatment, particularly for individuals with opioid use disorders.
- Integration with primary care providers to identify, refer, and follow-up individuals at risk of or misusing substances, including pregnant women.

***Addressing the Need:***

- Enhance the use of EBP across the system of care.
- Integrate substance use disorder and mental health services with primary care services.
- Continue to provide training and encourage the use of Person-Centered Recovery planning.
- Increase and enhance Recovery Support services.
- Expand the availability of after care and follow up services.
- Increase awareness of the availability of services and enhance the referral network.
- Encourage and facilitate collaboration among community partners.
- Increase Universal Screening by medical providers and other referring community partners using SBIRT Principles
- Continue to enhance the current system of care.

- Enhance childcare and transportation services to increase accessibility
- Create a web-based treatment locator program
- Provide education on substance use during pregnancy, NAS, Plans of Safe Care, and medication-assisted treatment.
- Include injury prevention education and strategies as part of SUD treatment and NAS discharge to prevent injuries and fatalities to infants.
- Continue to provide technical assistance to support the 2020/2021 priorities.

#### **Data Sources Used:**

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

##### **Prevalence Data:**

Reports of injection drug use are rising among individuals in the state substance abuse treatment sample. However, according to the CDC the Appalachian regions of the state are experiencing lower opioid injection drug use but a higher rate of other opioid use. The change in the number of individuals reporting ever having injected drugs showed a significant increase from SFY 2017 to SFY 2018. Of the 20,950 individuals treated for substance use disorder in the Community Mental Health Centers (CMHCs) during SFY 2018, 8,151, or 38.9%, reported having used IV drugs (DBHDID, 2019a).

Kentucky has seen an increase in individuals seeking service at CMHCs who have a diagnosis associated with opioid use disorder. Between SFY2013 and SFY2018, there was a 32.6% increase (DBHDID, 2019b).

Overall, between 2013 and 2018 there were a total of 33,104 individuals identified who sought substance use treatment in Kentucky and had a history of intravenous drug use. Between 2013 and 2018, Kentucky experienced an increase in this population of 69.2%. This data only includes individuals who sought services at the CMHCs.

Addiction to prescription opioid painkillers is the strongest risk factor for heroin addiction (CDC 2015)

- Persons with an addiction to a prescription opioid painkiller are 40 time more likely to develop an addiction to heroin
- Kentucky has the sixth highest rate of opioid prescribing in the US at 86.8 opioid painkiller prescriptions for every 100 people (CDC, 2017)

Opioids drive continued increase in drug overdose deaths:

- Overdose deaths have continued to increase from 16,849 in 1999 to over 70,000 in 2017, with a majority of those deaths involving opioids. (NIDA 2019)
- Drug overdose deaths in Kentucky increased by 10.3% from 2016 to 2017 (Akers et al., 2018).
- Kentucky saw an 18.9% increase of overdose deaths involving heroin from 2013 to 2017, with approximately 16% of overdose deaths involved the use of heroin in 2017(Akers, D. & Ward, P., 2018)
- Kentucky ranks 4<sup>th</sup> in the nation at 37.2 drugs overdose deaths per 100,000 (CDC, 2019)

Hepatitis C (HCV)

- Over 70% of persons who inject drugs long term may be infected with HCV (CDC, 2015)
- Approximately 73% of young adults with hepatitis C report injection drug use as their principal risk factor
- Kentucky rates of acute hepatitis C is more than double the national rate (CDC, 2018).
- From 2008-2015, Kentucky had the highest rate of new hepatitis C cases in the United States (Kentucky One Health, 2017)

HIV

- Kentucky has relatively low rates of HIV/AIDS, but a much higher rate of Hepatitis C. in The rate for Hepatitis C for 2015 was 2.7 per 100,000 and 2.3 per 100,000 for 2016. Approximately 9% of all new HIV infections occur among injection drug users,
- Of the 220 counties across the US identified as highly vulnerable to an HIV outbreak, 54 are in KY.

Kentucky currently has twenty-two (28) licensed Narcotic Treatment Programs (NTP), two (2) publicly funded and twenty (26) independently owned that provide Medication Assisted Treatment (MAT) in combination with Behavioral Health services to treat Opioid Use Disorder (OUD) Six of the independently owned NTPs have obtained licensure to bill Medicaid for Behavioral Health services associated with Methadone treatment. In July, 2019, KY Medicaid will begin covering Methadone treatment using a bundled rate method.

Over the past three (5) years, MAT services have become more widely available across the state. All fourteen CHMC Regions currently provide access to MAT services either directly or through MOA with community partners. DBHDID contract with CMHC requires them to inform clients with OUD that MAT services are available and to make provide services or make referrals as appropriate.

**Unmet Needs and Critical Service Gaps:**

- Although MAT services are more widely available across the state, there remains resistance and stigma in many communities to the use of medications to treat substance use disorder, limiting some clients access to a client centered services and a complete continuum of care.
- With the significant increase in individual's experiencing overdose due to opioid use, there is a need to provide immediate interventions that connect clients to SUD services.
- Although there has been a significant increase in the availability of services to address OUD treatment needs across the state, the ongoing epidemic opioid misuse and abuse, including intravenous heroin use, continues to strain the system of care.
- With the expansion of Medicaid, more individuals who previously were unable to afford services, now have coverage and can access services from a variety of providers. However, Kentucky remains a mostly rural and mountainous state, with many of the services clustered in the urban and more populated areas. Access to services for many in the state remains difficult due to poverty, transportation and location of services.
- Data collection for services continues to be incomplete. DBHDID has traditionally collected data from the CMHC client/event data set and Medicaid collects data for services covered under that program. However, DBHDID does not have access to data from programs that only accept private pay or private insurance.

**Addressing the Need:**

- Continue to ensure that all CMHCs screen for IV drug use on initial contact and refer clients for appropriate services.
- Increase the availability of peer support services with Specialized training in opioid use disorder (OUD) state wide
- Increase availability of Needle Exchange programs
- Provide peer support and referral services to Needle Exchange programs to link individuals to treatment
- Develop referral protocols and model programs for clients who present with overdose to emergency rooms
- Increase the availability of Evidence Based OUD services including MAT.

**Data Sources Used:**

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- Center on Drug and Alcohol Research (CDAR) University of KY.
- CDC Vital Signs
- Kentucky Injury Prevention and Research Center.
- 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://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/mmwr/preview/mmwrhtml/mm6417a2.htm?s_cid=mm6417a2_w)
- [http://www.cdc.gov/nchstp/stateprofiles/pdf/Kentucky\\_profile.pdf](http://www.cdc.gov/nchstp/stateprofiles/pdf/Kentucky_profile.pdf)
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Centers for Disease and Prevention. (2015). Increases in Hepatitis C Virus Infection Related to Injection Drug Use Among Persons Aged ≤30 Years — Kentucky, Tennessee, Virginia, and West Virginia, 2006–2012 Retrieved from [https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6417a2.htm?s\\_cid=mm6417a2\\_w](https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6417a2.htm?s_cid=mm6417a2_w)

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National Institute on Drug Abuse. (2019). Overdose Death Rates. Retrieved from <https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates>

### **Individuals with Tuberculosis**

#### ***Prevalence Rate:***

Kentucky continues to show a declining rate of TB, as reported by the Kentucky Department for Public Health (DPH). A total of sixty-seven (65) cases of TB were reported for 2017 and 2018, which is a rate of 1.5 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.

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

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.

***Addressing the Need:***

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 Community Mental Health Centers (CMHC) and annually at the licensed Opioid Treatment Programs (OTP). Review teams, which include a peer reviewer from the field, examine client service records for documentation of a referral for TB screening, evidence that the client was provided with information, and the option to be tested for HIV. Review team members also interview clients and program staff and review personnel records and agency policies to ensure requirements are met and the appropriate services are provided. The DBHDID continues to ensure appropriate training is available to substance use treatment staff and that continuing education is provided offering the most current information on infectious diseases.

***Data Sources Used:***

- Kentucky Department for Public Health, <http://chfs.ky.gov/NR/rdonlyres/620D69CA-AB10-4D36-8453-BCC771165F4A/0/2015CaseRatesByCountyFINAL.pdf>
- Talwar A, Tsang CA, Price SF, et al. Tuberculosis — United States, 2018. MMWR Morb Mortal Wkly Rep 2019;68:257–262. DOI: <http://dx.doi.org/10.15585/mmwr.mm6811a2External>

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

***Prevalence Data:***

According to the Kentucky HIV/AIDS Surveillance Report dated 06/30/2017, there were 139 new HIV infections diagnosed among Kentucky residents in calendar year 2017. Kentucky's annual HIV diagnosis rates have remained fairly steady from 2006-2016 with slight fluctuations between 7.1 to 8.9 cases per 100,00 population. This is comparatively lower than the US estimated rate of 12.3 per 100,000 for 2015.

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.

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

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

***Addressing the Need:***

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 use prevention and treatment professionals along with continuing education focused 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.

***Data Sources Used:***

- Department for Public Health, [http://chfs.ky.gov/NR/rdonlyres/DCA0FF73-C42B-41FD-AC90-733939C239FD/0/AnnualReport\\_2016.pdf](http://chfs.ky.gov/NR/rdonlyres/DCA0FF73-C42B-41FD-AC90-733939C239FD/0/AnnualReport_2016.pdf)

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

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

Kentucky specific data reveal:

- Approximately 26% of Kentucky high school students reports currently smoking cigarettes or cigars or using smokeless tobacco or electronic vapor products. (YRBS, 2017)
- Among youth, 13.2% of Kentucky's high school students 11<sup>th</sup> graders report binge drinking in the past month. (YRBS 2017).
- Among those 18 and older, Kentucky reports 17% using marijuana and 7% any illicit drug use other than marijuana. (KIP, 2013-14). Among youth, 21% of Kentucky 10<sup>th</sup> graders report using alcohol in the past month compared to 23.5% nationally (KIP, 2014; MTF, 2015).

It is important to note that opioids have now become one of the most lethal and preferred drug for many individuals across the nation and Kentucky. Although alcohol, marijuana and tobacco are still the top three drugs used by adolescents, results from the 2017 YRBS show that 2.1% of Kentucky high school students has tried heroin; 11% has taken prescription pain medicine without a prescription or differently than prescribed, and 2.5% has ever injected an illegal drug.

The larger metropolitan areas of Lexington, Louisville, and Northern Kentucky have been especially hard hit by this epidemic. A growing number of youth and young adults previously abusing expensive prescription drugs are now using heroin, which is cheaper and easier to buy. This is taking a deadly toll on Kentucky’s transition-age youth. 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. (KIPRC 2016). The Kentucky Opioid Response Effort (KORE), funded through SAMHSA STR and SOR dollars, is the state’s effort to implement a comprehensive targeted response to Kentucky’s opioid crisis by expanding access to a full continuum of high quality, evidence-based opioid prevention, treatment, and recovery supports. It is also important to note that Kentucky has earmarked KORE funds for transition age youth and adolescent prevention, treatment, and recovery programming. This is indicative of transformation in thinking and leadership support for adolescent treatment services in the state.

Results of the 2014-2015 National Survey on Drug Use and Health (NSDUH) reveal further distressing statistics for Kentucky’s youth. As noted in Table 1, cigarette smoking by Kentucky’s adolescents remains significantly higher than the national average. In addition, while similar to national percentages, the majority of young people who experienced a major depressive episode within the last year did not receive treatment.

ITEM	12- 17 KY	12-17 US
Past Year Marijuana Use	6.4%	7.2%
Past Month Alcohol Use	8.2%	10.6%
Past Month Cigarette Use	7.8%	4.5%
Had at least one major depressive episode (MDE) in the past year	11.1%	11.9%
Had MDE in past year and did not receive treatment	57.1%	61.1%

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

The Kentucky Incentives for Prevention (KIP, 2018) survey, a school-administered survey that assesses the extent of alcohol, drug, and tobacco use among 11 to 18 year olds throughout Kentucky added questions about military connectedness. This is an attempt to determine whether the substance use prevention, treatment, and recovery needs of military-connected youth are different than for youth who are not in military-connected families. Table 2 depicts the prevalence of prescription drug use and mental health correlates among 10<sup>th</sup> graders from military-connected families for any prescription drug use as well as the three main prescription drug classes. Tenth graders from military-connected families consistently had higher 30-day rates of prescription drug use. Military-connected youth also had higher rates of mental distress as indicated by self-harm, suicidal ideation, suicide plans, and suicide attempts. Recognizing the needs of this special population, the Kentucky Youth Treatment initiative includes military personnel of transition age and military-connected youth as special populations of focus

Table 2. Prevalence of Prescription Drug Use and Mental Health Correlates among 10th Graders from Military-Connected Families (KIP, 2018)			
Family Member on Active Duty or Veteran			
	No/Don't Know N (%)	Yes, Exactly 1 N (%)	Yes, More than 1 N (%)
<b>30-Day Prescription Drug Use</b>			
Any prescription	384 (2.2)	129 (2.6)	229 (3.4)
Opioids	431 (2.5)	143 (2.8)	262 (3.9)
Tranquilizers	228 (1.3)	66 (1.3)	129 (1.9)
Stimulants	227 (1.3)	75 (1.5)	120 (1.8)
Any of above	705 (4.1)	232 (4.7)	392 (5.9)
<b>Mental Health</b>			
Serious Psychological Distress (past 30 days)	3,658 (20.6)	1,188 (23.3)	1,754 (25.4)
Self-harm (ever in lifetime)	3,122 (17.7)	1,073 (21.1)	1,578 (23.0)
Suicide ideation (past year)	2,541 (14.1)	897 (17.3)	1,291 (18.5)
Suicide plan (past year)	1,943 (10.8)	706 (13.6)	1,045 (15.0)
Suicide attempt (past year)	1,309 (7.3)	483 (9.3)	719 (10.3)

Starting with a system of care Children's Mental Health Initiative (CMHI) grant in 2004, Kentucky began a steady track to building an infrastructure for agencies and communities to support youth who are struggling with substance use issues. Funding for services and provision of quality services for youth has been a focus of the state. DBH has a full-time staff member that serves as the Adolescent Treatment/Youth Coordinator. This position has been instrumental in facilitating infrastructure and service delivery efforts aimed at the population of focus.

Adolescent substance use services are eligible for state block grant dollars however, Kentucky allocates the majority of these funds to adult SUD providers, with very little being earmarked for adolescents. Likewise, Early and Periodic Screening Diagnostic and Treatment (EPSDT) has been available to pay for residential SUD services for eligible youth, but this has been difficult to access. With a Medicaid state plan change in January of 2014 and the implementation of the Affordable Care Act, Kentucky's Medicaid services expanded to cover substance use treatment for eligible recipients of all ages, thereby allowing youth to obtain substance use treatment services without having to utilize EPSDT, thus making it easier for youth and their families to obtain services. In addition to adding covered services, the changes to Kentucky Medicaid opened the Medicaid behavioral health provider network, making a wider variety of geographically accessible treatment options available. The above changes couple with Kentucky having been a recipient of several SAMHSA/CSAT grants focused on adolescents and young adults, Kentucky has been able to not only build services but also improve the quality of those services available for youth in the Commonwealth. Finally, Kentucky has also been able to leverage funding from other sources such as pharmaceutical settlement awards and SAMHSA State Opioid Response funding to continue to enhance the availability of and access to high quality substance use treatment services for adolescents

while waiting for an set aside of Federal Block Grant dollars specifically for adolescent treatment services

As funds specific to adolescent substance use treatment have become available, Kentucky has made great strides in promoting evidence-based practices and has implemented 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 KY Adolescent Treatment Consortium, the System of Care Academy funded in part by a system of care grant, and by securing an adolescent track at the KY School for Alcohol and Drug Studies. Training for providers and youth-serving staff include but are not limited to: Adolescent Community Reinforcement Approach, Motivational Interviewing, Seven Challenges, and Functional Family Therapy as well as general adolescent provider competency-building such as group skills, gender-specific treatment, and brain development.

A comprehensive array of services for youth with substance use disorders is now available to varying degrees across Kentucky. CMHCs, private providers, and Psychiatric Residential Treatment Facilities (PRTF) that have become licensed as Alcohol and Drug Entities and by Medicaid as Behavioral Health Services Organizations provide services for adolescents. Kentucky has recently updated their Alcohol and Other Drug Entity Licensing that now includes adolescent specific language. Thus allowing Kentucky to not only provide a more comprehensive array of behavioral health services for children and youth that adhere to the system of care values and principles but also allows the SUD services to be more supportive of adolescent specific developmental treatment needs.

As mentioned Kentucky is a recipient of a SYT-I grant, a follow up grant to the SAT-ED. With this grant, Kentucky has expanded access to developmentally appropriate, evidence-based assessment, treatment, and recovery support services for adolescents and transition-age youth. More specifically, Kentucky used funds for infrastructure improvement by training adolescent specific clinical staff in the use of the Adolescent Community Reinforcement Approach and other evidence based practices. Using evidence based practices with fidelity allows for not only improved access to high quality services but also improved outcomes for adolescents and transition-age youth (ages 12-25) who have substance use disorders and/or co-occurring substance use and mental health disorders and their families/primary caregivers.

Identified barriers in Kentucky to improving adolescent substance use services traditionally included a lack of state funds, a lack of service options, and a lack of community awareness about the problem. Data points to continued concerns with adolescent substance use issues yet providers across the state have seen a drop in youth and family seeking services. The lack of parental concern and awareness and the lack of community partner referrals has decreases cause a gap in services for youth at a young age. We fear those youth then resurface at an older age with more serious SUD and SUD related issues. Yet we have no data to indicate as such, as this is a new phenomenon.

***Infrastructure Needs:***

Through training and collaborative efforts with agencies across the commonwealth, many providers and social service agencies are now screening and assessing for youth substance use issues. However, the method of screening is not standardized across the state. Continued work is needed to encourage use of an evidence based screening and assessment tool for initial screening/assessment process (i.e. GAIN Family of instruments), with a standard way to screen and communicate results across agencies including schools and in our transitional age population, including our military families and young adults.

Kentucky has been able to address and support evidence based treatment and assessment however, the need to continue the use of these with fidelity continues to be a struggle, especially due to staff movement and turnover rate. Moreover, there is a tendency to for staff to be trained but not continue the use of the practices or use with fidelity to the model. Kentucky is working to continue to support infrastructure in using evidence based treatment and assessment by offering trainings in evidence based practices that have components of both coaching and fidelity as well as train the trainer options so that the infrastructure maintains its strength. Kentucky will 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 for child/adolescent mental health providers as well as for substance abuse providers who treat adolescents.

Through blended funding, we will also continue to support the infrastructure concerning building the policy and practices that are best suited for adolescent and young adult treatment. By better understanding the needs of the state through utilizing mapping of services and finances, funding can be restructured to offer more treatment and aftercare specifically geared toward adolescents and transitional age youth in need of behavioral health services and to identify service gaps and offer ideas to expand the continuum of services and supports.

**Data Sources Used:**

- Centers for Disease Control and Prevention (CDC). (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.
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- Substance Abuse and Mental Health Services Administration. National Survey on Drug Use and Health (NSDUH). Available at <https://nsduhweb.rti.org/>
- Kentucky Youth Advocates <http://kyyouth.org>
- [Monitoring the Future, 2015 https://www.drugabuse.gov/related-topics/trends-statistics/monitoring-future/monitoring-future-survey-overview-findings-2015](https://www.drugabuse.gov/related-topics/trends-statistics/monitoring-future/monitoring-future-survey-overview-findings-2015)
- Kentucky Injury Prevention and Research Center (KIPRC, 2016) : <https://odcp.ky.gov/Documents/2015%20KY%20ODCP%20Overdose%20Fatality%20Report%20Final.pdf>

# Planning Steps

## Quality and Data Collection Readiness

### Narrative Question:

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.*

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**Footnotes:**

## Quality and Data Collection Readiness

### **1. Briefly describe the state's data collection and reporting system and what level of data can be reported currently (e.g., at the client, program, provider, and/or other levels).**

The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) collects data from its contracted providers serving individuals in the community and in the state operated and state contracted facilities. The community-based data and facility data share common data elements and thus are relational and serve DBHDID on project-based analyses.

#### Community-Based Mental Health and Substance Use Data

DBHDID collects data from Community Mental Health Centers and other funded providers on a monthly basis. This data supports DBHDID's efforts to monitor client-level demographic and diagnostic statistics, service utilization, and provider & human staffing used to provide direct care behavioral health services (including services for mental health, substance use, and developmental & intellectual disabilities). DBHDID uses this data as source for federal Block Grant reports, National Outcome Measures (NOMS), Treatment Episode Data Set (TEDS), Client Level Data reporting (CLD), Uniform Data Reporting System (URS) and a variety of other uses. Specific to the CLD, Kentucky has successfully reported CLD using the original MH-CLD methodology since the inception year.

#### Facility Data

DBHDID daily collects data from its state operated and state contracted facilities which for behavioral health include 3 state psychiatric hospitals and 1 state psychiatric unit within a medical facility. The data collected includes client level admission and discharge information and includes demographics, diagnostic, and living arrangement (housing) status at admission and discharge. The BHDID uses this data as source for federal National Outcome Measures (NOMS), Client Level Data reporting (CLD), Uniform Data Reporting System (URS) and a variety of other uses such as SMHA Profiles and surveys.

#### Prevention Data

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

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

The Prevention Data System is maintained by Prevention and Health Promotion Branch staff, with reports developed in conjunction with RPC Directors and other special projects of the

Branch, and generated and distributed monthly by Prevention and Health Promotion Branch staff.

The reports provide RPC Directors ability to evaluate level of effort put forth in each county, with information used in planning future activities; as well, for state staff to track progress towards attaining Work Plan objectives. The Regional Prevention centers are required by contract to enter data on their substance abuse prevention efforts on a monthly basis. The PDS data is used in the compiling of our annual SAPT Block Grant Report.

The Kentucky Incentives for Prevention (KIP) survey is the primary data source used to set block grant priorities and track outcomes for Substance Use Prevention. The KIP survey, in 155 of 172 of Kentucky's school districts, provides data on the county or school district level for grades 6,8,10, and 12. The KIP survey, implemented in even numbered years, is modeled after the national *Monitoring the Future* Survey. Last year 110,487 students participated in the KIP Survey, 22,759 of which were 10th graders. In addition to the KIP Survey, Kentucky utilizes usage rates through the National Survey on Drug Use and Health (NSDUH), which is implemented annually among randomly selected youth aged 12 and older and the Youth Risk Behavioral Survey System. The NSDUH data allows for tracking general usage rates among youth ages 12-17 on an annual basis. NSDUH also provides much needed adult data which is used to set priorities for the over 17 population. YRBSS is implemented every two years in odd numbered years and provides state level consumption data.

**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.).**

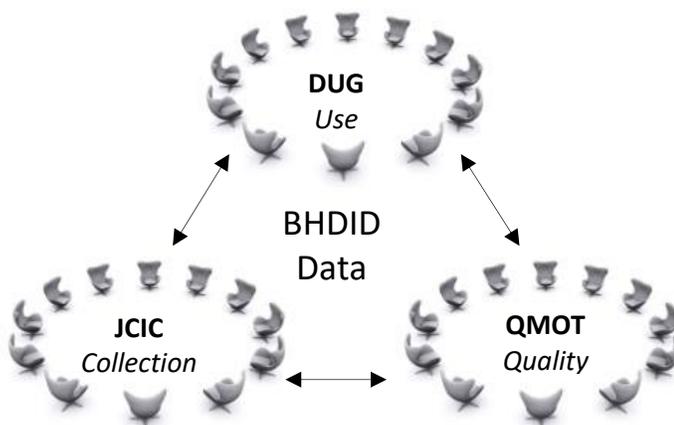
The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (BHDID) operates its community-based and facility data system within the Department. The BHDID is one Department within the Cabinet for Health and Families Services which also houses the Department for Medicaid Services, the Department for Community Based Services (DCBS is Kentucky's child welfare department), and the Department for Public Health. Each Department within the Cabinet houses its own data system(s). For purpose of project-based analysis, the various department data sets can be made relational via common data elements.

**3. Is the state currently able to collect and report on the draft measures at the individual client level (that is, by client served, but not with client-identifying information)?**

Yes, for most measures. DBHDID is challenged by collecting justice involvement data which, beyond the self-report data that is collected from behavioral health providers, data-sharing memorandum of agreements with other state agencies are required. Such agreements are difficult to maintain due to inconsistent political climate which determines whether the agreements can be established. A second area of challenge for Kentucky is the collection of school attendance data. The difficulty exists because such data is maintained at the local school/district level. Data quality among Kentucky's 173 school districts appears to be inconsistent, and aggregated data is not readily available from the state-level Department for Education.

Kentucky hosts three data-related standing teams that involve state and community partners. Each team plays a key role in defining data elements, defining processes to ensure accurate,

complete and timely data collection and defining indicators and measures of quality. Contributions from all three teams lead to successful implementation of data collection, issue resolution, and measure development.



The Data Users Group (DUG) is comprised of DBHDID staff and contracted data managers. This team provides recommendations and direction for the collection, analysis, architectural design & structure, use of data and information relevant to desired outcomes management across the Department. The team evaluates issues related to data collection, data analysis, data quality, data architecture and structure that support the provision of quality services and explores areas for improvement.

The Joint Committee for Information Continuity (JCIC) is comprised of department staff and IT representatives from the fourteen CMHCs and other contracted providers. This team makes recommendations concerning information management to the Department. The committee facilitates the development of data-related contract items between the Department and CMHCs. As a central function, the committee provides direction and assistance in the continued development of the information system to manage a public behavioral health system.

The Quality Management & Outcomes Team (QMOT) is comprised of the quality assurance officers from the fourteen CMHCs. This team provides direction for the collection of information relevant to desired outcomes, methods of measurement, and design of processes for continuous outcomes management across the Department. The team evaluates outcomes that support the provision of quality services and explores areas for improvement.

#### **4. If not, what changes will the state need to make to be able to collect and report on these measures?**

The state must further clarify the draft measures. It would be helpful to have a technical assistance webinar that reviews details of each measure and clearly explains SAMHSA's established expectations which often seem vague (e.g., when will states be required to report CLD data in a TEDS-like methodology?). Also, it would be helpful to hear from our federal partners about any expected changes in structure or organization of SAMHSA data contractors to whom states directly send data. We request that SAMHSA regularly keep states updated on

any possible changes to these contractors and perhaps include states experiences (feedback) on how well they work before making changes.

Specifically regarding the justice-involvement measure, the current political environment appears to allow formal agreements of sharing data with justice-serving state agencies. During this window of opportunity, the BHDID is attempting to establish data-sharing processes that can be maintained regardless of political climate. Specifically, the BHDID is attempting to attain data on arrests associated with the 202A evaluation for mental illness.

Specifically regarding the school attendance measure, the BHDID currently has no plan to change the method of current data-collection or to add a new methodology to collect data directly from the Department of Education. Current collection includes: 1) DBHDID maintains a self-report, school-attendance data field in the CMHC data set; and 2) A set of evaluation data collected within a program that serves a sub-group of youth having Severe Emotional Disorder who receives a higher intensity level of care. With awareness of the issue, DBHDID will continue to watch for windows of opportunity as they may arise.

**Please indicate areas of technical assistance needed related to this section. Please answer the questions as it relates to the state's ability to collect client level data. If technical assistance is needed in this area, please identify so.**

Convening states together via webinars, conference calls, or in-person meetings has proven a powerfully effective way to resolve data-collection and data-reporting issues. Facilitated meetings, among states on specific issues shared by all, would allow states to share solutions and achieve confirmation of some problems inherent to the data required by federal partners. Having those discussions facilitated by the federal partner opens up understanding of barriers to reporting the required data.

DBHDID receives data directly from the CMHCs and other contracted providers per contract requirement. Each CMHC operates as a quasi-governmental agency so they contract with various data-management vendors and electronic medical record vendors. The primary authority needed to ensure quality of data collected and timeliness of issue resolution rests between the CMHCs and their vendors; so the department has little control if vendors are unable to resolve data reporting issues for the CMHCs with whom they contract. The fact that vendors often do not highly prioritize state data reporting remains an ongoing issue. It would be helpful to learn from SAMHSA or other states ideas on how this issue can be successfully resolved. Further in the larger picture, states and federal agencies are affected by the lack of data quality accountability within private agencies; particularly those agencies that become electronic health vendors for community providers thus indirectly responsible for reporting to state agencies. It would be helpful if federal partners that require state data reporting would advocate for regulating data quality that holds accountable private electronic health record vendors working with state behavioral health (or other) data. Often the lack of quality control on private electronic health record vendors becomes the barrier to data quality for the community partner, the state and thus the federal partner.

# 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 access to employment for Adults with SMI

**Objective:**

Increase the percentage of Adults having SMI, served by the 14 CMHCs, who are employed by 1% from SFY2019 (baseline) to SFY2021 (end year for SFY2020-SFY2021 MHBG Combined Plan).

**Strategies to attain the objective:**

- \* Each of the 14 CMHCs is required by contract to report employment status annually through the MIS system (Client and Event Data Set)
- \* Provide awareness opportunities and training regarding Recovery Principles and the importance of Supported Employment in the service delivery array. KY uses the Individual Placement and Support (IPS) Supported Employment Model.
- \* Provide training and technical assistance to ensure that CMHCs understand how to engage clients in Supported Employment and bill for this service.
- \* Provide training and technical assistance and fidelity monitoring to ensure most effective implementation of IPS Supported Employment services.
- \* Provide training for how to most effectively supervise the work of IPS Supported Employment specialists.

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1  
**Indicator:** Adults with SMI who are employed  
**Baseline Measurement:** The SFY2019 percentage of Adults with SMI served by the 14 CMHCs who are employed. SFY2019: 18.22% = 7,979/43,765  
**First-year target/outcome measurement:** Increase by .25% the percentage of Adults with SMI served by the 14 CMHCs who are employed from SFY2019. This is a comparison across consecutive years. FROM SFY2019: 18.22% TO SFY2020: 18.47%  
**Second-year target/outcome measurement:** Increase by .25% the percentage of Adults with SMI served by the 14 CMHCs who are employed from SFY2019. This is a comparison across consecutive years. FROM SFY2019: 18.22% TO SFY2021: 18.72%

**Data Source:**

MIS Client/Event Data Set used by the Department and the 14 CMHCs.

**Description of Data:**

Data report to show per State Fiscal Year (SFY): Report ID: BG\_Adult\_1\_5\_State  
 \* the total number of unduplicated Adults w SMI served by the 14 CMHCs,  
 \* the total number of unduplicated Adults w SMI served by the 14 CMHCs who are employed,  
 \* the percentage of Adults w SMI served by the 14 CMHCs who are employed.

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

The Department's MIS system expects the Employment Status field to be updated at least annually or at any time employment status changes and will report those employed at year end for the purposes of this measure.

**Priority #:** 2

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

**Priority Type:** MHS

**Population(s):** ESMI

**Goal of the priority area:**

Increase access to evidence-based practices for individuals with early serious mental illness/first episode of psychosis (ESMI/FEP).

**Objective:**

Fully implement Coordinated Specialty Care (CSC) as an evidence-based practice to serve individuals with ESMI/FEP, in at least two (2) additional outpatient sites from SFY 2019 (baseline year) until the end of SFY 2021. KY has named ESMI/FEP programs iHope.

**Strategies to attain the objective:**

Provide training and technical assistance to all outpatient sites funded to provide CSC to this population.  
Utilize consultation from national experts in the field.  
Convene biannual meetings with all key contacts from CMHCs regarding this population, to provide technical assistance/education regarding CSC and the ESMI/FEP population.

**Annual Performance Indicators to measure goal success**

<b>Indicator #:</b>	1
<b>Indicator:</b>	Coordinated Specialty Care (CSC) as an evidence-based practice to individuals with ESMI/FEP.
<b>Baseline Measurement:</b>	At the end of SFY 2019, three (3) outpatient iHOPE sites had fully implemented Coordinated Specialty Care to serve individuals with ESMI/FEP (CMHC Regions 4, 6, and 11).
<b>First-year target/outcome measurement:</b>	By the end of SFY 2020, at least one (1) additional outpatient site will offer fully implemented CSC to individuals with ESMI/FEP.
<b>Second-year target/outcome measurement:</b>	By the end of SFY 2021, at least one (1) additional outpatient sites offering fully implemented CSC to individuals with ESMI/First Episode of Psychosis.

**Data Source:**

Department Periodic Report (DPR) Form 113H/CMHC Contract Reporting Requirement  
MIS Client/Event Data Set used by DBHDID and 14 CMHCs.

**Description of Data:**

**DEFINITIONS:**

The following implementation stage definitions are from:

"The Snapshot of State Plans for Using the Community Mental Health Block Grant 10 percent set-aside to address first episode psychosis" (August 2018, page 5)

The state's current level of program implementation, which is defined here as the highest level any CSC program has reached in the state. The five levels of implementation are:

- 1) The Exploration stage requires states to identify their communities' needs, assess organizational capacity, identify programs that meet community needs, and understand program fidelity and adaptation.
- 2) The Installation stage occurs once a program has been selected and the state begins making the changes necessary to implement the program. This includes training and community outreach and education activities.
- 3) Initial Implementation occurs when the program has first been implemented and practitioners begin to put into practice the techniques learned during the exploration and installation stages.
- 4) Full Implementation occurs once staffing is complete, caseloads are full, services are provided, and funding streams are in place.
- 5) Program Sustainability occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the program. For the purposes of this report, program sustainability also includes the expansion of existing services.

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

Coordinated Specialty Care was first implemented in Kentucky in SFY 2017. DPR form 113H was first required in SFY 2018.

Fully achieved, there should be five (5) fully implemented CSC programs by the end of SFY 2021.

**Priority #:** 3  
**Priority Area:** Children with Severe Emotional Disturbance (SED)  
**Priority Type:** MHS  
**Population(s):** SED

**Goal of the priority area:**

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

**Objective:**

Increase the total unduplicated number of children with SED who receive Peer Support services by 1% from SFY 2019 to SFY 2021.

**Strategies to attain the objective:**

CMHCs with Transition Age Youth specialized programming are required by contract to have Peer Support services available to children and youth being served.  
Provide training and technical assistance to ensure that CMHCs understand how to recruit, retain and support Youth and Family Peer Support Specialists in the workplace and how to appropriately document and bill for services.  
Provide awareness activities and training regarding resiliency and recovery principles and guidance in the process of fully including Peer Specialists in the service delivery array.  
Provide training and technical assistance regarding the supervision of Peer Specialists.  
Provide technical assistance to CMHCs regarding accurate coding procedures for reporting Peer Support services in client/event data set.

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1  
**Indicator:** Peer Support services for children with SED.  
**Baseline Measurement:** Total number of children who received Peer Support services from the 14 CMHCs in SFY 2018=949  
**First-year target/outcome measurement:** Increase by .25% (of 949) the total number of children who receive Youth and Family Peer Support services, from the 14 CMHCs, during SFY 2020.  
**Second-year target/outcome measurement:** Increase by .25% (of 949) the total unduplicated number of children and youth with SED who receive Youth and Family Peer Support services from the 14 CMHCs during SFY 2021.

**Data Source:**

MIS Client/Event data set used by DBHDID and the 14 CMHCs.

**Description of Data:**

Data report to show the total number of children served by the 14 CMHCs who received Peer Support services in the SFY (including youth or family, individual or group Peer Support). Report form AMART using service codes 147-150. may be some duplication across services but unduplicated count of children within a service. Additional children to be served equals 24 in SFY 2020 and an 24 additional in SFY 2021.

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

N/A

**Priority #:** 4  
**Priority Area:** Primary Substance Use Prevention  
**Priority Type:** SAP  
**Population(s):** PP

**Goal of the priority area:**

Increase the perception of harm of electronic cigarettes  
Reduce the incidence of Underage Drinking

**Objective:**

Increase the perception of harm of electronic cigarettes by 10 graders who participate in the KY Incentives for Prevention (KIP) Survey

Decrease the number of 10th graders who reported drinking alcohol in the past 30 days

**Strategies to attain the objective:**

- \* Educate youth, parents, educators about the harmful effects of electronic cigarette use
- \* Work to update current school and community smoke-free policies to address electronic cigarette use
- \* Conduct Reward/Remind type activities with retailers related to sale of electronic cigarettes to minors
- \* Improve early prevention screening and assessment of adolescents in school settings
  
- \* Educate parents about "host parties" and the negative psychological effects of alcohol consumption by adolescents
- \* Work to establish Social Host Ordinances
- \* Implement Strategies such as "I Won't be the One" to reduce underage use social access to alcohol
- \* Improve early prevention screening and assessment of adolescents in school settings

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1

**Indicator:** Number of 10th graders who participate in the KIP survey who report perception of harm of electronic cigarettes.

**Baseline Measurement:** 2018 KIP Survey results indicate that 42.8% of 10th graders, who participate in the KIP survey reported that using electronic cigarettes on a regular basis had moderate to great risk

**First-year target/outcome measurement:** The first year measure is a process measure based on total number of activities that address electronic cigarette use among youth as measured by data entered into the Prevention Data System (based on the 2018 KIP data analysis). Based on a data pull, for SFY 19, a total of 21 Kentucky residents, under the age of 19, received prevention services targeting tobacco use. First-year measure for the block grant will increase by 200 activities as a result of the emphasis placed on prevention of this substance.

**Second-year target/outcome measurement:** Increase by .5% the percentage of 10th graders, who participate in the KIP survey, who report use of electronic cigarettes on a regular basis has "moderate" to "great risk" (43.5%)

**Data Source:**

Kentucky Incentives for Prevention (KIP) Survey 2018; Kentucky's Prevention Data System

**Description of Data:**

The KIP Survey provides information about student perceptions about the health dangers of electronic cigarettes and perceived accessibility of electronic cigarettes in the community. The 2018 survey included the addition of several new questions related to electronic cigarettes. Once the survey data are gathered and analyzed, each participating school district receives a report outlining district-specific results, and depicting comparisons to the region, state and (when available) the rest of the country.

The KIP survey, conducted every other year, is Kentucky's largest source of data related to student use of alcohol, tobacco, and other drugs (ATOD), as well as a number of factors related to potential substance use. In 2018, over 128,000 students representing 159 school districts (of the state's 173) completed the survey, and the information gathered provided an invaluable substance abuse prevention tool for 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::**

Results of KIP survey conducted in 2020 are available in 2021

**Indicator #:** 2

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

**Baseline Measurement:** 2018 KIP Survey results indicate 16.8% of 10th graders answered that they consumed alcohol, on at least one occasion, in the past 30 days.

**First-year target/outcome measurement:**

The first year measure is a process measure based on the total number of activities that address underage drinking use among youth as measured by data entered into the Prevention Data System (based on the 2018 KIP data analysis). Based on a data pull, for SFY 19, a total of 5,590 youth, under age 19, received prevention services targeting underage drinking. First-year measure for the block grant will increase by 10% the number of (6,149) activities as a result of the emphasis placed on prevention of this substance.

**Second-year target/outcome measurement:**

Decrease by 2% the number of 10th graders that report having consumed alcohol, on at least one occasion, in the past 30 days.

**Data Source:**

Kentucky Incentives for Prevention (KIP) Survey 2018, Kentucky's Prevention Data System

**Description of Data:**

The KIP Survey provides information about student perceptions and use of alcohol, tobacco and other drugs. Once the survey data is gathered and analyzed, each participating school district receives a report outlining district-specific results, and depicting comparisons to the region, state and (when available) the rest of the country.

The KIP survey 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 2018, over 128,000 students representing 159 school districts (of the state's 173) completed the survey, and the information gathered provided an invaluable substance abuse prevention tool for 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::**

Results of KIP survey conducted in 2020 are available in 2021

**Priority #:**

5

**Priority Area:**

Pregnant Women/Women with Dependent Children who have Substance Use Disorders (SUDs)

**Priority Type:**

SAT

**Population(s):**

PWWDC

**Goal of the priority area:**

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

**Objective:**

Pilot a project to create a model of Plan of Safe Care (POSC) that meets the Child Abuse Prevention Treatment Act (CAPTA) requirements, is multi-disciplinary and intended to support the mother and infant prior to and after discharge from the hospital.

**Strategies to attain the objective:**

Identify services and supports that will be provided to the mother and infant, delineates who is responsible for ensuring that the mother is aware of, and does access, needed services and supports.

Recognize the important role of trauma and adverse childhood experiences in this population.

Stabilize the mother in the post-partum period and provide ongoing supports for positive parenting and a safe home environment for the infant. Create opportunities to reduce adverse childhood experiences for the infant, thereby improving long-term outcomes, and reducing the risks of repeating the cycle of substance use as they grow into their teenage years.

**Annual Performance Indicators to measure goal success****Indicator #:**

1

**Indicator:**

Plan of Safe Care (POSC) Implementation

**Baseline Measurement:**

Establishment of POSC sites to serve PWWDC with SUDs

**First-year target/outcome measurement:**

At the end of SFY2020, four (4) Community Mental Health Centers (CMHC) will become a

fully established Plan of Safe Care site. (CMHC regions 6,11,14,15)

**Second-year target/outcome measurement:** By the end of SFY2021, at least one (1) additional Plan of Safe Care site will be established at a CMHC.

**Data Source:**

Opioid STR Table B2 (KORE funding and CMHC contract Reporting Requirement)  
Annual Statement of Revenues and Expenditures

**Description of Data:**

By the end of 2021, there will be at least 5 POSC sites implemented.

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

N/A

**Priority #:** 6

**Priority Area:** Persons who inject drugs

**Priority Type:** SAT

**Population(s):** PWID

**Goal of the priority area:**

Reduce the outbreak of Hepatitis by increasing the availability and awareness of Syringe Exchange Programs (SEPs) statewide

**Objective:**

Monitor the number of Syringe Exchange Programs across the Commonwealth of KY

**Strategies to attain the objective:**

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

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1  
**Indicator:** The number of syringe exchange programs (SEPs) in place across the Commonwealth  
**Baseline Measurement:** At the end of SFY2019, there are 62 SEPs across the Commonwealth.  
**First-year target/outcome measurement:** Increase by 2, the total number of SEPs from SFY2019. This is a comparison across consecutive years.  
**Second-year target/outcome measurement:** Increase by 2, the total number of SEPs from SFY2019. This is a comparison across consecutive years.

**Data Source:**

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

**Description of Data:**

The Kentucky Department for Public Health monitors the number of SEPs statewide and also posts to their website the days/hours of operation for each program. The ODCP and the KY Harm Reduction Coalition and the Ky DBHDID work to educate individuals and communities about the cost, benefits, myths and best practice guidelines for initiating and maintaining SEPs.

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

Syringe Exchange Programs (SEPs) have existed and been studied extensively in the United States since 1988. The SEPs are community-based programs that provide access to sterile needles and syringes free of cost, facilitate safe disposal of used needles and syringes and offer safer injection education. The SEPs in Kentucky also provide linkages to critical services and programs including substance use

disorder treatment programs; overdose revention education; screening, care and treatment for HIV and viral hepatitis; prevention of mother-to-child transmission; hepatitis A and hepatitis B vaccination; screening for other sexually transmitted diseases and tuberculosis; partner services and other medical, social and mental health services.

In direct response to Senate Bill 192, enacted during the 2015 regular legislative session, the Kentucky Department for Public Health has published guidelines for local health departments implementing harm reduction and syringe exchange programs.  
NO SABG FUNDS WILL BE USED TO SUPPORT THE SEPS.

**Priority #:** 7  
**Priority Area:** Individuals who receive Substance Use Disorder (SUD) services and have or are at risk for Tuberculosis (TB)  
**Priority Type:** SAT  
**Population(s):** TB

**Goal of the priority area:**

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

**Objective:**

Ensure all clients presenting for substance use services are adequately screened for TB.

**Strategies to attain the objective:**

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

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1  
**Indicator:** Screen for TB persons who present for substance use services at the 14 CMHCs.  
**Baseline Measurement:** During SFY2019, 12 of 14 CMHCs had written policies and procedures regarding the screening for TB for all individuals seeking services for substance use disorders  
**First-year target/outcome measurement:** Thirteen of 14 CMHCs will submit their written policies and procedures regarding the screening for TB for all individuals seeking services for substance use disorders. This is a comparison across consecutive years. FROM SFY2019: 12 TO SFY2020: 13  
**Second-year target/outcome measurement:** Fourteen of 14 CMHCs will submit their new or updated written policies and procedures regarding the screening for TB for all individuals seeking services for substance use disorders. This is a comparison across consecutive years. FROM SFY2019: 12 TO SFY2020: 14

**Data Source:**

Submission of copies of TB-related policies and procedures, by 14 CMHCs, through the Plan and Budget process conducted in April

**Description of Data:**

Written policies and procedures submitted by CMHCs

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

N/A

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

**Footnotes:**

## Planning Tables

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

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2020/2021. ONLY include funds expended by the executive branch agency administering the SABG

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

Activity (See instructions for using Row 1.)	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	\$31,799,571		\$0	\$46,866,250	\$26,673,324	\$0	\$0
a. Pregnant Women and Women with Dependent Children**	\$6,528,200		\$0	\$0	\$1,845,500	\$0	\$0
b. All Other	\$25,271,371		\$0	\$46,866,250	\$24,827,824	\$0	\$0
2. Primary Prevention	\$0		\$0	\$0	\$0	\$0	\$0
a. Substance Abuse Primary Prevention	\$8,559,380		\$0	\$3,300,875	\$663,746	\$0	\$0
b. Mental Health Primary Prevention							
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)							
4. Tuberculosis Services	\$0		\$0	\$0	\$0	\$0	\$0
5. Early Intervention Services for HIV	\$0		\$0	\$0	\$0	\$0	\$0
6. State Hospital							
7. Other 24 Hour Care							
8. Ambulatory/Community Non-24 Hour Care							
9. Administration (Excluding Program and Provider Level)	\$400,000		\$0	\$1,399,800	\$3,284,800	\$0	\$0
<b>10. Total</b>	<b>\$40,758,951</b>	<b>\$0</b>	<b>\$0</b>	<b>\$51,566,925</b>	<b>\$30,621,870</b>	<b>\$0</b>	<b>\$0</b>

\* Prevention other than primary prevention

\*\* The 20 percent set-aside funds in the SABG must be used for activities designed to prevent substance misuse.

**Footnotes:**

# Planning Tables

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

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2020/2021.

Planning Period Start Date: 7/1/2019      Planning Period End Date: 6/30/2021

Activity (See instructions for using Row 1.)	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. Primary Prevention							
a. Substance Abuse Primary Prevention							
b. Mental Health Primary Prevention <sup>†</sup>		\$0	\$0	\$0	\$0	\$0	\$0
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG) <sup>**</sup>		\$1,786,000	\$0	\$0	\$0	\$0	\$0
4. Tuberculosis Services							
5. Early Intervention Services for HIV							
6. State Hospital			\$76,099,800	\$46,051,000	\$136,450,400	\$1,857,000	\$0
7. Other 24 Hour Care		\$0	\$30,002,800	\$6,029,800	\$10,021,392	\$30,200	\$0
8. Ambulatory/Community Non-24 Hour Care		\$15,891,272	\$2,054,524	\$3,548,000	\$76,728,770	\$0	\$0
9. Administration (Excluding Program and Provider Level) <sup>***</sup>		\$113,674	\$236,000	\$206,000	\$5,589,060	\$0	\$0
<b>10. Total</b>	<b>\$0</b>	<b>\$17,790,946</b>	<b>\$108,393,124</b>	<b>\$55,834,800</b>	<b>\$228,789,622</b>	<b>\$1,887,200</b>	<b>\$0</b>

\* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED

\*\* Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside

\*\*\* Per statute, Administrative expenditures cannot exceed 5% of the fiscal year award.

**Footnotes:**

# Planning Tables

**Table 3 SABG Persons in need/receipt of SUD treatment**

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	4028	303
2. Women with Dependent Children	24716	3907
3. Individuals with a co-occurring M/SUD	43671	12237
4. Persons who inject drugs	10379	8151
5. Persons experiencing homelessness	622	2649

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

KY funds one program in the largest metropolitan area that is a Homeless Shelter providing services for men with SUD and thus the aggregate number in treatment might appear inflated. It also seems likely that the self report number of 622 is low.

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**Footnotes:**

In Need Estimates: UK-CDAR Report

In Treatment Estimates: Amart Reports - SFY 2018

# Planning Tables

**Table 4 SABG Planned Expenditures**

Planning Period Start Date: 10/1/2019      Planning Period End Date: 9/30/2021

Expenditure Category	FFY 2020 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment *	\$15,899,785
2 . Primary Substance Abuse Prevention	\$4,279,690
3 . Early Intervention Services for HIV **	\$0
4 . Tuberculosis Services	\$0
5 . Administration (SSA Level Only)	\$200,000
<b>6. Total</b>	<b>\$20,379,475</b>

\* Prevention other than Primary Prevention

\*\* For the purpose of determining the states and jurisdictions that are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state a state's AIDS case

rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

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**Footnotes:**

# Planning Tables

**Table 5a SABG Primary Prevention Planned Expenditures**

Planning Period Start Date: 10/1/2019    Planning Period End Date: 9/30/2021

Strategy	A	B
	IOM Target	FFY 2020 SA Block Grant Award
1. Information Dissemination	Universal	\$190,149
	Selective	\$0
	Indicated	\$0
	Unspecified	\$0
	<b>Total</b>	<b>\$190,149</b>
2. Education	Universal	\$142,612
	Selective	\$47,537
	Indicated	\$0
	Unspecified	\$0
	<b>Total</b>	<b>\$190,149</b>
3. Alternatives	Universal	\$180,642
	Selective	\$9,507
	Indicated	\$0
	Unspecified	\$0
	<b>Total</b>	<b>\$190,149</b>
4. Problem Identification and Referral	Universal	\$19,015
	Selective	\$47,537
	Indicated	\$123,597
	Unspecified	\$0
	<b>Total</b>	<b>\$190,149</b>
	Universal	\$2,139,170

5. Community-Based Process	Selective	\$427,834
	Indicated	\$285,223
	Unspecified	\$0
	<b>Total</b>	<b>\$2,852,227</b>
6. Environmental	Universal	\$190,149
	Selective	\$0
	Indicated	\$0
	Unspecified	\$0
	<b>Total</b>	<b>\$190,149</b>
7. Section 1926 Tobacco	Universal	\$0
	Selective	\$0
	Indicated	\$0
	Unspecified	\$0
	<b>Total</b>	<b>\$0</b>
8. Other	Universal	\$0
	Selective	\$0
	Indicated	\$0
	Unspecified	\$0
	<b>Total</b>	<b>\$0</b>
<b>Total Prevention Expenditures</b>		<b>\$3,802,972</b>
<b>Total SABG Award*</b>		<b>\$20,379,475</b>
<b>Planned Primary Prevention Percentage</b>		<b>18.66 %</b>

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

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**Footnotes:**

## Planning Tables

**Table 5b SABG Primary Prevention Planned Expenditures by IOM Category**

Planning Period Start Date: 10/1/2019      Planning Period End Date: 9/30/2021

Activity	FFY 2020 SA Block Grant Award
Universal Direct	\$1,711,338
Universal Indirect	\$1,140,892
Selective	\$532,416
Indicated	\$418,326
<b>Column Total</b>	<b>\$3,802,972</b>
<b>Total SABG Award*</b>	<b>\$20,379,475</b>
<b>Planned Primary Prevention Percentage</b>	<b>18.66 %</b>

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

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**Footnotes:**

## Planning Tables

**Table 5c SABG Planned Primary Prevention Targeted Priorities**

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2020 and FFY 2021 SABG awards.

Planning Period Start Date: 10/1/2019    Planning Period End Date: 9/30/2021

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

**Footnotes:**

# Planning Tables

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

Planning Period Start Date: 10/1/2019      Planning Period End Date: 9/30/2021

FY 2020			
Activity	A. SABG Treatment	B. SABG Prevention	C. SABG Combined*
1. Information Systems	\$80,000	\$0	\$0
2. Infrastructure Support	\$10,000	\$20,000	\$0
3. Partnerships, community outreach, and needs assessment	\$0	\$228,397	\$0
4. Planning Council Activities (MHBG required, SABG optional)	\$10,000	\$0	\$0
5. Quality Assurance and Improvement	\$25,000	\$8,000	\$0
6. Research and Evaluation	\$0	\$365,321	\$0
7. Training and Education	\$255,000	\$55,000	\$0
<b>8. Total</b>	<b>\$380,000</b>	<b>\$676,718</b>	<b>\$0</b>

\*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

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**Footnotes:**

The dollar amounts above are for one year only (2020).

Amount of SABG Primary Prevention funds (from Table 4, Row 2) to be used for Non-Direct-Services/System Development Activities for SABG Prevention, Column B, and/or SABG Combined, Column C = \$476,718.

Amount of SABG Administration funds (from Table 4, Row 5) to be used for Non-Direct-Services/System Development Activities for SABG Prevention, Column B, and/or SABG Combined, Column C = \$200,000.

## Planning Tables

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

MHBG Planning Period Start Date: 10/01/2019      MHBG Planning Period End Date: 09/30/2021

Activity	FFY 2020 Block Grant
1. Information Systems	\$423,059
2. Infrastructure Support	\$48,134
3. Partnerships, community outreach, and needs assessment	\$208,045
4. Planning Council Activities (MHBG required, SABG optional)	\$13,687
5. Quality Assurance and Improvement	\$50,000
6. Research and Evaluation	
7. Training and Education	\$640,000
<b>8. Total</b>	<b>\$1,382,925</b>

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**Footnotes:**

The dollar amounts above are for one year only (2020).  
 No changes needed due to updated correspondence from SAMHSA.

# Environmental Factors and Plan

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

### Narrative Question

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Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.<sup>22</sup> Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.<sup>23</sup> It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.<sup>24</sup>

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.<sup>25</sup> SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.<sup>26</sup> For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.<sup>27</sup>

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.<sup>28</sup>

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.<sup>29</sup> The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.<sup>30</sup> Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes<sup>31</sup> and ACOs<sup>32</sup> may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.<sup>33</sup> Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.<sup>34</sup>

One key population of concern is persons who are dually eligible for Medicare and Medicaid.<sup>35</sup> Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.<sup>36</sup> SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.<sup>37</sup> Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.<sup>38</sup> SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with

partners to mitigate regional and local variations in services that detrimentally affect access to care and integration. SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.<sup>39</sup> Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs. SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.<sup>40</sup>

SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.<sup>41</sup> However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

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

<sup>23</sup> Research Review of Health Promotion Programs for People with SMI, 2012, <http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper>; About SAMHSA's Wellness Efforts, <https://www.samhsa.gov/wellness-initiative>; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, *JAMA*; 2007; 298: 1794-1796; Million Hearts, <https://www.samhsa.gov/health-care-health-systems-integration>; Schizophrenia as a health disparity, <http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml>

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

<sup>25</sup> Social Determinants of Health, Healthy People 2020, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>; <https://www.cdc.gov/nchstp/socialdeterminants/index.html>

<sup>26</sup> <http://www.samhsa.gov/health-disparities/strategic-initiatives>

<sup>27</sup> <http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/>

<sup>28</sup> Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. [https://www.integration.samhsa.gov/integrated-care-models/FG-Integrating\\_12.22.pdf](https://www.integration.samhsa.gov/integrated-care-models/FG-Integrating_12.22.pdf); Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, <https://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf>; Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. <http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf>; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf>; American Psychiatric Association, <http://www.psych.org/practice/professional-interests/integrated-care>; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series ( 2006), Institute of Medicine, National Affordable Care Academy of Sciences, [http://books.nap.edu/openbook.php?record\\_id=11470&page=210](http://books.nap.edu/openbook.php?record_id=11470&page=210); State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, <http://nasadad.org/nasadad-reports>

<sup>29</sup> Health Care Integration, <http://samhsa.gov/health-reform/health-care-integration>; SAMHSA-HRSA Center for Integrated Health Solutions, (<http://www.integration.samhsa.gov/>)

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

<sup>31</sup> Health Homes, <http://www.integration.samhsa.gov/integrated-care-models/health-homes>

<sup>32</sup> New financing models, <https://www.integration.samhsa.gov/financing>

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

<sup>34</sup> What are my preventive care benefits? <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>

<sup>35</sup> Medicare-Medicaid Enrollee State Profiles, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html>; About the Compact of Free Association, <http://uscompact.org/about/cofa.php>

<sup>36</sup> Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, <http://www.cbo.gov/publication/44308>

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

<sup>38</sup> TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014; 71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013; 70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

<sup>39</sup> Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, <http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORX/PEP13-RTC-BHWORX.pdf>; Creating jobs by addressing primary care workforce needs, <https://obamawhitehouse.archives.gov/the-press-office/2012/04/11/fact-sheet-creating-health-care-jobs-addressing-primary-care-workforce-n>

<sup>40</sup> About the National Quality Strategy, <http://www.ahrq.gov/workingforquality/about.htm>; National Behavioral Health Quality Framework, Draft, August 2013, <http://samhsa.gov/data/NBHQF>

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

**Please respond to the following items in order to provide a description of the healthcare system and integration activities:**

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.  
  
CMHCs are required to assess the physical health of each consumer they serve during the intake process and at least annually thereafter. Clinicians and case managers work closely with community primary care physicians, local health departments, and other health care providers to address the overall health needs of adults. The Department has assisted several regions in improving tools used to assess physical health concerns and continue to encourage further assessment and integration of physical and mental health care.  
  
With support from a federal grant, Kentucky has partnered with Mountain Comprehensive Care and Centerstone of Kentucky to enhance opportunities for people to receive health, wellness and recovery services, building on current service continuums that include care coordination, the provision primary care, and embed behavioral health services. The sites serve as pilots for future state-wide integrated care policy directives.
2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.  
  
Some areas of Kentucky are currently providing co-located, integrated services, including evidence based screening and assessments, diagnosis, prevention, and treatment according to a shared, individualized care plan, as well as outreach, engagement, and retention strategies.
3. a) Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs?  Yes  No  
  
b) and Medicaid?  Yes  No
4. Who is responsible for monitoring access to M/SUD services by the QHP?  
DBHDID and several other entities monitor access to services but there is not a comprehensive plan in place to date.
5. Is the SSA/SMHA involved in any coordinated care initiatives in the state?  Yes  No
6. Do the M/SUD providers screen and refer for:  
  
a) Prevention and wellness education  Yes  No  
  
b) Health risks such as

- ii) heart disease  Yes  No
- iii) hypertension  Yes  No
- iv) high cholesterol  Yes  No
- v) diabetes  Yes  No
- c) Recovery supports  Yes  No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care?  Yes  No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services?  Yes  No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?  
Ensuring that the public, state agency personnel (Medicaid, Department of Insurance) and others remain aware of the provisions and how to respond when access does not occur as required is often the greatest obstacle.

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

N/A

Please indicate areas of technical assistance needed related to this section

N/A

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

**Footnotes:**

Data Source: CMHC Form 115 & KCI

# Environmental Factors and Plan

## 2. Health Disparities - Requested

### Narrative Question

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In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)<sup>42</sup>, [Healthy People, 2020](#)<sup>43</sup>, [National Stakeholder Strategy for Achieving Health Equity](#)<sup>44</sup>, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for [Culturally and Linguistically Appropriate Services in Health and Health Care](#) (CLAS)<sup>45</sup>.

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

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."<sup>46</sup>

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status<sup>47</sup>. 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<sup>48</sup>. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

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

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

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<sup>42</sup> [http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS\\_Plan\\_complete.pdf](http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf)

<sup>43</sup> <http://www.healthypeople.gov/2020/default.aspx>

<sup>44</sup> [https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS\\_07\\_Section3.pdf](https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf)

<sup>45</sup> <http://www.ThinkCulturalHealth.hhs.gov>

**Please respond to the following items:**

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?
  - a) Race  Yes  No
  - b) Ethnicity  Yes  No
  - c) Gender  Yes  No
  - d) Sexual orientation  Yes  No
  - e) Gender identity  Yes  No
  - f) Age  Yes  No
2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population?  Yes  No
3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers?  Yes  No
4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations?  Yes  No
5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards?  Yes  No
6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care?  Yes  No
7. Does the state have any activities related to this section that you would like to highlight?  
N/A  
Please indicate areas of technical assistance needed related to this section  
N/A

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**Footnotes:**

## Environmental Factors and Plan

### 3. Innovation in Purchasing Decisions - Requested

#### Narrative Question

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While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

$$\text{Health Care Value} = \text{Quality} \div \text{Cost}, (\mathbf{V} = \mathbf{Q} \div \mathbf{C})$$

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General,<sup>49</sup> The New Freedom Commission on Mental Health,<sup>50</sup> the IOM,<sup>51</sup> NQF, and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).<sup>52</sup> The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."<sup>53</sup> SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series (**TIPS**)<sup>54</sup> are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (**KIT**)<sup>55</sup> was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

<sup>49</sup> United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

<sup>50</sup> The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

<sup>51</sup> Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

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

<sup>53</sup> <http://psychiatryonline.org/>

<sup>54</sup> <http://store.samhsa.gov>

<sup>55</sup> <http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf>

**Please respond to the following items:**

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions?  Yes  No
2. Which value based purchasing strategies do you use in your state (check all that apply):
- a)  Leadership support, including investment of human and financial resources.
  - b)  Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
  - c)  Use of financial and non-financial incentives for providers or consumers.
  - d)  Provider involvement in planning value-based purchasing.
  - e)  Use of accurate and reliable measures of quality in payment arrangements.
  - f)  Quality measures focus on consumer outcomes rather than care processes.
  - g)  Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
  - h)  The state has an evaluation plan to assess the impact of its purchasing decisions.
3. Does the state have any activities related to this section that you would like to highlight?  
N/A  
Please indicate areas of technical assistance needed related to this section.  
N/A

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**Footnotes:**

## Environmental Factors and Plan

### 4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

#### Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention\* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

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

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode ([RAISE](#)) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

\* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

#### Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)?  Yes  No
2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI?  Yes  No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

Kentucky is utilizing implementation science as outlined by the National Implementation Research Network throughout the execution of first episode of psychosis programming. Several evidence based practices are being utilized in the implementation of first episode of psychosis programming, including:

- Early Assessment and Support Alliance (EASA) Coordinated Specialty Care Model – Kentucky is following the EASA model of Coordinated Specialty Care (CSC). Kentucky is utilizing EASA for technical assistance regarding CSC programming, as EASA utilizes the team based CSC model of care within the Oregon community mental health centers, which is very similar to Kentucky. EASA is providing overall technical assistance for CSC within Kentucky, including guidance on program implementation, differential diagnoses including Structured Clinical Interview for DSM 5 (SCID-5) Training, multi-family group psychoeducation, and ongoing, site-specific technical assistance;
- Individual Placement and Support (IPS) Model of Supported Employment – along with the inclusion of supported education, IPS is being used within the Coordinated Specialty Care team. DBHDID recently collaborated with the University of Kentucky on the submission of a SAMHSA grant proposal related to enhancing IPS supported employment/education

for transition age youth;

-Specialized Screening and Assessment Tools – training and support specific to first episode of psychosis programming continues to be provided to designated staff across the state. These tools include the Prodromal Questionnaire Brief (PQB), the Structured Clinical Interview for DSM-5 (SCID-5), and the Structured Interview for Psychosis-Risk Syndromes (SIPS). This will provide CSC teams, as well as other outpatient clinic staff, with more accurate screening, assessment and treatment for youth and young adults that experience psychosis;

-Cognitive Behavioral Therapy for Psychosis (CBTp) – A 3 day CBTp skills training was provided to key CMHC staff across the state. An additional 2 day CBT overview training was provided this past year. Additional CBT trainings focusing on anxiety, substance use, and suicide prevention will be provided as well as additional coaching and follow-up feedback related to these CBT practices. This will provide CSC teams as well as other outpatient clinicians, specific skills to utilize when providing treatment to youth and young adults that experience psychosis;

-Applied Suicide Intervention Skills Training (ASIST) – for community partners;

-Assessing and Managing Suicide Risk (AMSR) – training for mental health staff as youth and young adults with early psychosis are at extremely high risk for suicide; and

-Multi Family Psychoeducation – educational and supportive sessions with several families at one time, focusing on specific diagnostic categories.

3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

Kentucky is utilizing implementation science as outlined by the National Implementation Research Network (NIRN) throughout the execution of first episode programming. In addition, CMHC provider contract language requires the use of evidence based practices for programs that are funded by DBH to serve this target population. CMHC contract language also requires identified key contacts from each CMHC to attend statewide meetings and trainings, many that include information regarding evidence based practices for this population.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with ESMI?  Yes  No

5. Does the state collect data specifically related to ESMI?  Yes  No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI?  Yes  No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

Kentucky is implementing Coordinated Specialty Care as an evidence based practice for the 10% set-aside for ESMI. Kentucky is modeling its programming after the Early Assessment and Support Alliance (EASA), which includes components of Recovery After an Initial Schizophrenic Episode (RAISE) and OnTrack NY best practice programming. Kentucky is requiring Coordinated Specialty Care to include a team based approach with project leadership, outreach and community based services, medication management with low doses of atypical antipsychotic medications, cognitive behavioral therapy, family education and support, employment and education support, occupational therapy, targeted case management and peer support services. Coordinated Specialty Care services are aimed at bridging the gap between child, adolescent, and adult behavioral health programs and are highly coordinated with physical health care.

8. Please describe the planned activities for FFY 2020 and FFY 2021 for your state's ESMI programs including psychosis?

All fourteen (14) community mental health centers are required to designate two (2) key contacts (one from the adult mental health system of care and one from the children's mental health system of care) within their agency for first episode of psychosis programming. These individuals are responsible for disseminating information on first episode of psychosis as well as attend and participate in collaborative meetings and trainings. At present, there are eight (8) community mental health centers that provide Coordinated Specialty Care with funding from DBH. These programs are called iHOPE. EASA will provide each iHOPE Program with monthly consultation calls. State program administrators will also provide bimonthly onsite technical assistance for iHOPE teams. EASA will also provide statewide training for clinical staff on Coordinated Specialty Care, the Structured Clinical Interview for DSM 5 (SCID-5) and Differential Diagnosis. Ongoing coaching will be provided regarding Cognitive Behavioral Therapy for Psychosis as well as the Structured Interview for Psychosis-risk Syndromes. All regions will be expected to participate in statewide training and workshops on evidence based practices for first episode programming. The fidelity process has been finalized for the iHOPE Programs. All iHOPE programs will be expected to complete a fidelity review during SFY 2020.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

Each community mental health center is required to submit quarterly client and program data regarding the 10% set aside. In addition, CMHCs are required to submit monthly event data on each individual served as well as annual client level data for each individual served. Kentucky has made several changes to data collection processes, in an effort to capture more inclusive data for this population.

10. Please list the diagnostic categories identified for your state's ESMI programs.

Kentucky has chosen to provide targeted Coordinated Specialty Care to youth and young adults between the ages of 15 – 30 with early serious mental illness, including individuals with the diagnoses of schizophrenia spectrum and other psychotic disorders, and other diagnoses that include psychosis as identified in the DSM-5. (Delusional Disorder, Brief Psychotic Disorder, Schizoaffective Disorder, Schizophreniform Disorder, Unspecified Schizophrenia Spectrum and Other Psychotic Disorder, Other Schizophrenia Spectrum and Other Psychotic Disorder, Major Depressive Disorder with psychotic features (single or recurrent), and

Bipolar I with psychotic features (manic or depressed). Kentucky is focusing on youth and young adults who have experienced a first episode of psychosis within the last year.

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

N/A

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**Footnotes:**

# Environmental Factors and Plan

## 5. Person Centered Planning (PCP) - Required MHBG

### Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

1. Does your state have policies related to person centered planning?  Yes  No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

During SFY 2015, DBH hired national consultants (Janis Tondora, Psy.D., and Diane Grieder, M.Ed.) from Alipar to train CMHC/DBH staff in concepts of Person Centered Planning for mental health treatment, and specifically in how to transform service delivery into a recovery oriented service system, based on the strengths of each individual. In addition, these consultants have been providing technical assistance to providers regarding medical necessity and how to structure services in a person-centered manner but also satisfy medical necessity.

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

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

DBHDID encourages all providers to utilize the recovery principles and incorporate the PCRP model into their treatment planning process. Peers are also utilized to encourage open communication between clients and providers and to facilitate active participation of clients in setting goals and strategies for achieving the goals. In accordance with the PCRP model, the use of the individual's own words in their goal statements and recovery oriented/direct language. Medical necessity is addressed on the PCRP in the objectives and interventions, which specifically address noted barriers, and identified strategies to reaching those identified goals. Also in accordance with the PCRP model, providers are encouraged to give the individual assurance that they were listened to and to share in the understanding of how various interventions are working them towards their goals. This model requires individuals to assist in developing, signing to verify their involvement, and then to receive, or at least be offered, a copy of their individual plan.

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

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

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

N/A

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### Footnotes:

# Environmental Factors and Plan

## 6. Program Integrity - Required

### Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: <http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf>. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

### Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?  Yes  No
2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?  Yes  No
3. Does the state have any activities related to this section that you would like to highlight?

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

Regulation/legislative review;  
Business information/intelligence gathering, analysis and reporting;  
Contract monitoring;  
Risk Management; and  
Training support and facilitation.

Within this Division are two branches - the Data Analytics Branch and the Program Support Branch:

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

Program Support Branch: Composed of four primary work units: Contract Monitoring, Education/Event Coordination, Risk Management, and Legislation/Regulations. Each work unit is led by a Team Leader, and staff works with other Divisions to ensure

the delivery of high-quality products, accountability, and transparency. Activities and services include:

- Contract monitoring database administration and reporting;
- Training and event facilitation, including curriculum development;
- Continuing education units (CEUs), publications, equipment webinars, and video conferencing;
- Risk management database administration and reporting;
- Residential and community mortality review;
- Certified investigator training; and
- Kentucky Administrative Regulations and legislation review, updates and drafting.

Please indicate areas of technical assistance needed related to this section

N/A

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**Footnotes:**

# Environmental Factors and Plan

## 7. Tribes - Requested

### Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the [2009 Memorandum on Tribal Consultation](#)<sup>56</sup> to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

<sup>56</sup> <https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf>

### Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?  
None
2. What specific concerns were raised during the consultation session(s) noted above?  
N/A
3. Does the state have any activities related to this section that you would like to highlight?  
No federally-recognized Tribes or Tribal Lands exist within the Commonwealth of Kentucky. However, the Division of Behavioral Health continues its dialogue with the Kentucky Council on Native American Heritage. Staff within the division continues to work with the Kentucky Incentives for Prevention Survey Statistician to obtain cross tabulation on Native American's past 30 days' consumption of all substances included on the survey. Contracted providers are required to collect client demographic information for all individuals served, including race and ethnicity.  
Please indicate areas of technical assistance needed related to this section.  
N/A

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

### Footnotes:

# Environmental Factors and Plan

## 8. Primary Prevention - Required SABG

### Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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

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

### Please respond to the following items

#### Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)?  Yes  No
2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply)  Yes  No
  - a)  Data on consequences of substance-using behaviors
  - b)  Substance-using behaviors
  - c)  Intervening variables (including risk and protective factors)
  - d)  Other (please list)
    - Prescription Drug Monitoring Programs (PDMP) data from Kentucky All Scheduled Prescription Electronic Reporting System (KASPER)
    - Behavioral Health Data (past year depressive episodes, self harm, suicidal ideation, suicide attempts)
    - Children who have family member or someone close to them who have served in the military
    - School safety, bullying, gambling
3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)
  - Children (under age 12)
  - Youth (ages 12-17)
  - Young adults/college age (ages 18-26)
  - Adults (ages 27-54)
  - Older adults (age 55 and above)
  - Cultural/ethnic minorities
  - Sexual/gender minorities

- Rural communities
- Others (please list)

Service Member Veterans and Families

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

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

Kentucky All Schedule Prescription Electronic Reporting (KASPER)

Kentucky Violent Death Reporting System

CDC Wonder

Kentucky State Police Data

Kentucky Center for School Safety

Kentucky Poison Control

Kentucky Injury Prevention & Research Center

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds?

Yes  No

If yes, (please explain)

If no, (please explain) how SABG funds are allocated:

The needs assessment data is used primarily to determine priorities and allocate discretionary funding such as the Partnership for Success (PFSII) and currently the PFS2015. The majority of the Block Grant funding is allocated to Kentucky's 14 Regional Prevention Centers (RPC). Each RPC is required to conduct biannual needs assessment of every county within their region. Local priorities are identified for each county. Allocations are then made to the RPC based on each county's local needs assessment data. Kentucky has thus far not required the RPCs to allocate SABG primary prevention funds based on a state needs assessment.

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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## Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce?  Yes  No

If yes, please describe

All Regional Prevention Center staff are required to be Certified Prevention Specialists within three (3) years of their hire date. The Kentucky Board of Certified Prevention Professionals (KCBPP) determines whether individuals have met the knowledge, training and educational requirements for the individual to sit for the Certified Prevention Specialist (CPS) exam. The Board is composed of representatives from the Alcohol, Tobacco and Other Drug (ATOD) prevention field across Kentucky and continually updates and implements standards for prevention specialists in the state. The certification process includes 150 hours of training in identified domains, 2,000 hours of professional ATOD prevention experience, and a passing score on an international examination. Not only does certification enhance the field of alcohol, tobacco, and other drug prevention, but more importantly, assures the quality of service to the individuals and communities served by approximately 80 certified prevention specialists across the Commonwealth. Quality of services, competence, professional growth, ethical conduct and continuing education are all benefits of certification.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce?  Yes  No

If yes, please describe mechanism used

a. Training: The Kentucky Prevention System continues to rely on the high-quality prevention training that is offered through the Kentucky School of Alcohol and Other Drug Studies, Prevention Academy, and the Kentucky Prevention Network. State Prevention Staff are actively involved in the planning and content of each of these training venues. In addition, we collaborate with key stakeholders to embed prevention specific topics into other training venues, for example, the Division's annual System of Care conference. Training needs of prevention providers are assessed on an annual basis and a plan is developed to ensure that delivery of trainings match the needs of the community-level providers. We also access national level technical assistance through Prevention Technology Transfer Center, and Prevention Solutions (formerly the CAPT), including the Substance Use Prevention Skills Training (SAPST), online courses and webinars. The focus throughout SFY 2018 and 19 has been on increasing the capacity of the prevention workforce to utilize the SPF and develop comprehensive plans to meet the needs of the communities they serve. This focus will continue in order to increase and then maintain the capacity of providers to deliver programming with fidelity to the Strategic Prevention Framework (SPF) model.

1. Kentucky School prevention programming included: Prevention Praxis – Moving the Strategic Prevention Framework from Theory into Practice; Influencing Supportive Public Policy for Prevention; Building the Capacity for Change; From Skills to Action: Empowering Youth in Advocacy and Policy Change; Effective Group Facilitation and Collaboration Skills for Prevention Specialists and Other Group Leaders; Agenda mapping – Logical and Easy Planning; Prevention Ethics.
2. Prevention Academy consists of the delivery of the SAPST during the first week followed by a second week covering current topics, populations and substances of focus in the state. Each subsequent offering will include a series of customized trainings to meet the needs of the community-level providers in delivering services.

3. Prevention Solutions/CAPT provided training on developing logic models, and Prevention Ethics and also provided TA/coaching for our state SAPST facilitators and training of state-level providers in delivery the Ethics training.
4. Kentucky Prevention Network provided a number of sessions during its annual conference and spring trainings, including: Improving Needs Assessment and Planning through Public Health Informatics and Analysis; Changing the Conversation: The Role of Prevention During Our Nation's Opioid Crisis; Professional Fitness: Unmasking Hidden Biases; and Juul/E-Cigarettes: The Health Consequences, How Communities can Respond, and How to Best Support Cessation.
5. SAPST training is provided to new staff on an ongoing basis. Two trainings were offered in 2018 and three have been offered in 2019. Training attendees include health department staff, Family Youth Resource Center and school staff, Drug Free Communities Coordinators as well as Regional Prevention center Staff.

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

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies?  Yes  No

If yes, please describe mechanism used

All Regional Prevention Centers are required to assess community readiness for each community they serve. Each local provider completed a readiness assessment during SFY 2018 and 19 utilizing the Tri-Ethnic Community Readiness Model. Center staff have received additional training in the assessment process. Additional analysis support is provided through the evaluation contract for the prevention portion of the Block Grant by REACH Evaluation. The readiness components are included in the RPCs' work plans which are monitored by state staff.

## Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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## Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years?  Yes  No

If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan

Kentucky developed a strategic plan in 2017 focused on increasing capacity to address substance use disorder prevention. In SFY 20, Branch staff will utilize the data collected by each of the fourteen (14) RPCs during their local needs' assessment process and the regional work plans developed from that data to revise the statewide strategic plan. Additionally, evaluation efforts conducted as part of the State Opioid Response grant program components will utilized to inform the needs assessment process. The revised plan will be uploaded once it is complete.

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan)  Yes  No  N/A

3. Does your state's prevention strategic plan include the following components? (check all that apply):

- a)  Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
- b)  Timelines
- c)  Roles and responsibilities
- d)  Process indicators
- e)  Outcome indicators
- f)  Cultural competence component
- g)  Sustainability component
- h)  Other (please list):
- i)  Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds?  Yes  No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds?  Yes  No

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

Kentucky's Evidence Based Work Group is comprised of Regional Prevention Center and Department of Behavioral Health prevention professionals with over 100 years combined prevention experience. The group is coordinated by a Department of Behavioral Health Prevention Branch state employee. The Evidence Based Work Group meets monthly to discuss how best to

capture prevention activities in our electronic database, the Prevention Data System, so that we can use the data to report back to our funders, as well as evaluate efforts. Our EBP criteria is currently under review by an evaluation agency, REACH of Louisville. They have provided an initial process and is refining based on a review of program listings, type of study, number of studies showing evidence, etc. and will be refining based on feedback. This final process will be utilized to determine the evidence-based nature of each prevention approach, and add or remove prevention approaches based on whether they are evidence-informed, evidence-based, or promising practice. They are also providing information on the evidence-based nature of our current list of prevention approaches.

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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

## Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:
  - a)  SSA staff directly implements primary prevention programs and strategies.
  - b)  The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
  - c)  The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
  - d)  The SSA funds regional entities that provide training and technical assistance.
  - e)  The SSA funds regional entities to provide prevention services.
  - f)  The SSA funds county, city, or tribal governments to provide prevention services.
  - g)  The SSA funds community coalitions to provide prevention services.
  - h)  The SSA funds individual programs that are not part of a larger community effort.
  - i)  The SSA directly funds other state agency prevention programs.
  - j)  Other (please describe)
  
2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:
  - a) Information Dissemination:  
 Kentucky funds its fourteen Regional Prevention Centers to implement CSAP's strategies in each county of their regions based on local needs resource and readiness assessments. These needs assessments are part of the annual RPC Work Plans. Work plans are monitored at the state level to ensure that the strategies are consistent with CSAP's criteria for Identifying and Selecting Evidence Based Interventions. Some examples of strategies that are being funded by block dollars under each of the six strategies are as follows:  
 -Information Dissemination: Awareness campaigns on proper storage, monitoring and disposal of prescription medication, promotion of permanent prescription drop-box locations, brochures on prevention resources
  - b) Education:  
 -Education: Project Alert, Lifeskills, Too Good for Drugs, Prime for Life, Generation Rx, Tobacco Retail Underage Sales Training
  - c) Alternatives:  
 -Alternatives: Making Healthy Choices, Project Prom, mentoring programs
  - d) Problem Identification and Referral:  
 Problem Identification & Referral: Prevention providers currently utilize TEG TAP; Question, Persuade, and Refer (QPR);

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

**e)** Community-Based Processes:

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

**f)** Environmental:

-Environmental: social host ordinances, smoke free school grounds, smoke free communities, alcohol compliance checks, tobacco compliance checks, point of sales strategies for tobacco, sticker shock, responsible beverage server training, alcohol and tobacco environmental scans, Training for law enforcement on best practices for conducting Party Patrols - surveillance, disruption and follow up regarding underage drinking parties.

- 3.** Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means?  Yes  No

If yes, please describe

## Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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

## Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years?  Yes  No

If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- a)  Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- b)  Includes evaluation information from sub-recipients
- c)  Includes SAMHSA National Outcome Measurement (NOMs) requirements
- d)  Establishes a process for providing timely evaluation information to stakeholders
- e)  Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- f)  Other (please list:)
- g)  Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

- a)  Numbers served
- b)  Implementation fidelity
- c)  Participant satisfaction
- d)  Number of evidence based programs/practices/policies implemented
- e)  Attendance
- f)  Demographic information
- g)  Other (please describe):

-Activity Type

-Intervention Type (universal direct, universal indirect, selective, indicated)

-Staff Time

-Partners

-CSAP strategy

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

- a)  30-day use of alcohol, tobacco, prescription drugs, etc

- b)  Heavy use
- Binge use
- Perception of harm
- c)  Disapproval of use
- d)  Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- e)  Other (please describe):

- risk factors (suspension, weapons, drug sales, car theft, aggression)
- age of onset
- school safety
- problems at school
- mental health
- accessibility
- lifetime use
- bullying
- violence

**Footnotes:**

# Behavioral Health Prevention & Promotion Branch Strategic Plan

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

## OUTLINE

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- I. Introduction
- II. Executive Summary
- III. Mission and Vision Statement
- IV. Branch Context
- V. Summary of Core Strategies
- VI. Program Portfolio & Plans
- VII. Business Model
- VIII. Organizational Capacity Development Plans
- IX. Appendixes

2-19-2018

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## EXECUTIVE SUMMARY

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

In this strategic plan, we commit to:

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

## MISSION & VISION

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### **Mission Statement**

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

### **Vision Statement**

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

## BRANCH CONTEXT

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

**Current Operations:**

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

**Programs and Tools:**

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

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

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

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

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

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

**Kentucky Initiative for Zero Suicide (KIZS):** The KIZS program is a five-year federal discretionary grant with goals of developing and implementing statewide evidence-based youth (ages 10 – 24) suicide prevention and intervention strategies. The grant goals also promote and implement a system of suicide intervention, treatment and recovery utilizing the seven elements of the Zero Suicide Framework across youth-serving behavioral health care providers across the state. This program has two resource positions to engage the needed stakeholders for developing a suicide free community.

- PES – The Suicide Prevention Enhancement Site Coordinator will serve as the liaison and technical assistance coordinator to support the pilot site in planning and implementation of suicide safer communities, regional training and marketing strategies, and disseminate statewide. The PES will assure the project's goals are met through needed prevention technical assistance.
- TES - The Treatment Enhancement Site Coordinator will serve as the liaison and technical assistance coordinator to support the pilot site in planning and implementation of suicide safer communities, regional training and marketing strategies and then dissemination of concepts statewide. The TES will assure the project's goals are met through needed treatment technical assistance.

**Prevention Enhancement Sites (PES):** PES are statewide content matter specialists - Alcohol, Tobacco, Marijuana, Faith-Based, Suicide, and Substance Exposed Infants—hosted within RPC's. As experts, they provide technical assistance to state- and community-level stakeholders on the latest research, evidence-based practices, data trends, legislation, and training opportunities in their respective subject matter. PES disseminate updates to the statewide prevention network via email, trainings, and webinars. PES respond to information requests from many different agencies across the state, and integrate their work within the RPC work plans, ensuring efforts are aligned with identified needs within the individual RPCs and across the prevention system.

**KY Alliance of Boys & Girls Clubs (B&GC):** The Kentucky Alliance of Boys & Girls Clubs represents participating Boys & Girls Club-affiliated organizations across the Commonwealth. The Alliance provides substance use prevention education to youth who are members of the Club, using the SMART Moves curriculum. The SMART Moves curriculum is a multi-session, resiliency-based curriculum designed for elementary through high school-aged students, with an additional parent component provided. The Branch works with the B&GC to ensure that the chosen curriculum is implemented with fidelity and that quarterly programmatic data are collected and financial reports are accurate and timely.

**Kentucky Council on Problem Gambling (KYCPG):** The Kentucky Council on Problem Gambling is a collaborative that provides evidence-based gambling prevention information and education to all ages through an annual education and awareness conference, and via their website. The Branch partners with KYCPG in its conference planning, keeps the RPCs aware of the shared risk and protective factors connecting problem gambling and substance use and strives to include substance prevention stakeholders in KYCPG's efforts.

**Zero Tolerance (ZT):** The Zero Tolerance program focuses on implementing the Zero Tolerance requirements outlined in Kentucky Administrative Regulations (908 KAR 1:315) for those individuals under 21 who are found to be in control of a motor vehicle with a blood alcohol concentration (BAC) of .02 to .08. Currently this program has no funding. The Branch considers this program an example of an Indicated Prevention approach (i.e., a universal prevention approach with groups of individuals who have been identified as exhibiting early warning signs of problems). It is developing a provider network and assessing the availability of the program across the state.

**Prevention Data System (PDS):** The PDS is a data collection and planning tool utilized by Kentucky's RPCs and PES to document their annual work plan, as well as record activities that occur in their communities to support that work plan. The resulting information supports BHPP Branch's grant writing, grant reporting and communication efforts, and assists RPCs in tracking outcomes of prevention work done in their communities.

**REACH Evaluation:** REACH has been the evaluation component of the Prevention Branch since 2002. REACH Evaluation is the contractor responsible for administration, scoring, and dissemination of results of the Kentucky Incentives for Prevention (KIP) survey - Kentucky's largest source of data related to student use of alcohol, tobacco, and other drugs (ATOD), as well as a number of factors related to potential substance abuse. The survey is offered every other year, with REACH responsible for eight survey administrations in 2003, 2004, 2006, 2008, 2010, 2012, 2014, and 2016. The KIP survey provides information about student self-reported use of substances (e.g., within the last

30 days, last year), student perceptions about substance use (e.g., level of risk, peer and parent disapproval), and perceived accessibility of substances in the community. In 2016, over 110,000 students representing 149 school districts completed the survey, and the information gathered provided an invaluable substance abuse prevention tool for those communities. Districts utilize their KIP results extensively for grant-writing purposes, prevention activities, and various other needs related to program planning. RPCs also heavily rely on KIP Survey data to inform their required Needs Assessment process.

**State Epidemiological Outcomes Workgroup (SEOW):** REACH Evaluation assumes the primary role in managing and coordinating all SEOW activities, including production of all major deliverables. Currently, staff at REACH Evaluation has worked closely with the SEOW members to produce comprehensive state and community profiles as well as a series of short reports highlighting priority substance abuse and mental health issues. The SEOW utilizes a public health approach to prevent substance abuse and its consequences in Kentucky as originally outlined by the Strategic Prevention Framework (SPF). The SEOW also expands the focus of data-driven monitoring and surveillance of substance abuse to include mental and behavioral health correlates through comprehensive analyses of state and local data. The SEOW consists of approximately 20 representatives from a variety of government, state, and academic entities such as the Office of Drug Control Policy, Department for Public Health, State Workforce Cabinet, University of Louisville, and University of Kentucky.

## CORE FUTURE GOALS

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### **1. Strengthen internal operations and infrastructure**

In order to support progress toward Branch goals, team members must be trained and focus on maximizing all resources, including funding and time. To accomplish this, we must:

- Provide cross training for Branch staff
- Support staff members in becoming Certified Prevention Specialists
- Establish a consistent internal and external communication process
- Add a Statewide Substance Use Prevention Strategic Planning component to the Branch's Strategic Plan

### **2. Increase awareness of the effectiveness and need for prevention throughout Kentucky**

Prevention changes lives. This team uses an evidence-based, data-driven approach to inform its work. To increase the state's prevention capacity, the Branch will increase the effectiveness of prevention strategies in Kentucky by pursuing training and technical assistance activities and opportunities that are used to improve the existing stakeholders' use of evidence based strategies. By enlisting and engaging additional partners to implement universal, selective and indicated prevention strategies, the Branch will work toward creating a broader understanding of the impacts evidence-based, data –driven approaches can have on the behavioral and physical health of communities.

### **3. Nurture partnerships and community relationships**

To successfully promote a model of shared risk and protective factors, our team must maintain or establish strong ties among stakeholders serving through governmental agencies and nonprofit organizations within the communities that we serve. The foundation of this work is in establishing consistent messaging for the prevention system, in order to create sustainable efforts and partnerships.

### **4. Proactively address programmatic opportunities and needs**

In order to effectively utilize resources within the Kentucky prevention system, the team must identify needs and opportunities and then seek funding opportunities that support these identified capacity gaps. By proactively determining areas of need and opportunity, the team will have a sense of the big picture and will be able to make informed decisions about the pursuit of future funding opportunities and its impact on the system as a whole.

**Core Strategy: Strengthen internal operations and infrastructure**

Program/Focus Area	Goal(s)	Long-Term Objectives
Human Resources	Attract and retain qualified staff for all services and activities.	<ul style="list-style-type: none"> <li>● Hire an administrative assistant or program coordinator position</li> <li>● Pursue formation of an AmeriCorps VISTA position for the Branch</li> <li>● Apply for a Center for Substance Abuse Prevention Fellow position for the Branch</li> <li>● Maintain relationships with local practicum placement universities for future possible intern placement</li> <li>● Update job descriptions to capture each position's role</li> <li>● Hire a marketing position to coordinate outcomes, stories of success, useful tools, etc.</li> <li>● Develop onboarding toolkit to guide RPCs in hiring process that results in staff who meet the skill sets required in regulation and align with the Department's goals.</li> </ul>
Information Technology & Management Information Systems	<p>Increase the operations, management efficiency and effectiveness of the Branch efforts.</p> <p>Strengthen existing partnership with REACH by intentionally leveraging existing and future contracts.</p>	<ul style="list-style-type: none"> <li>● Improve the current Prevention Data System (PDS) for tracking all necessary information required for funding sources and management decision-making</li> <li>● Improve the output capabilities of the PDS to include standard reports available for all users</li> <li>● Provide RPCs with regular analysis reports of the data that they have entered</li> <li>● Implement system of incentives and consequences for RPC data entry</li> <li>● Build technological capacity within the Branch</li> </ul>

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<p>Organizational Structure and Culture</p>	<p>Sustain an organizational structure and culture that supports clear lines of accountability and a culture that rewards creativity and new ways of doing things.</p>	<ul style="list-style-type: none"> <li>● Establish an efficient meeting structure</li> <li>● Continue to promote Prevention Power Hours as an opportunity for learning about new topics and introduce them as an opportunity for connecting with partners</li> <li>● Promote and support opportunities within each position to expand and enhance managed programs</li> <li>● Encourage creative and research supported approaches to address identified barriers</li> <li>● Create program evaluation opportunities for managed programs to improve practice and policy</li> </ul>
<p>Fund Development</p>	<p>Establish a funding mechanism based on need and data collected in the PDS.</p> <p>Maintain current government funding (e.g., block grant)</p> <p>Pursue new funding opportunities (federal discretionary funding opportunities)</p>	<ul style="list-style-type: none"> <li>● Partner on KORE and other appropriate grants within and across Branches to better leverage funding dollars.</li> <li>● Transition RPC budgets from a fixed annual allocation to a performance-based model</li> <li>● Adopt a list of “shovel-ready” programs for new funding opportunities</li> <li>● Increase RPC/prevention providers' capacity to support the Branch's attainment of funding goals.</li> </ul>
<p>Cost Management</p>	<p>Improve cost accounting and reporting to team members, RPCs, and PES.</p>	<ul style="list-style-type: none"> <li>● Establish regular financial and programmatic review meetings for managed programs</li> <li>● Develop quarterly financial analysis tools to assess the status of contracts and expenditures</li> <li>● Provide guidance to RPCs on contract language prior to finalization</li> </ul>

		<ul style="list-style-type: none"> <li>• Provide guidance to RPCs and CMHC CFOs on required financial forms and reporting expectations</li> <li>• Develop and disseminate a staffing form to RPCs and provide guidance on requirements for updates</li> </ul>
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<b>Core Strategy: Increase awareness of the effectiveness and need for prevention throughout Kentucky</b>		
<b>Program/Focus Area</b>	<b>Goal(s)</b>	<b>Long-Term Objectives</b>
Prevention Enhancement Sites (PES)	<p>Adopt a model of data-informed decision making</p> <p>PES recognized as subject matter experts</p> <p>Evaluate PES – what value do they add to the prevention system by the RPCs</p> <p>Possible restructuring of subject matter (i.e., adding a sustainability PES)</p>	<ul style="list-style-type: none"> <li>• Promote PES at local and national conferences to highlight their expertise</li> <li>• PES embed their work plans within the RPC work plans, acting as a resource for RPCs by deepening the existing work being done statewide in their respective subject area</li> <li>• Increase capacity of PES staff to be viewed as subject matter experts in their focus area</li> <li>• Encourage participation in training opportunities that increase subject matter expertise of PES</li> <li>• Create guidance documents that outline the specific requirements needed to qualify as a PES (contact hours prior to hire, CPS within 2 years, etc.), job duties, and constituents</li> <li>• RPCs actively seek out and utilize PES expertise</li> <li>• Create a process to be used when filling a vacant PES position</li> <li>• Update marketing materials for PES distribution</li> <li>• Strengthen relationships between PES, YES, and RPC.</li> </ul>
Program Evaluation	Effectively leverage standing data	<ul style="list-style-type: none"> <li>• Create a new state profile</li> </ul>

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	partnership with REACH	<ul style="list-style-type: none"> <li>● Implement an evaluation of the SMART Moves program</li> <li>● Establish a regular cycle of program evaluation across program areas</li> <li>● Increase use of the State Epidemiological Outcomes Workgroup's (SEOW) data and data interpretation expertise in developing state and regional substance use priorities</li> </ul>
Branch	Create a statewide prevention plan that reflects a comprehensive set of strategies to address substance use prevention and suicidal behavior through the lens of risk and protective (resiliency) factors	<ul style="list-style-type: none"> <li>● Establish a timeline for completing a needs assessment</li> <li>● Create an example of a comprehensive work plan for substance use</li> <li>● Use the SPF framework to inform the prevention planning</li> </ul>

<b>Core Strategy: Nurture partnerships and community relationships</b>		
<b>Program/Focus Area</b>	<b>Goal(s)</b>	<b>Long-Term Objectives</b>
External Communications	<p>Advocate for the branch by increasing the visibility and community awareness of BHPP.</p> <p>Make sure the BHPP is properly recognized for its achievements and closely identified as a critical component in the efforts to make Kentucky a healthier state for all.</p> <p>Manage sharing of the story of prevention -- both the positive outcomes of having it and negative consequences for avoiding it.</p>	<ul style="list-style-type: none"> <li>● Develop a consistent message describing the work of the prevention system sponsored by the Branch.</li> <li>● Update existing messaging materials.</li> <li>● Establish a communications plan that consistently promotes the successes of the Branch to internal and external partners by leveraging national attention.</li> <li>● Create online repository of stories, tools, and examples that communities can use in their work</li> <li>● Regularly update intranet and internet with prevention system messaging, education materials, success stories, and calendar events.</li> <li>● Establish a recurring newsletter to partners.</li> </ul>

		<ul style="list-style-type: none"> <li>• Celebrate and share the successes of RPCs/prevention providers</li> <li>• Leverage current Kentucky School award system to spotlight positive prevention work being done in Kentucky.</li> <li>• Establish regular communication mechanism between REACH and Branch staff</li> </ul>
Resource and Business Development	Strengthen partnerships	<ul style="list-style-type: none"> <li>• Use stories of effective partnerships to make the case to potential new partners</li> <li>• Foster a relationship with the Department of Public Health</li> <li>• Foster a relationship with the Department of Education</li> <li>• Foster a relationship with the Family Resource and Youth Service Centers</li> <li>• Foster a relationship with the Administrative Office of the Courts (CDW)</li> <li>• Foster a relationship with the Department of Juvenile Justice</li> <li>• Foster a relationship with the Kentucky Association of Sexual Assault Programs (KASAP)</li> <li>• Foster a relationship with the Center for School Safety</li> </ul>

<b>Core Strategy: Proactively address programmatic opportunities and needs</b>		
<b>Program/Focus Area</b>	<b>Goal(s)</b>	<b>Long-Term Objectives</b>
Prevention Enhancement Sites (PES)	Strengthen the autonomy and viability of each PES position	<ul style="list-style-type: none"> <li>• Create an annual work plan for PES to follow</li> <li>• Leverage webinar technology for PES trainings</li> <li>• Establish schedule of training topics and themes to advance all PES roles</li> <li>• Establish clear purpose and goals for the statewide work of the PES</li> </ul>

<p>Youth Empowerment System Grant (YES)</p>	<p>Increase the number of youth engaged in YES programs</p> <p>Prioritize an evidence based prevention perspective in all YES outcomes</p>	<ul style="list-style-type: none"> <li>● Build relationships with youth through the Branch and RPCs</li> <li>● Align application to meet prevention perspective guidelines</li> <li>● Establish connections between YES and other Branch programs (ex: Synar, Suicide Prevention)</li> <li>● Add 'connecting with adult sponsors of YES funding' into RPC duties</li> <li>● Implement trainings as a qualification for potential grantees</li> </ul>
<p>KY Alliance of Boys &amp; Girls Clubs (B&amp;GC)</p>	<p>Increase attendance of SMART Moves trainings</p>	<ul style="list-style-type: none"> <li>● Establish an ongoing evaluation process with REACH</li> <li>● Encourage the implementation of the parent curriculum</li> <li>● Connect RPCs with clubs in their region</li> </ul>
<p>Zero Tolerance (ZT)</p>	<p>Implement state regulations as written for the betterment of the community</p>	<ul style="list-style-type: none"> <li>● Assess the placement of the ZT program in the Branch</li> <li>● Strengthen relationships with judges (or improve their knowledge of what is needed)</li> <li>● Increase marketing to promote comprehensive primary prevention</li> <li>● Create an annual budget for the program</li> </ul>
<p>Kentucky Council on Problem Gambling (KYCPG)</p>	<p>Continue to support the KYCPG annual conference</p>	<ul style="list-style-type: none"> <li>● Encourage PES to use the conference as a platform for sharing their expertise</li> <li>● Support gambling prevention efforts to other prevention providers by promoting the shared risk and protective factors between gambling and substance use</li> </ul>
<p>Kentucky Initiative for Zero Suicide (KIZS)</p>	<p>Increase utilization of the Zero Suicide Framework among behavioral health service providers in Kentucky</p> <p>Reach more practitioners</p>	<ul style="list-style-type: none"> <li>● Build additional Kentucky Suicide Prevention Coalitions</li> <li>● Work collaboratively through shared risk and protective factors</li> <li>● Relaunch the Suicide Prevention Consortium of Kentucky</li> <li>● Create a set of marketing toolkits that highlight ways other sectors play a role in suicide prevention</li> </ul>

Synar Grant	<p>Increase the number of tobacco clerks who are trained through the TRUST Program</p> <p>Maintain a retail violation rate of below 10% for annual Synar Tobacco Retail inspections.</p> <p>Build state-level capacity for a tobacco retail licensing law.</p>	<ul style="list-style-type: none"> <li>Engage communities to promote the TRUST Program to local tobacco retailers.</li> <li>Promote non-adversarial relationships between local tobacco prevention coalitions and tobacco retailers.</li> <li>Support local efforts to conduct tobacco inspections.</li> </ul>
Partnership for Success 2015 (PFS)	<p>Reduce prescription drug and heroin overdoses &amp; non-medical use of prescription drugs, heroin and suicides among 12-25 year-olds with a special focus on service members, veterans and family members.</p>	<ul style="list-style-type: none"> <li>Increase RPC capacity to address non-medical use of prescription drug, heroin and suicides.</li> <li>Increase RPC capacity to deliver prevention services to service members, veterans and family members.</li> </ul>
Regional Prevention Center (RPC) Network	<p>Strengthen and build capacity of the RPC network</p>	<ul style="list-style-type: none"> <li>Maintain a tracking system for staffing, to include certifications</li> <li>Implement data-driven decision making model that uses the SPF process and is supplemented by information entered into the PDS</li> <li>Implement an performance-based funding formula</li> <li>Assess opportunities for RPCs to have more financial independence in their work</li> <li>Identify alternative approaches to staffing RPCs and RPC program delivery</li> <li>Reimagine the RPC job description and create plan for implementing proposed changes</li> </ul>
REACH Evaluation	<p>Strengthen and extend the connections with the Branch's primary evaluation partner</p>	<ul style="list-style-type: none"> <li>Work to improve the number of school districts participating in the Kentucky Incentives for Prevention (KIP) Survey to increase the Branch's understanding of youth substance use trends</li> <li>Integrate REACH staff into Branch meetings on a regular basis to improve communication regarding current and future projects.</li> </ul>
State Epidemiological Outcomes Workgroup (SEOW)	<p>Strengthen and extend the data-driven monitoring and surveillance of substance abuse activities conducted in the Division of</p>	<ul style="list-style-type: none"> <li>Increase the Branch's involvement with the State Epidemiological Outcomes Workgroup (SEOW) to improve its data collection and</li> </ul>

	Behavioral Health	interpretation activities.
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# Environmental Factors and Plan

## 9. Statutory Criterion for MHBG - Required for MHBG

### Narrative Question

#### Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

### Please respond to the following items

#### Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) administers a recovery oriented, comprehensive, community-based system of behavioral health care for adults with serious mental illness and their families through contracts with Kentucky's Regional Boards, also known as Community Mental Health Centers (CMHC). DBHDID works with the Kentucky Department for Medicaid Services so that basic services, like outpatient and rehabilitation services, are available and have similar requirements for Medicaid and non-Medicaid eligible individuals.

DBHDID contracts with the fourteen private, not-for-profit Community Mental Health Centers to provide services to citizens in all 120 counties of the state. CMHCs are required to specifically describe their current system of care for adults and to state their plans for development regarding key system components, within the annual Plan & Budget process. These components include:

- Consumer and Family Support
- Emergency Services
- Behavioral Health Treatment Services, including Co-occurring Treatment for Mental Health and Substance Abuse, Substance Abuse Treatment, and Mental Health Services for Deaf and Hard of Hearing
- Case Management Services
- Rehabilitation Services
- Housing Options
- Physical Health Interface
- Continuity of Care
- Homeless Outreach
- Rural Outreach

KDBHDID is committed to working collaboratively with CMHCs to continuously enhance continuity of care, service effectiveness and accountability. See attachment for a complete list of services offered by CMHC region.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

- |   |   |
|---|---|
| a) Physical Health  | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| b) Mental Health  | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| c) Rehabilitation services  | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| d) Employment services  | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| e) Housing services   | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| f) Educational Services   | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| g) Substance misuse prevention and SUD treatment services   | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| h) Medical and dental services  | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| i) Support services   | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| j) Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA) | <input checked="" type="radio"/> Yes <input type="radio"/> No |

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

#### HEALTH, MENTAL HEALTH, AND REHABILITATION SERVICES

##### 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 is provided in the physical healthcare arena. Continuity of care across these systems is critical for individual recovery and success in establishing chosen roles in the community.

The National Diabetes Statistics Report, 2017, from the Center for Disease Control, analyzed health data through 2015. This report acknowledged that 30.3 million Americans have diabetes, and 84.1 million American adults have prediabetes. The southern and Appalachian regions, which include some parts of Kentucky, had the highest proportion of diagnosed diabetes. Nearly 16% of adults diagnosed with diabetes were smokers, nearly 90% were overweight, and more than 40% were physically inactive. These results are representative of some Kentuckians, and many Kentuckians with SMI.

##### MEDICAL/DENTAL

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

Kentucky's Community Mental Health Centers are now able to provide Medicaid reimbursable primary health care services to individuals who are eligible through the Medicaid program. <http://www.lrc.ky.gov/kar/907/001/047.htm> links to the Medicaid state regulation that outlines the program requirements for providing this level of care. SFY 2018 Plan and Budget submissions indicated six (6) of the fourteen (14) regions are currently providing primary care services to individuals they are serving in their programs. Several other regions reported being in the development stage of providing this service.

In addition, all fourteen (14) regions reported having some type of formal agreement with at least one health care provider in their area. Many regions also reported numerous informal agreements with health care providers in their area, such as agreements with local medical facilities to offer mobile health services, collaboration with private hospitals to provide assessments and healthcare for individuals being served through CMHCs, nutrition work with local health centers for individuals receiving treatment at CMHC, in addition to numerous agreements regarding screening and assessment.

Several regions across the state have been working on integrating behavioral and physical health care. One region in western Kentucky (Pennyroyal) received a SAMHSA grant a few years ago and created Pennyroyal Healthcare Services, to provide physical health care to individuals. At present, there are two healthcare clinics, one in Hopkinsville and one in Princeton that provide physical health care to many individuals served by Pennyroyal behavioral health clinics.

One region in eastern Kentucky (Mountain) was awarded a grant in SFY 2013 regarding health care for individuals who are homeless. The first "Homeplace Clinic" was located in the lower level of the CMCH outpatient clinic in Johnson County, a very rural location in Kentucky, and provided services to individuals from surrounding counties. This project has made an integrated, holistic approach possible for individuals served in this area. Services provided thus far include preventative care, disease management, basic laboratory services, health education, medication management, patient assistance programs, mental health and substance use services (collaboration includes co-location of behavioral health providers), as well as referrals to other medical providers for dental, vision, and specialized medical care. Mountain currently has expanded to five (5) Homeplace Clinics, one which targets individuals with SMI.

Another region in southeastern Kentucky (Kentucky River) has opened two (2) physical health clinics, one in Perry county and one in Knott county. Individuals served by Kentucky River are offered the option of receiving healthcare from one of these clinics if they live nearby. In addition, Kentucky River has instituted Health and Wellness Centers through their outpatient services.

Another region in Northern Kentucky (NorthKey) has opened a primary physical health care clinic in Covington, co-located in the outpatient behavioral health clinic. Currently there have an advanced practice registered nurse providing care three (3) days per week. Their goal is to move to five (5) days per week in the near future. The primary care clinic is assisting individuals in managing high blood pressure and diabetes among other illnesses and conditions that are common among adults with SMI.

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, targeted case managers and clinicians that have knowledge of local resources and well-developed relationships with local providers tend to lead to better access to dental services. There are, in many communities, those dentists who will serve individuals in need who have no ability to pay. However, overall access to dental care is generally considered poor.

#### MENTAL HEALTH

The grid below demonstrates the availability of the wide array of services for adults with serious mental illness in each of the fourteen (14) Regional Boards. The grid is updated annually based on required Plan and Budget submissions.

#### MENTAL HEALTH TREATMENT

Each regional board provides a full array of outpatient services including, but not limited to, individual psychotherapy, group psychotherapy, psychiatric evaluations, walk-in emergency appointments, psychopharmacology, medication education and peer support services. Every effort is made to place these outpatient clinics within close geographic proximity for individuals in order 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 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.

#### SUBSTANCE ABUSE TREATMENT AND PREVENTION

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 restructured contracts, restructured data systems to define and collect data for all new services, and has been working to provide continued guidance to providers through the development of service standards and other technical assistance.

Substance use specific services provided 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 individual evaluations are made available, within budget limitations, to criminal justice agencies and other agencies within the Cabinet for Health and Family Services for individuals with substance use issues.

The Division of Behavioral Health 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 substance use will have a major impact on the health and well-being of every Kentuckian. From peer pressure of youth to use alcohol and drugs to the risks of being involved in a drunk driving accident, all Kentuckians are at risk for substance related problems. The 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 substance use.

#### CO-OCCURRING DISORDERS

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

Steps that have been taken by the Division include:

- Restructuring the Plan and Budget process to include plans for all treatment, including substance use disorder treatment and individuals with co-occurring mental health and substance use disorders;
- Including language in required Plan and Budget forms that address having programming that is integrated for mental health and substance use;
- Rewriting contracts with Regional Boards to include a requirement for all programs, established by CMHCs to be Co-Occurring Capable as measured by either the Dual Diagnosis Capability in Addiction Treatment (DDCAT) or Dual Diagnosis Capability in Mental Health Treatment (DDMHT) tools;
- Including administrative staff in traditional "mental health" branches in the Division of Behavioral Health who have experience in administering substance use and co-occurring programs;
- Requiring in contracts with Regional Boards that all regions hire at least 2.0 Full Time Equivalent (FTE) peer support specialists with lived experience in substance use disorders or co-occurring substance use and mental health disorders;
- Working with the Kentucky Institute for Excellence to provide national consultants and a learning collaborative around Motivational Interviewing for all regional staff across the state;
- Providing some workshops at Kentucky School (which has traditionally been designed for substance use disorders) that focus on integrated treatment; and
- 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. The DBHDID continues to provide technical assistance and fidelity assessments.

One result of these statewide assessments, was the realization that programs across the state did not include many peer led mutual support groups. Mutual support and mutual aid groups are identified as one 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 assist in the development of co-occurring mutual support groups in many regions across the state. Specifically, this individual in recovery assisted with development of Double Trouble in Recovery (DTR) mutual support groups across the state. DTR is an evidence based model for peer led group support for individuals with co-occurring mental health and substance use disorders. It is a twelve-step self-help peer group. At present, The Veteran's Administration and at least nine (9) regions provide DTR as a support for individuals and more groups are continuing to be developed. DBHDID continues to offer technical assistance and materials to assist with the development of this support across the state.

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

In working to establish and support ACT teams across the state it became apparent that a large number of the individuals with SMI being served also had co-occurring substance use disorders. 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. All Assertive Community Treatment (ACT) teams across the state have had access to training in IDDT and continue to receive support and technical assistance through collaboration between the DBHDID and Case Western Reserve University.

Kentucky has been training peer support specialists since 2006. However, initially, peers were only trained who were in recovery from mental health or co-occurring disorders. For several years now, peers in recovery from substance use disorders have been certified as peer support specialists as well. When the 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 individuals in recovery from mental health, substance use or co-occurring disorders to become peer support specialists. Peer support for all populations is now a billable Medicaid service.

#### EMERGENCY SERVICES

Since 1995, the DBHDID has made a concerted effort to develop a statewide network of Crisis Stabilization Programs and include crisis stabilization units, mobile crisis teams, and emergency walk in crisis intervention appointments. These programs, which primarily serve individuals with serious mental illness (SMI) are a major factor in Kentucky's effort at decreasing inpatient utilization. Department staff supports the ongoing development and enhancement of the network by facilitating quarterly meetings of Emergency Service and crisis stabilization program directors and training events. The Department supports a full range of crisis services, including:

- 24-hour emergency hotlines;
- Warm lines;
- Walk-in Crisis Services;
- Mobile Crisis Services;
- Suicide Hotlines;
- Residential Crisis Stabilization Units;
- Crisis Intervention Services;
- Overnight Crisis Beds;
- 23 Hour Observation Beds in Hospitals; and
- After Hours Face to Face Crisis Evaluations.

Regional Boards have flexibility in how they choose to provide emergency services based upon the unique needs and population within their region. As such, the ideal array is not available in every region. For example, nine (9) of the fourteen (14) regions offer residential Crisis Stabilization Units or overnight beds. The flexibility does enable the regions to expand crisis services to meet their unique needs and two regions have set aside at least one (1) bed in their facility to serve the crisis needs of adults with Developmental and Intellectual Disabilities. This has become a specific need in other regions and the Adult Crisis Directors group shares information and specific protocols for various populations, when an individual is admitted to a Crisis Stabilization Unit (CSU).

See Environmental Factor #15 for more detailed information about Crisis Services.

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

The Psychiatric Rehabilitation Association ([www.psychrehabassociation.org](http://www.psychrehabassociation.org)) defines psychiatric rehabilitation as services that help individuals with mental illness develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning and social environments of their choice. Psychiatric rehabilitation services are services that are collaborative, person directed, individualized, and based in evidence.

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

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

The DBHDID incorporates the philosophy of "psychiatric rehabilitation" (outcomes improve when skills are taught in a social setting) and "recovery" (outcomes and satisfaction improve when individuals develop new meaning and purpose in life and grow beyond the catastrophic effects of mental illness) to assist in the enhancement of a continuum of Community Support Services for individuals with serious mental illness. As psychiatric rehabilitation technology has

evolved, KDBHDID has promoted rehabilitation and recovery models through training, education, technical assistance, and targeted funding opportunities.

Currently the DBHDID, Kentucky Medicaid, the Regional Boards, and other providers have not adopted a specific model of practice. Some programs have independently adopted a specific model but have had some difficulty implementing and maintaining a commitment to training and outcome measurement. The Psychiatric Rehabilitation model offers a method that would specifically address improvement in skills, functioning, social environment, and role attainment with a proven process, intervention, and technology base.

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

KDBHDID supports psychiatric 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. As of SFY 2018, nine (9) regions provide therapeutic rehabilitation services for individuals with SMI;
- The Division of Behavioral Health designates a statewide Individual Placement and Support (IPS) Supported Employment coordinator;
- Collaboration between the Division of Behavioral Health and several agencies (Office of Vocational Rehabilitation, Kentucky Institute for Excellence, Human Development Institute of the University of Kentucky, NAMI Kentucky, and others) have established implementation support for IPS Supported Employment for adults with SMI across the state. IPS in Kentucky began through a Johnson and Johnson grant through Dartmouth in 2010. IPS is currently provided in sixty-two (62) counties across the state within twenty (20) sites. DBHDID, in collaboration with the other involved agencies, participates in an International IPS Supported Employment learning collaborative and coordinates with Weststat consultants for technical assistance on a quarterly basis;
- The Division of Behavioral Health, in collaboration with the Office of Vocational Rehabilitation, hosts an annual IPS conference, inviting IPS supported employments specialists and their supervisors, vocational rehabilitation counselors, and others from across the state to participate in learning opportunities and to discuss barriers and strategies to address the barriers;
- Contracts with Regional Boards require all regions to provide access to Assertive Community Treatment (ACT), IPS Supported Employment, and Peer Support services for adults with SMI. As of SFY 2018, all regions across the state have developed ACT teams and are providing ACT services to adults with SMI. Thirteen (13) of the fourteen (14) Regional Board provide IPS Supported Employment 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;
- Eleven (11) regions are providing Comprehensive Community Supports to individuals with SMI, a relatively new service designed to provide skill building services in community settings to assist with independent living; and
- Three (3) 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 often inconsistent and often inadequate to meet the need. Only a fraction of adults with SMI in the state participate in rehabilitation programs offered through the Regional Boards.

The delivery of quality, timely rehabilitation services has been enhanced since approval of the 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, and all services are available off-site, often in community settings. However, quality, timely delivery remains challenged by a number of factors including:

- Kentucky Medicaid reimbursement rates for 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 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 qualify for Medicaid benefits.

Specific to Children and youth, there are a wide variety of initiatives that address the need for coordinated 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 twenty (20) national, state and local, and public and private organizations dedicated to embedding six (6) research-based Protective Factors into services and supports for children and their families. Supporting families is key strategy for promoting school readiness and preventing child abuse and neglect. All families experience times of stress, and research demonstrates that children grow and learn best in families who have the supports and skills to deal with those times. By supporting families and building their skills to cope with stressors, we can increase school readiness and reduce the likelihood abuse will occur in families. 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 2018 Annual Plan and Budget applications reveals that Regional Boards continually strive to address barriers and meet the clinical service needs of children and families. Some examples of this include:

- All regions offer off-site therapy services at the home of the child and throughout the community;
- The CMHCs employ 335 Service Coordinators to provide targeted case management to children and adolescents with SED;
- Ten (10) of the fourteen (14) regions offer specialized summer programs;

- Thirteen (13) 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 119 additional staff who have experience serving children birth through five and their families;
- Nine (9) regions employ Youth Peer Support Specialists; and
- Twelve (12) regions employ Family Peer Support Specialists;

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. Three (3) of the Regional Boards operate day treatment programs and three (3) 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.

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 support the Kentucky IMPACT programs. These funds are used to support program operation, including employment of Local Resource Coordinators that serve as staff to the 18 Regional Interagency Councils (RIACs) and flexible funds to meet the needs of youth and families. 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.

A list of community services for children, youth and families is listed in the chart below:

#### 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 work with the University of Massachusetts, the Kentucky Partners for Youth Transition, and collaboration with IPS supported employment training and coaching for the adult population.

#### 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 (5) 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.

KDHBID does not assume custody of children within the state, nor does it operate a children's psychiatric hospital or any other residential program for children. The Regional Boards, under contract with the Department, do offer a limited amount of residential care. Therapeutic foster care is offered in three (3) of the fourteen (14) regions. There are also a few Boards that offer overnight respite services on a limited basis.

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 (2) state agencies to ensure that the behavioral health needs of children are appropriately identified and addressed. DCBS and DJJ contract with Regional Boards and private providers to meet the residential needs of children in their custody.

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

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

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

### 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.

### Project AWARE (Advancing Wellness and Resilience in Education)

In 2019, 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.

### Kentucky Interagency Transition Council for Persons with Disabilities

Chaired by the Division of Exceptional Children within KDE, the Kentucky Interagency Transition Council for Persons with Disabilities is made up of over 22 state agencies, including DHBID. Their mission is to facilitate the work of state, regional and local agencies as they assist young persons with disabilities (all types) in moving from school to community living and employment. The Department's participation on the Council has offered a valuable forum for sharing of program information and resources as well as data to better address the needs of young people served by the various agencies.

### Kentucky Educational Collaborative for State Agency Children

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children in the custody or supervision of the Commonwealth and who are being served in programs funded and/or operated by DJJ, DCBS, or KDBHDID 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 are extended to children in the custody of state agencies, in day treatment programs, and schools on the campuses of residential programs. KECSAC links the schools, family and children's services, community mental health, juvenile justice, private providers, and institutions of higher learning. The Department's participation on KECSAC has enhanced communication between treatment and education providers and prompted more opportunities for cross-disciplinary training.

#### SUBSTANCE ABUSE TREATMENT AND PREVENTION OVERVIEW

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

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

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

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

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

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

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

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

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

## Medical Care

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

According to the Centers for Disease Control, thirty-five percent of low-income children between two and five years of age in Kentucky are overweight or at risk for becoming overweight. According to the Youth Risk Behavior Survey (2009), 61% of public high school students did not participate in sufficient moderate physical activity. Over 33% are overweight or obese (at or above the 85th percentile for body mass index). Almost 15% of high school students are seriously overweight, and an additional 15% are heavy enough to be considered "at risk" of becoming overweight adults. Obesity among Kentuckians is epidemic and Kentucky's children are among the most obese in the nation. A statewide plan to address this epidemic is a public/private partnership, The Partnership for a Fit Kentucky, which supports the Kentucky Department for Public Health's CDC Obesity Prevention Grant. The focus is on promoting nutrition and physically active communities. This website is a clearinghouse of the Partnership for a Fit Kentucky's initiatives. The intent is to link resources, network programs, provide tools that work, and strengthen partnerships in order to develop cutting edge initiatives. More information about this initiative can be found on the web site [www.fitky.org](http://www.fitky.org).

There are School-Based Health Centers in a handful of schools (9 of 174 school districts) across the state; the Kentucky School-Based Health Center Collaborative is advocating for legislation and funding to sustain such Centers. Schools and community health organizations across the country have concluded that providing medical services in the school building is one of the most effective approaches to reducing health problems and healthcare costs.

## Oral Health

Kentucky Department for Medicaid Managed Care has contracted with managed care organizations to provide dental care to Medicaid members.

Kentucky has one of the worst oral health profiles for children of any U.S. state; the state lacks dental providers in poor and rural areas, and many of its providers historically have not accepted Medicaid. A 2005 report produced by the nonprofit group Kentucky Youth Advocates revealed that half of the state's children between ages two and four had cavities and that only a third of those children covered by Medicaid had used dental services in the past year. The Kentucky Oral Health Coalition, is a statewide group of dental providers, public health professionals, advocates, educators, and others working together to improve the oral health of all people in Kentucky. The coalition began in March 2012 and is staff by a well-known Kentucky children's advocacy organization, Kentucky Youth Advocates. This coalition is currently working to increase oral health literacy; increase school based oral health care; and increase the number of dentists accepting Medicaid. Learn more about the Kentucky Oral Health Coalition at [www.kyoralthcoalition.org](http://www.kyoralthcoalition.org). Kentucky Youth Advocates reports that poor oral health stems from multiple factors including lack of access to care, lack of importance placed on oral health, lack of oral health knowledge, lack of money to pay for care, and many others.

The Kentucky Department for Public Health's Oral Health Program believes that children learn best when they are healthy, and dental health is a key component of overall health. The Oral Health Program provides the following initiatives to help children maintain good dental care: a fluoride varnish program, a sealant program, a community water fluoridation program, a rural school fluoridation program, a fluoride supplement program, oral health education and Healthy Smiles Kentucky.

The University of Kentucky College of Dentistry in coordination with other agencies provides a myriad of dental services for children:

- Inpatient and outpatient specialized dental services for children at the University of Kentucky Children's Hospital and the UK Medical Center. This includes the provision of services for dental patients with special needs. (physical, medical and other special needs);
- Primary dental services at an indigent care clinic serving north Lexington and a clinic in south Lexington;
- Seal Kentucky - a mobile dental sealant program providing on-site dental screening and preventive dental sealant services at eastern Kentucky elementary schools;
- East Kentucky Mobile Dental Program - provides dental prevention and treatment services on-site at elementary schools in central and eastern Kentucky;
- Western Kentucky Mobile Program - provides dental prevention and treatment services on-site at nine elementary schools in three western Kentucky counties;
- "Ronald McDonald" Mobile Dental Program - in partnership with Ronald McDonald Foundation provide on-site services at underserved preschools and elementary schools in Fayette and surrounding counties; and
- School-Based Dental Clinics in Rural Kentucky.

The pediatric dentistry program at the University of Louisville School of Dentistry provides services to patients between 6

months and 14 years of age. Special needs patients of any age are accepted. The program focuses on preventive dentistry such as cleanings, x-rays and fluoride treatments in addition to fillings, stainless steel crowns and extractions. Emergencies or outpatient treatment is provided at Kosair Children's Hospital for very young children with excessive decay or special needs of any age.

Several faith based organizations have provided the financial support needed to start these services and to keep them operating. In addition, some Christian groups have opened free clinics in church buildings, which are staffed by volunteer dentists who come to the region from all over the state for weeklong mission trips. And yet others hold dental events in Walmart parking lots, handing out free samples of toothpaste, dental floss and toothbrushes to anyone who wants them. Still, case managers and clinicians that have knowledge of local resources and well-developed relationships with local providers tend to lead to better access to dental services. There are, in many communities, those dentists who will serve children in need who have no ability to pay for dental care. However, overall access is generally considered poor.

In 2008 the General Assembly passed HB 186 which requires a dental screening the first year that a 3, 4, 5 or 6 year-old child is enrolled in a public school, public preschool or Head Start program. The law took effect for the 2010-2011 school year. Supporters hope this law will decrease the number of school days that Kentucky's students miss due to pain associated with dental problems and will establish a dental home for children from early in life, so that more children receive routine dental care and become less reliant on costly and sometimes invasive emergency care in childhood and later in life.

#### Vision Care

Kentucky Medicaid provides coverage for members of all ages for most examinations and certain diagnostic procedures performed by ophthalmologists and optometrists. Professional dispensing services, lenses, frames and repairs are covered for persons under age 21.

All Kentucky children are required to have an eye exam by a board certified Optometrist or Ophthalmologist before they enter school. This is in addition to the requirement for immunizations and dental and hearing screenings. For children with vision problems, the Kentucky Lions Eye Foundation (KLEF) is a great resource for assistance with screenings, exams, and eye glasses. Though located in Louisville, KLEF serves citizens across the state by operating the Vision Van, Eye Clinics around the state and providing thousands of photo screenings at the Kentucky State Fair. KLEF includes specialty services for children at their Pediatric Clinic.

Visually Impaired Preschool Services (VIPS) is a Kentucky non-profit agency that provides assessments, early intervention services, child care consultation and play groups/classes for infants, toddlers, and preschoolers who are blind or visually impaired. For parents and caregivers, VIPS provides various opportunities for education and support. While their main offices are located in Lexington and Louisville (metropolitan areas of the state), there is also an Outreach Program that serves rural areas of the state.

#### SUPPORT SERVICES

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

- Respite Services;
- Intensive In-home Services;
- After School Programs;
- Family Peer Support;
- Specialized Summer Programs;
- Therapeutic Child Support Services; and
- Transition Planning for Transition Age Youth.

#### Youth and Family Involvement and Support

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

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

KDHBDID tries to lead by example that the voices of youth, parents and caregivers should help shape not only individual treatment decisions, but also program development and policy determinations at the local, regional, and state levels. This principle is strengthened by the advocacy efforts of parents and youth at various points in the system of care.

#### Kentucky Partnership for Families and Children

The Kentucky Partnership for Families and Children (KPFC) is a statewide, family organization working to ensure "that all families raising youth and children affected by behavioral health challenges will achieve their fullest potential." KPFC's mission is to empower families affected by behavioral health challenges to initiate personal and systems change. The board of directors consists of twenty-one to thirty-one members: twelve parent representatives from various community mental health center regions, two transitional-age youth representatives, seven child-family serving agency representatives, and ten flexible positions to assist with identified needs. As a family organization, over 51% of KPFC's board of directors must be parents/primary caregivers raising children with behavioral health disabilities and more than 50% of staff are also parents/primary caregivers that have raised, or are raising, children with behavioral health disabilities.

KPFC's programs and/or activities include:

- Dissemination of a quarterly newsletter via hard-copy or e-newsletter to over 3,000 members;
- Participation on numerous committees with various child-family serving agencies to represent parent and youth voices and perspectives;
- Operation of a web site ([www.kypartnership.org](http://www.kypartnership.org)) and a toll-free phone number (800-369-0533) for parents to access information about KPFC and resource information statewide;
- Provision of an infrastructure for Kentucky Youth MOVE which is comprised of 14-26 year olds who have a behavioral health challenge;
- Provision of the Kentucky Family Leadership Academy and the Kentucky Family Peer Support Specialist Core Competency Training;
- Partnerships with regional community mental health boards to establish Regional Youth Councils and to assist in the identification of youth leaders that will help facilitate the meeting;
- Distribution of resource information and learning opportunities for families raising young children from birth to five that have an emotional-social delay;
- Opportunities for teens (13 – 26 years old) with behavioral health challenges and their parents to learn, connect and network as part of the youth and parent movement; and
- Strengthening of Kentucky's family-driven and youth-guided system of care.

#### Early Childhood Mental Health

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

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

- To provide program and child level consultation to early care and education (child care) programs regarding social, emotional, and behavioral issues;
- To provide training for child-serving agencies and individuals on working with young children with social, emotional, and behavioral needs and their families; and
- To provide evaluation, assessment, and therapeutic services for children from birth through the age of five and their families.

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

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

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

#### 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. Kentucky has been fortunate to be awarded several consecutive grants to address Adolescent Substance use. Some additional partner agencies have been added (beyond the 14 CMHCs) to implement and sustain evidence-based practices. 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](http://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 KDHBDDID 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>.

#### 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.

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

### 3. Describe your state's case management services

Targeted Case Management (TCM) for adults with Serious Mental Illness (SMI) or children with Severe Emotional Disturbance (SED) is a covered service in Kentucky's Medicaid state plan. Targeted Case Management for individuals with Substance Use Disorders (SUD) is also a covered service. DBHDID also provides funding to cover the service for those without insurance or another payor source. TCM for individuals with either SMI or SED (or SUD) and a co-occurring "chronic physical health condition" is also a covered service, with defined client eligibility and provider credentialing requirements. The DBHDID is responsible for credentialing all Targeted Case Managers in Kentucky regardless of who employs them (if they are billing Medicaid or DBHDID) or which population they are serving. The majority of the credentialing activity occurs through an on-line portal.

(<http://dbhdid.ky.gov/dbh/tcm.aspx> and for an overview for processes for all curricula

<http://dbhdid.ky.gov/kdbhdid/documents/cap/pdf>). Both KY Medicaid and DBHDID have promulgated regulations for TCM that dictate credentialing and service provision. These are as follows:

- KY DBHDID Regulation for TCM: Eligibility and Training Requirements

<https://apps.legislature.ky.gov/law/kar/908/002/260.pdf>

- KY Medicaid Regulation for TCM:

Coverage provisions and requirements regarding targeted case management for individuals with a severe mental illness and children with a severe emotional disability

<https://apps.legislature.ky.gov/law/kar/907/015/060.pdf>

Reimbursement provisions and requirements regarding targeted case management for individuals with a severe mental illness and children with a severe emotional disability.

<https://apps.legislature.ky.gov/law/kar/907/015/065.pdf>

Coverage provisions and requirements regarding targeted case management for individuals with a substance use disorder

<https://apps.legislature.ky.gov/law/kar/907/015/040.pdf>

Reimbursement provisions and requirements regarding targeted case management for individuals with a substance use disorder

<https://apps.legislature.ky.gov/law/kar/907/015/045.pdf>

Reimbursement provisions and requirements regarding targeted case management for individuals with a co-occurring SMI or SED or SUD and a Chronic Physical Health Condition

<https://apps.legislature.ky.gov/law/kar/907/015/050.pdf>

Reimbursement provisions and requirements regarding targeted case management for individuals with a co-occurring SMI or SED or SUD and a Chronic Physical Health Condition

<https://apps.legislature.ky.gov/law/kar/907/015/055.pdf>

As described in Criterion 2, Kentucky's statutory definitions for SMI and SED are more stringent than the federal definitions and thus the prevalence rates are lower than those used nationally. Based on an estimated prevalence rate of 2.6% of the adult population in KY, the 14 CMHCs served nearly 51% (43,765 of 86,217) of the estimated number of individuals with SMI and 6.45% (5,564) of those individuals received TCM services, in SFY 2019. Based on an estimated prevalence rate of 5% of the child (under age 18) population in KY, the 14 CMHCs served nearly 51% (25,944 of 51,169) of the estimated number of those individuals with SED and 13% received TCM (6,753) services, in SFY 2019 (unduplicated counts).

DBHDID has created guidance documents for determining TCM eligibility, which includes SMI, SED and SUD designation.

<http://dbhdid.ky.gov/kdbhdid/>

4. Describe activities intended to reduce hospitalizations and hospital stays.

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 psychiatric hospital and other facilities to the community. Providing appropriate aftercare following a hospital stay or transition from a higher level of care is critical to reducing hospital readmission rates, enhancing community housing tenure and ultimately improving quality of life.

KDBHDID addresses continuity of care for adults with SMI through several avenues. Through contracts with the fourteen (14) Regional Boards, KDBHDID requires the regions 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, contract language 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. There are also a series of various meetings designed to assist with continuity of care planning.

- Continuity of Care committee meetings occur at least quarterly within each state operated/contracted psychiatric hospital, and include DBHDID staff, CMHC staff, other community partners, as well as hospital staff, in order to facilitate collaboration between the hospitals and the Regional Boards. Agendas include system wide issues such as admission and discharge processes, follow up processes for outpatient appointments and medication access, strategies to reduce readmission rates, and general communication issues.

- Olmstead committee meetings occur monthly within each state operated/contracted psychiatric hospital, and include DBHDID staff, CMHC staff, other community partners, as well as hospital staff, in order to facilitate collaboration and planning for transitioning to lower levels of care for individuals identified under the Olmstead Act. DBHDID provides funding to each state operated/contracted psychiatric hospital Catchment area. Olmstead funds are overseen by a Regional Board in each of the four (4) state psychiatric hospital Catchment areas. These flexible funds are designated for necessary goods and services for identified individuals that meet the Olmstead criteria:

- o Have resided in the hospital over 90 days;
- o Have had repeat admissions to the hospital over the course of one year and need flexible funding to remain in the community;
- o Treatment professionals determine that community placement is appropriate;
- o Community treatment is chosen via fully informed awareness; and
- o Placement can be reasonable accommodated.

- Regional Transition committee meetings occur within each state operated/contracted psychiatric hospital, and include DBHDID, CMHC staff, Kentucky Protection and Advocacy, Department for Aging and Independent Living, Department for Community Based Services, Kentucky Long Term Care Ombudsman, Managed Care Organizations, the Independent Reviewer of the Amended Settlement Agreement, and other community stakeholders for that Catchment area. The purpose for these meetings is to discuss and plan for transitioning individuals that fit the ASA criteria:

- o Adults with SMI who are transitioning from personal care homes or at risk of being readmitted to a personal care home.
- o Adults with SMI who have been admitted to the state psychiatric hospital and fit the above criteria.

DBHDID has worked with each of the state operated/contracted psychiatric hospitals and their assigned Regional Boards to assist with the development of a Memorandum of Agreement (MOA) between the two entities. In order to assure a seamless system of care, the need 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, additional behavioral health crisis services, such as mobile crisis, continued development of other community support services as effective alternatives to inpatient services for adults with serious mental illness, as well as opportunities for community partners to discuss pertinent strategies for creating “warm hand-offs”.

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, peer support, and comprehensive community supports. 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. 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, peer support, and assertive community treatment;
- 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.

## Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

## Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1. Adults with SMI	86,216	43,000
2. Children with SED	51,169	24,000

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

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

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

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

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

### Variable Criteria

Age Age 18 or older

Diagnosis Major Mental Illness

- Schizophrenia Spectrum and Other Psychotic Disorders
- Bipolar and Related Disorders
- Depressive Disorders
- Trauma and Stressor Related Disorders

Disability Clear evidence of functional impairment in two or more of the following domains:

- Societal/Role Functioning: Functioning in the role most relevant to his/her contribution to society and, in making that contribution, how well the person maintains conduct within societal limits prescribed by laws, rules and strong social mores.
- Interpersonal Functioning: How well the person establishes and maintains personal relationships. Relationships include those made at work and in the family settings as well as those that exist in other settings.
- Daily Living/Personal Care Functioning: How well the person is able to care for him/herself and provide for his/her own needs such as personal hygiene, food, clothing, shelter and transportation. The capabilities covered are mostly those of making reliable arrangements appropriate to the person's age, gender and culture.
- Physical Functioning: Person's general physical health, nutrition, strength, abilities/disabilities and illnesses/injuries.
- Cognitive/Intellectual Functioning: Person's overall thought processes, capacity, style and memory in relation to what is common

for the person's age, gender, and culture. Person's response to emotional and interpersonal pressures on judgments, beliefs and logical thinking should all be considered in making this rating.

Duration One or more of these conditions of duration:

- Clinically significant symptoms of mental illness have persisted in the individual for a continuous period of at least two- (2) years.
- The individual has been hospitalized for mental illness more than once in the last two- (2) years.
- There is a history of one or more episodes with marked disability and the illness is expected to continue for a two (2) year period of time

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

The following table uses the federal prevalence rate SPMI formula of 2.6% and the 2010 census data to estimate the percentage of the targeted population serviced by the Regional Boards during SFY 2018.

Adult Census 2010/Estimated Prevalence (2.6% of the Adult Census)/Kentucky Adults with SMI Served in SFY 2018/% of Served

Four Rivers	161,545/4,200/4,626/110%
Pennyroyal	158,100/4,111/917/22%
RiverValley	161,977/4,211/2,057/49%
LifeSkills	217,231/5,648/2,001/35%
Communicare	200,640/5,217/3,905/75%
Centerstone	730,843/19,002/7,266/38%
NorthKey	326,235/8,482/2,903/34%
Comprehend	42,757 1,112 626 56%
Pathways	170,601 4,436 3,959 89%
Mountain	119,756 3,114 4,448 143%
KY River	89,550/ 2,328/2,219/95%
Cumberland River	181,110/ 4,709/2,432/52%
Adanta	160,202/ 4,165/ 2,474/59%
Bluegrass	595,449/ 15,482/3,525/23%
TOTAL	3,315,996/86,216/43,358 /50%

#### Children with SED

#### Estimate of Prevalence – Children's Mental Health

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. 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.

Note: The data for SFY 2019 is not certified until October 2019 thus SFY 2018 data is used.

Regional Boards Child Census 2010 Estimated Prevalence (5% of the Child Census) Kentucky Children with SED Served in SFY 2017 Penetration Rate of Children with SED Served in SFY 2017 Kentucky Children with SED Served in SFY 2018 Penetration Rate of Children with SED Served in SFY 2018

Four Rivers	44,367	2,218	1,394	63%	1,637	74%
Pennyroyal	51,686	2,584	486	19%	403	16%
RiverValley	51,495	2,575	1,187	46%	1,173	46%
LifeSkills	66,964	3,348	1,289	39%	1,165	35%
Communicare	68,477	3,424	2,309	67%	2,320	68%
Centerstone	228,248	11,412	5,490	48%	5,272	46%
NorthKey	112,412	5,621	2,272	40%	2,295	41%
Comprehend	13,721	686	650	95%	608	89%
Pathways	48,935	2,447	2,081	85%	2,084	85%
Mountain	34,337	1,717	2,054	120%	2,305	134%
Kentucky River	25,212	1,261	1,108	88%	1,488	118%
Cumberland River	55,508	2,775	2,552	91%	2,283	82%
Adanta	47,054	2,353	1,228	52%	1,166	50%
Bluegrass	174,955	8,748	1,973	23%	1,757	20%
TOTAL	1,023,371	51,169	20,588	40%	23,675	46%

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs.

**Criterion 3**

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

- a) Social Services  Yes  No
- b) Educational services, including services provided under IDE  Yes  No
- c) Juvenile justice services  Yes  No
- d) Substance misuse prevention and SUD treatment services  Yes  No
- e) Health and mental health services  Yes  No
- f) Establishes defined geographic area for the provision of services of such system  Yes  No

## Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

## Criterion 4

a. Describe your state's targeted services to rural population.

Adults with SMI

Using the Rural-Urban Continuum Codes and the 2010 Census information, Kentucky has 35 (29%) counties considered metropolitan, 49 (41%) counties considered nonmetropolitan urban, and 36 (30%) counties considered completely rural. See table below:

Rural-Urban Continuum Codes Description of Rural-Urban Continuum Codes # of KY Counties

- 1 Metro - Counties in metro areas of 1 million population or more 14
- 2 Metro - Counties in metro areas of 250,000 to 1 million population 11
- 3 Metro - Counties in metro areas of fewer than 250,000 population 10
- 4 Nonmetro - Urban population of 20,000 or more, adjacent to a metro area 2
- 5 Nonmetro - Urban population of 20,000 or more, not adjacent to a metro area 4
- 6 Nonmetro - Urban population of 2,500 to 19,999, adjacent to a metro area 19
- 7 Nonmetro - Urban population of 2,500 to 19,999, not adjacent to a metro area 24
- 8 Nonmetro - Completely rural or less than 2,500 urban population, adjacent to a metro area 11
- 9 Nonmetro - Completely rural or less than 2,500 urban population, not adjacent to a metro area 25

Kentucky adult population distribution by CMHC region is shown in the chart below:

Regional Boards/CMHCs Adult Census 2010 Urban Adult Population Rural Adult Population

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

Kentucky adults with SMI who live in rural areas and were served by CMHC regions for SFY 2016 are listed in the table below:

Region Rural SMI Pop Rural SMI Served Percent Rural SMI Served

- 1. Four Rivers 2,085 1,335 64%
- 2. Pennyroyal 1,799 947 53%
- 3. River Valley 1,392 756 54%
- 4. Lifeskills 3,024 1,108 37%
- 5. Communicare 3,185 2,268 71%
- 6. Centerstone 803 284 35%
- 7. NorthKey 1,128 511 45%
- 8. Comprehend 768 455 59%
- 9/10. Pathways 2,160 1,846 85%
- 11. Mountain 3,114 3,307 106%
- 12. Kentucky River 2,328 2,125 91%
- 13. Cumberland River 4,709 2,798 59%
- 14. Adanta 3,670 1,944 53%
- 15. Bluegrass 2,300 900 39%
- Total 32,465 20,584 63%

\*Based on SFY 2016 data

The three most common barriers to mental health services in rural areas are isolation, transportation issues, and limited workforce.

Isolation can partially be attributed to the geographical distance between neighbors and/or amenities, but may be more closely associated with the heightened stigma associated with mental health services in rural areas and the difficulty of ensuring confidentiality and anonymity in a small community.

One strategy to address isolation in rural areas is the recruitment and development of family support/peer support staff, to assist in decreasing stigma and enhancing needed outreach and support to individuals and families. Family peer support specialists are parents of children with severe emotional disabilities who have been trained to support other family members of these children. Kentucky also utilizes youth peer support specialists and adult peer support specialists in their continuum of behavioral health care, to enhance meaningful access, engagement and outcomes.

Transportation barriers remain one of the greatest concerns among providers, consumers and family members. The Human Service Transportation Delivery (HSTD) program pools existing public transportation funds including Medicaid non-emergency transportation. HSTD services are coordinated by the Kentucky Transportation Cabinet and provides non-emergency, non-ambulance medical transportation services to eligible Medicaid, Vocational Rehabilitation, and Department of the Blind recipients. A total of 12 transportation regions statewide operate 24 hours a day/seven days a week with a single broker or broker/provider established in each region. Consumers access transportation services through a toll-free phone number. Eight (8) of fourteen (14) Regional Boards report engaging in initiatives to better coordinate transportation services for adults with SMI in their regions. When no other source of funding is available, flexible funding for individuals eligible for targeted case management services may be utilized to pay transportation costs. Transportation remains, however, the number one barrier to accessing services in rural parts of the Commonwealth as reported by the CMHCs.

Rural communities often have fewer workforce and fewer resources to provide mental health services. It is important for rural mental health agencies to develop collaborative agreements with primary care physicians, senior citizen centers, church groups, government agencies, and other organizations. Rural case managers have been resourceful in assisting persons with a serious mental illness in meeting their needs through the identification and development of local resources, and are critical linkages to formal and informal services and supports in rural Kentucky. Some changes in Kentucky law over the years have created licensure categories for additional professionals to provide mental health services. DBHDID will continue to work with rural communities and other entities in addressing funding, training, and in bringing all stakeholders together at the state and local level to strategize best practices.

The advantages of establishing telehealth capability across rural areas are well known. Due to difficulties in recruiting qualified medical and clinical staff to work in more rural areas, telehealth can be used to extend staff coverage from a central site to outlying rural clinics and other services sites. Most Regional Boards now report delivering or accessing services from the telehealth network.

While the problems of isolation, transportation and workforce are common to rural areas in Kentucky, each rural community has its own unique issues because of cultural, geographical and social differences. Thus, the strategies to address them must be collaborative among local, regional and state level stakeholders.

#### Children with SED

Using the Rural-Urban Continuum Codes and the 2010 Census information, Kentucky has 35 (29%) counties considered metropolitan, 49 nonmetropolitan urban (41%), and 36 nonmetropolitan completely rural (30%). See table below:

#### Rural-Urban Continuum Codes Description of Rural-Urban Continuum Codes # of KY Counties

- 1 Metro - Counties in metro areas of 1 million population or more 14
- 2 Metro - Counties in metro areas of 250,000 to 1 million population 11
- 3 Metro - Counties in metro areas of fewer than 250,000 population 10
- 4 Nonmetro - Urban population of 20,000 or more, adjacent to a metro area 2
- 5 Nonmetro - Urban population of 20,000 or more, not adjacent to a metro area 4
- 6 Nonmetro - Urban population of 2,500 to 19,999, adjacent to a metro area 19
- 7 Nonmetro - Urban population of 2,500 to 19,999, not adjacent to a metro area 24
- 8 Nonmetro - Completely rural or less than 2,500 urban population, adjacent to a metro area 11
- 9 Nonmetro - Completely rural or less than 2,500 urban population, not adjacent to a metro area 25

Data Source: USDA, Economic Research Service, May 2013

Kentucky children with SED who live in rural areas (based on 2010 US Census Data) and were served by CMHC regions for SFY 2016 are listed in the table below:

#### Region Rural SED Pop Rural SED Served % Rural SED Served

- 1. Four Rivers 1,147 500 44%
- 2. Pennyroyal 986 265 27%
- 3. River Valley 851 434 51%
- 4. Lifeskills 1,839 669 36%
- 5. Communicare 2,053 1,777 87%

- 6. Centerstone 521 279 54%
  - 7. NorthKey 778 370 48%
  - 8. Comprehend 473 426 90%
  - 9/10. Pathways 1,176 1,101 94%
  - 11. Mountain 1,717 1,566 91%
  - 12. Kentucky River 1,261 1,077 85%
  - 13. Cumberland River 2,775 2,890 104%
  - 14. Adanta 2,079 1,007 48%
  - 15. Bluegrass 1,390 583 42%
  - Total 19,046 12,944 61%
- \*Based on SFY 2016 data

**b.** Describe your state's targeted services to the homeless population.

Adults with SMI

KDBHDID recognizes the importance of system coordination among the numerous agencies and programs involved with services to Kentucky's homeless population. At the state level, KDBHDID participates in the Kentucky Interagency Council on Homelessness (KICH), a group of state and local providers, consumers and government officials, established to develop statewide systems and policies that forge partnerships among state agencies that allow communities to achieve local solutions to homelessness, in addition to establishing targets for permanent supported housing production.

The Council's Plan to Prevent and End Homelessness, which is an expression of a collective commitment to actively seek long-term and sustainable solutions to homelessness, rather than continuing to simply manage episodes of homelessness as they occur. The significant focus of this plan is on investing local resources in a manner that better serves the homeless people, and in so doing, eliminates homelessness in Kentucky. Some areas addressed in this Plan include:

- Access to mainstream services;
- Access to health insurance, including Medicaid;
- Assistance with disability applications through the SSI/SSDI Outreach, Access and Recovery (SOAR) initiative;
- Implementing a Move-Up strategy from Permanent Supportive Housing to subsidized housing;
- Serving victims of intimate partner violence experiencing homelessness; and
- Ending youth and family homelessness.

KDBHDID, KICH and Kentucky Housing Corporation (KHC) continue to collaborate on the SSI/SSDI Outreach, Access, and Recovery (SOAR) Initiative, developed a Case Management Manual for homeless service providers and a Homelessness Rights Manual (both available on the KICH website), and promote education and training for discharge planning in public institutions. Efforts are also underway to increase access and availability of housing options for homeless individuals through the promotion of the "Housing First" model.

Most Community Mental Health Centers offer individualized services designed to alleviate homelessness as well as to provide "mainstream" mental health treatment to persons who are homeless and mentally ill. Of the fourteen Community Mental Health Centers in Kentucky:

- All regions give a service priority to homeless individuals;
- 10 regions do consultation with local shelters;
- 10 regions have staff dedicated to homeless individuals;
- 10 regions regularly visit local homeless shelters;
- 4 regions have a walk-in clinic; and
- 3 regions do street outreach.

KDBHDID has continued PATH Grant funding to the Community Mental Health Centers that received contracts in the prior year. The seven PATH regions are:

- Bluegrass.org, subcontracts and works with the HOPE Center, a private non-profit shelter and homeless service provider, to provide outreach, screening and diagnostic services, case management, mental health treatment, rehabilitation and staff training in the Lexington / Fayette County area.
- LifeSkills, Inc., which provides outreach, case management and training in the Bowling Green / Warren County area.
- NorthKey Community Care, which utilizes a multidisciplinary outreach team employed by the CMHC to provide screening, treatment, and case management, and subcontracts with Welcome House of Northern Kentucky, a private non-profit shelter and homeless service provider, for case management and payee services. The program serves the northern region of Kentucky, just south of Cincinnati, Ohio. The majority of clients served in the PATH program come from Boone, Campbell, and Kenton counties, which are the urban areas.
- Centerstone, who provides outreach, assessment, 24-hour crisis intervention, case management, referral and linkage to community resources and supportive services through their Homeless Outreach Team. The program is located in Jefferson County, Kentucky (the largest urban county in the Commonwealth).
- Pathways, Inc., which provides outreach and case management in the Ashland / Boyd County area.
- Kentucky River Community Care, which provides outreach, case management, housing support services, and support for six (6) emergency apartments for homeless persons with a mental illness located in Hazard / Perry County, but which also draws from Breathitt, Knott, Lee, Leslie, Letcher, Owsley, and Wolfe Counties in southeast Kentucky.

- Cumberland River Regional Board, which provides outreach, case management and housing support services in Laurel County.

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

The Department is also involved with other homeless initiatives including:

- The Homeless Prevention Project, which assists persons being discharged from state facilities in accessing housing and mainstream services, in an effort to limit discharges to homeless shelters. Community partners include the Lake Cumberland Regional Board, the Department of Corrections, the Department for Community Based Services, the Louisville Coalition for the Homeless, and Families and Children Place. This project assists persons serving out of the prison system, persons being discharged from psychiatric institutions, and persons aging out of foster care.
- Collaboration with KHC in the operation of local homeless planning boards ("Continuum of Care Committees") in Kentucky's area development districts (which correspond to the fourteen mental health regions). Regional Boards are encouraged to participate in this process for the benefit of individuals with serious mental illness who are homeless or may become homeless in their regions.
- Funding an Outreach Worker with the St. Johns' Day Center in Louisville to provide on-site assessment and link individuals with services at Centerstone.
- A Rural Homeless Outreach program in the Mountain Regional Board area, covered by CMHS Block Grant funds. The goal of this program is the identification of individuals with serious mental illness who are homeless and linkage with mainstream mental health services. Consultation and training to homeless service providers is also provided under this initiative.

#### Children with SED

The Kentucky Housing Corporation conducts a Point-In-Time Count of the Homeless every year to best monitor the homeless situation in Kentucky. The U.S. Department of Housing and Urban Development (HUD) requires such a count every other year, but KHC believes it best serves the people of Kentucky to conduct this count yearly.

According to the Kentucky Department of Education (KDE), which provides the most accurate number of homeless children, there were 33,198 homeless children statewide in all grades during the 2010-2011 school year and 35,891 for the 2011-2012 school year (an 8% increase).

To determine if a child is homeless, Kentucky Department of Education uses the Department of Education/McKinney-Vento Education for Homeless Children and Youth definition of homelessness which is broader than the HUD definition. The HUD definition of homelessness excludes those living in substandard housing conditions, doubled-up with family or friends, or expecting eviction within seven days who have a community support network to assist them. According to HUD, these individuals are precariously housed, not homeless. The Department of Education/McKinney-Vento Education for Homeless Children and Youth definition states that homeless students/people are those who lack a fixed, regular and adequate nighttime residence. This includes children and youth, ages three through 21 who are:

- Sharing housing due to loss of housing or economic hardship;
- Living in motels, hotels, dilapidated trailers or camping ground due to lack of alternative adequate housing;
- Living in emergency or transitional housing;
- Abandoned in hospitals;
- Awaiting foster care;
- Having a primary nighttime residence that is a public or private place not designed for, or ordinarily used as regular sleeping accommodations;
- Living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations; or
- Migratory students who live in housing described above.

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

According to the National Center on Family Homelessness report, America's Youngest Outcasts, one in every 50 American children is homeless each year and do not have a safe place to sleep. The National Center on Family Homelessness 2009 report, America's Youngest Outcasts: State Report Card on Child Homelessness. This ranking was based on the state's overall performance across four domains:

- 1) Extent of Child Homelessness (adjusted for population size) KY ranked 50th
- 2) Child Well-Being Ky ranked 46th

- 3) Risk for Child Homelessness KY ranked 36th
- 4) State Policy and Planning Efforts KY ranked 20th

<https://www.usich.gov/homelessness-statistics/ky>

c. Describe your state's targeted services to the older adult population.

According to the United States Census (2016 American Community Survey 5-year estimates) Kentucky's population for individuals age sixty (60) and older is approximately 901,866 individuals, accounting for about 21% of Kentucky's total population. This is an increase from the 2010 census of 829,193 individuals or approximately 19.1%. According to the Center for Disease Control (CDC), this population will more than double in the coming years due to two factors: aging baby boomers (persons born between 1946 and 1964) and longer life spans. In 2006, the first baby boomers began to cross the threshold into this population, accounting for the largest category of people. The last baby boomers will be over the age of eighty-five (85) in the year 2050.

Using the federal formula for severe and persistent mental illness, it is estimated that approximately 2.6% of adults in Kentucky, age sixty (60) and older, are diagnosed with a serious mental illness, such as depression, which is not a normal part of the aging process. Based on the 2010 Census population numbers, 2.6% of the population is approximately 21,558 individuals, however this number is estimated to be higher due to the population growth in this age group. In SFY 2016, Kentucky's community mental health centers served approximately 5,950 individuals over the age of sixty (60) with a serious mental illness (SMI), accounting for about 28% of the state's total SMI population of individuals over age sixty (60).

The diagnosis and treatment of mental illness can be more complex with older adults due the presence of another health diagnosis. For example, depression is more common in people who also have other illnesses (such as heart disease or cancer) or whose function becomes limited. The CDC reports that about 80% of older adults have at least one chronic health condition, 50% have two or more chronic health conditions, and major depression occurs in about 13% of the older adult population depending on their setting. Additionally, the CDC highlights an on-going concern of healthcare providers misdiagnosing depression, and other mental illnesses, due to a long standing belief and practice, that a decline in mental health is a natural part of the aging process. Many older adults are not treated for their mental health problems due to lack of recognition of the problem, ageism, stigma, and lack of trained professionals who can identify and treat these mental health disorders.

Specific challenges presented by older adults in Kentucky with behavioral health issues, as identified in the 2014 Behavioral Risk Factor Surveillance System (BRFSS) survey through the Centers for Disease Control (CDC), include:

- 23.9% of adults in have been told by a health professional that they have a depressive disorder which is higher than the national average;
- For adults, specifically age sixty-five (65) and older, 18.1% experience depression;
- 2.8% of older adults binge drink alcohol;
- 38.9% of older adults engage in little to no physical activities;
- 12.4% of older adults age use tobacco; and
- Older adults have an increased prevalence of arthritis, coronary heart disease, and diabetes (24.5%).

Older adults often have Medicare insurance coverage (only) and many of the behavioral health services they need are not part of the benefit package. For services that are provided, Medicare often will not reimburse for the professionals providing the services. There is a need for additional flexible funding to support the behavioral health services needed by older adults.

Kentucky is committed to addressing the need of expanded access to mental health treatment for older adults with serious mental illness. In 1999, Kentucky received a SAMHSA grant that eventually led to the development of a state level Mental Health and Aging Coalition. The state level coalition currently consists of representatives from KDBHDID, Department for Aging and Independent Living (DAIL), Area Agencies on Aging, Office of Vocational Rehabilitation, University of Kentucky, University of Louisville, Spaulding University, National Alliance on Mental Illness (NAMI), Medicaid Services, CMHCs, consumers, caregivers, and other interested stakeholders. For SFY 2018/2019, the Coalition strives to achieve the following on an ongoing basis:

- To encourage every local coalition to include at least one adult consumer of behavioral health services or caregiver representative of an older adult consumer of behavioral health services, in their coalition;
- To continue to support local Mental Health and Aging Coalitions across the state through the mini grant process;
- Target five (5) regions without local Mental Health and Aging Coalitions and assist them in establishing coalitions;
- Work with the Kentucky Association of Gerontology (KAG) to sponsor at least one (1) workshop focusing on mental health and aging at their annual state conference;
- Provide reimbursement for training expenses for coalition members and other related stakeholders to attend training on evidence based practices in the behavioral health field regarding behavioral health; and
- Review state data reports and other relevant information to better understand the behavioral health needs of older adults in Kentucky.

Mental Health Block Grant funds are used to support the following activities through local mental health and aging coalitions:

- Regional training/conferences for professionals, caregivers and consumers;
- Public education and awareness activities;

- Traveling exhibit boards;
- Development and distribution of resource manuals;
- Health fairs and depression screenings;
- Suicide prevention projects;
- Anxiety reduction programs;
- Providing funding opportunities for members of the various statewide Mental Health and Aging Coalitions to participate in the learning opportunities regarding mental health and aging of older adults; and
- Mental Health First Aid training.

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

- Staffing the statewide Mental Health and Aging Coalition to assist in reaching the Coalition's mission of educating the public, professionals, consumers, caregivers, and other stakeholders, regarding issues related to the aging process and mental health needs of older adults;
- Participating in training events regarding mental health and aging such as the annual Optimal Aging Conference and other local training events organized by the Area Development Districts; and
- Partnering in grant applications regarding older adults and mental health.

A staff person from the DBHDID serves as a designee for the DBHDID Commissioner on the National Association for State Mental Health Program Directors' (NASMHPD) Older Person's Division. Kentucky is a member of this national association that represents state mental health commissioners/directors and their agencies and provides support to inform, advocate for and provide a forum for the exchange of ideas and state agendas. The Older Person's Division keeps abreast of the national agenda and shares information with membership through monthly conference calls and periodic in-person meetings.

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

**Criterion 5**

Describe your state's management systems.

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

Component 1: Financial

Kentucky fully embraced the Affordable Care Act (ACA) during SFY 2014 and developed a state Health Benefit Exchange, where individuals could enroll in various insurance options. Kentucky also opted for Medicaid Expansion and over 300,000 individuals, who were not previously insured or who were underinsured, have enrolled in Medicaid, to date. In addition, a new Medicaid state plan amendment was approved by CMS in January of 2014. Many more behavioral health services became Medicaid reimbursable, most notably substance abuse services, an array of crisis services, and some evidence based practices for adults with SMI. Due to these achievements, the Governor's office elected to reduce traditional funding for behavioral health services, due to the realization that most individuals now had insurance, and most vital behavioral health services were now Medicaid billable. For SFY 2015, savings of \$21 Million were realized in the state budget for behavioral health. In SFY 2016, \$30 Million in savings were included.

Due to these changes, DBHDID evaluated purchasing options, redesigned CMHC contracts and implemented performance based contracting. In addition, the Cabinet for Health and Family Services continued to contract with five (5) Managed Care Organizations (MCOs) to coordinate behavioral health services for individuals with Medicaid across the state. Regional Boards must negotiate services and reimbursement rates, and provide authorization requirements with each separate MCO. Some regions have been more successfully at adjusting to these changes than others.

As described in earlier in this grant application, Regional Boards are required by statute and contract to provide a core array of services and are held accountable to selected performance indicators, but are given some autonomy in how funds are distributed based on regional priorities. Detailed mental health block grant expenditures are provided as an attachment to this document.

DBHDID is awarded state general funds for community mental health services as a result of an annual allocation from the state general assembly. The funding amounts are a result of a biennium budget proposed and ultimately passed by the General Assembly in the form of a budget bill. DBHDID also enters into contracts with other state agencies to provide specific behavioral health services. DBHDID also applies for and often receives other federal grant funds to support the systems of care for adults with SMI and children with SED.

Per Section 1911 of the Title XIX Block Grants, the state will expend the grant funds only for the purposes of:

- Carrying out the plan submitted for the fiscal year;
- Evaluating programs and services carried out under the plan; and
- Planning, administering and educational activities related to providing services under the plan.

DBHDID allocates mental health block grant funds as well as substance abuse prevention and treatment block grant funds, to Regional Boards and to agencies that are either public or not-for-profit entities in accordance with federal block grant requirements. No funds are used to satisfy any requirement for the expenditures of non-Federal funds. The mental health block grant funds are utilized by DBHDID to provide direct services for adults with SMI and children with SED and to support statewide initiatives that promote the systems of care for these populations. A small portion of funds are also used to support data collection and analysis and the operation of the Kentucky Behavioral Health Planning and Advisory Council. The table (in attachments) outlines exactly how the funds are allocated for the SFY 2020. SFY 2021 allocations will be determined at a later date.

Component 2: Staffing

DBHDID contracts directly with each Regional Board to provide direct services and each Board employs staff who deliver the services at the local level. Thus, DBHDID involvement in human resource development activities for the Regional Boards and their staff have traditionally been indirect, focusing on staff training, technical assistance and the establishment of minimum qualifications and core training requirements for providers.

The Medicaid state plan amendment that was approved in January of 2014 included new staff requirements for various services. Most services billable through Medicaid now require an independently licensed professional or an individual under supervision to obtain their license. Non-licensed providers who bill Medicaid must now be managed by a billing supervisor.

### Component 3a: Training for Mental Health Services Providers

DBHDID strives to provide access to on-going training and technical support for all Central Office staff as well as partner agencies and providers statewide. The Department seeks to utilize available technology to provide educational/training and consultation opportunities. One example is the Adobe Connect system of webinar technology. Several DBHDID staff were trained in the AdobeConnect technology and hosting of webinars is now an option for training opportunities.

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

During SFY 2015, DBHDID created a Program Integrity Division that included a Program Support Branch. This branch is in the process of streamlining procedures to assist all DBHDID programs in providing training.

The Department makes available a wide variety of trainings, technical assistance and coaching (free of charge) to the staffs of the CMHCs and other contracted providers.

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

The table (in attachments) outlines planned trainings for the SFY 2020 and SFY 2021.

### Component 3b: Training for Emergency Services Providers

The Department for Behavioral Health, Developmental and Intellectual Disabilities serves as a support agency for the Kentucky Emergency Support Function (ESF) 8 – Public Health and Medical Services group. ESF is led by the Department of Public Health, a sister agency to DBHDID, within the Cabinet for Health and Family Services. The ESF group assists with coordination of public health and medical related preparedness, response and recovery activities for any incident/event (emergency, disaster, exercise, or planned event) that requires state level coordination. One of the primary support organizations for the ESF is the Kentucky Community Crisis Response Board (KCCRB). This organization sits under the Kentucky Department for Military Affairs and was created under Kentucky Revised Statutes Chapter 36 and Chapter 42. KCCRB's Crisis Response Team (KCCRT) is activated by a Governor's Disaster Declaration in the case of natural or manmade disasters to provide psychological first aid. KCCRB provides Rapid Assessment & Response Teams deployed upon request to mitigate stress reactions to critical incidents and traumatic events. It is important to note that in many states, the responsibilities of KCCRB are housed within the mental health authority's office, thus Kentucky's system is rather unique since this responsibility lies elsewhere.

DBHDID requires the fourteen (14) Community Mental Health Centers (CMHCs) via contract, to maintain a community level behavioral health disaster plan (COOP Plan) regarding emergency preparedness that outlines expected regional response in the case of a crisis or disaster and that ensures collaboration with local community partners. Each CMHC is required to review their plan annually with the KCCRB and submit their plan electronically. In addition, each CMHC has designated an individual to serve as the point person for emergency preparedness in the region.

KCCRB is staffed by a multi-disciplinary team of trained individuals who volunteer their time to assist others who encounter a critical incident. Many of these volunteers are behavioral health professionals, and some are CMHC staff. As a part of the KCCRB effort, Psychological First Aid trainings are held across the state. Psychological First Aid is a SAMHSA endorsed program teaching first responders and others how to deal with individuals experiencing traumatic events. Individuals trained in Psychological First Aid learn to promote environments of safety, calmness, connectedness, self-efficacy, empowerment and hope in times of crisis. During SFY 2017, KCCRB reported 12 Psychological First Aid II trainings being held. Psychological First Aid I is now an online course. It is followed up by an 8 -hour face to face Psychological First Aid II course.

Mental Health First Aid (MHFA) training is another way the DBHDID is involved in providing training regarding behavioral health issues to emergency health providers by training first responders, other emergency health services providers, and other community members. MHFA is a public education program, which targets any member of the community, which helps with identification, understanding and responses to signs of mental illnesses and substance use disorders. It is managed by national entities and has rigorous requirements, including a week long training session, in order to be certified as a MHFA trainer. At the state level, each MHFA training is eight (8) hours and includes education on a five (5) step action plan where participants gain the knowledge and skills to assist an individual experiencing a mental health crisis by connecting him/her with the appropriate professional, peer, social or self-help care. The number of Mental Health First Aid trainers in Kentucky has ballooned over the last few years. DBH

contracts with the National Alliance on Mental Illness (NAMI) affiliate in Lexington to provide Adult MHFA trainings across the state, and to track both number of persons approved to provide the training, and the number of actual trainings occurring across the state. The audience included first responders and emergency 911 call staff, state guardians, police officers and police dispatchers, and others. Some of these trainers work for Kentucky Partnership for Families and Children (KPFC), a behavioral health advocacy agency for children and families.

DBHDID also provides training in behavioral health to state police and cadets at Eastern KY University.

DBHDID contracts for an array of trainings for CIT statewide and the creation of local CIT Boards. DBHDID staff participates in the planning and implementation of a statewide CIT annual conference.

**Footnotes:**

Adult Mental Health Services Array for SFY 2020

Regions	1	2	3	4	5	6	7	8	10	11	12	13	14	15
<b>Consumer and Family Support</b>														
Consumer Support Groups	0	0	0	x	x	x	x	0		x	X	x	x	X
Consumer Operated Services (COSP)	0	0	0	x	x	x	x	0		x				X
Social-Club Drop-In	0	0	0	0	x	0	0	0						
Local NAMI Kentucky Affiliates	0	x	X	x	x	x	x	0	x	x	X	x	x	X
Consumer Conferences	0	0	x	0	0	0	0	x	0		X			X
<b>Crisis Services</b>														
Emergency Help Line	0	x	x	x	x	x	x	x	x	x	X	x	x	X
Walk-In Crisis	x	x	x	x	x	x	x	x	x	x	x	x	x	X
Other Crisis Intervention Services	0	0	0	0	x	x	0	x	x	x			x	X
Mobile Crisis Services	x	x	x	x	x	x	x	x	x	x	X	x	x	X
Residential Crisis Stabilization	0	0	X	x	x	0	0	0	0	x	X	x	x	X
<b>Mental Health Treatment</b>														
Community Medications Support Program	0	x	x	0	x	x	x	0	x	x	X	x		X
Specialized Co-Occurring Disorders Services	0	x	X	0	x	x	x	0	x	x	X	x	x	X
Intensive Outpatient Program for Mental Health	0	0	0	0	x	0	0	0						
<b>Targeted Case Management (TCM) Services</b>														
TCM for Adults with SMI	x	x	x	x	x	x	x	x	x	x	X	x	x	X
TCM for SMI + Physical Health	0	x	x	0	x	x	0	x	x	x	x	x	x	X
Flexible Funds for SMI (Wraparound Funds)	x	x	x	x	x	x	x	x	x	x	x	x	x	X
Payee Services	0	x	x	x	0	x	0	0	x	x	x	x		
<b>Rehabilitation Services</b>														
Therapeutic Rehabilitation	0	x	x	x	0	x	x	x	x	x	x	x	x	X

Taken from the Plan and Budget Submissions April 2019

Adult Mental Health Services Array for SFY 2020

Supported Employment (IPS)	x	x	x	x	x	x	x	x	x	x	x	x	x	X
Educational Services (Supported Education)	0	0	0	0	x	0	0	0		x	x			X
Illness, Management and Recovery (IMR)	0	0	0	x	x	x	x	x	x	x	x	x		X
Adult Peer Support	X	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
Comprehensive Community Supports	X	0	x	x	x	x	x	0	x	x	x	x	x	X
Other*														
<b>Housing Options</b>														
Supported Housing Program	X	x	x	x	x	x	x	0	x	x	x	x	x	X
Residential Support	0	x	0	0	x	x	0	x	x	x	x	x		X
Housing Development	0	0	0	x	x	x	0	0		x			x	X
Other, please specify	0	0	0	x	0	0	0	0	x					X

Taken from the Plan and Budget Submissions April 2019

**Environmental Factor #9 Statutory Criterion for MHBG  
Criterion #5 - Component 3: Training**

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

<i>Trainings Relevant to <b>Adult</b> Services</i>			
<b>Type of Training</b>	<b>Intended Audience</b>	<b># of Participants Anticipated</b>	<b>Frequency/ Length of conference</b>
<b>Accessing Affordable Housing in Your Community</b>	CMHC Housing coordinators, housing specialists, case managers for adults with SMI, ACT staff, supervisors and other community partners.	Maximum of 25 for each session	1 2-day training in each hospital catchment area  annually
Assertive Community Treatment (ACT) Team Leader Technical Assistance Meeting	ACT team leaders	Approximately 25	Quarterly 4 hours
ACT Leadership Training	Regional Board staff on ACT teams, DBH staff, other Regional Boards staff, other providers of behavioral health services	Approximately 50	2 Days As Needed
Adult Crisis Director's Meetings	Directors of adult crisis stabilization units	Approximately 30	Quarterly 4 hours
Amended Settlement Agreement Meetings	In Reach Coordinators, ACT team staff, Regional Transition Coordinators, DBH, others as appropriate	Unlimited	Quarterly 1 Day
Community Support Program (CSP) Directors Technical Assistance Meetings	CSP Directors	Approximately 25	Quarterly 3 hours
Community Transition Team (CTT) Meetings	Directors of 3 state contracted programs for transitional care of adults with SMI	Approximately 15	Quarterly 4 hours
Olmstead Housing Initiative (OHI) Training	CMHC staff and other community agencies who receive assistance through OHI for housing of adults with SMI	Maximum of 25 for each session	1 day training, repeated across the state
<b>PCRP Supervisory Training</b>	Regional Board staff, DBH liaisons identified during initial training efforts as supervisors/coaches	Approximately 30	2 Day Supervision Training

<b>Trainings Relevant to <b>Adult</b> Services</b>			
<b>Type of Training</b>	<b>Intended Audience</b>	<b># of Participants Anticipated</b>	<b>Frequency/ Length of conference</b>
PCRPP Case Consultation Webinars	Regional Board staff	Staff of one region	1 hour monthly calls
PCRPP Supervision Webinars	Regional Boards staff identified as supervisors/coaches, DBH liaisons	Approximately 20	1 hour monthly calls
PCRPP State Workgroup Webinars	Regional Board management staff, DBH commissioner level staff, DBH Division leadership staff, DBH liaisons	Approximately 20	1 hour bimonthly calls

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

**Description of Trainings Relevant to Adult Services**

**Accessing Affordable Housing in Your Community**

Education regarding accessing affordable permanent community-based housing for individuals with SMI transitioning from personal care homes and other institutional settings. Includes housing resources, best practice basics, fidelity measurement, recovery oriented principles and supports to improve quality of life.

**ACT Team Leader TA Meetings**

DBHDID program administrator for ACT meets quarterly with ACT team leaders. Peer group meetings to discuss fidelity issues, procedural questions, and general education regarding SMI and the evidence based practice.

**ACT Leadership Training**

Two-day training from national consultant on ACT regarding improving leadership skills in a number of critical areas such as resource management, practice competencies, and team building.

**Adult Crisis Director’s Meetings**

DBH Program Administrator for adult crisis services hosts a quarterly peer group meeting for directors of adult crisis programs across the state. These meetings give an opportunity to share information, discuss issues and network with peers across the state.

**Amended Settlement Agreement Meetings**

Quarterly statewide meetings led by DBH staff to discuss issues related to the Amended Settlement Agreement for adults with SMI moving out of personal care homes. Technical assistance is given on various topics including data submission, evidence based practices, in reach, processes, etc.

**Community Support Program (CSP) Directors TA Meetings**

These meeting are held quarterly and are open to all Regional Board Community Support Directors as well as other community partners serving adults with SMI.

### Community Transition Team (CTT) Meetings

These are meetings held quarterly consisting of staff from three (3) programs traditionally known as specialized personal care homes and now known as supportive housing programs and transitional personal care home. Peer group for networking various issues and resources related to adults with SMI transitioning to community living.

### Olmstead Housing Initiative (OHI) Training

Provided by DBHDID in collaboration with Kentucky Housing Corporation (KHC) to education agencies on processes to secure housing assistance in the form of OHI vouchers which can be used for some flexible housing needs such as furniture, deposits, etc., for individuals with SMI who fit the Olmstead criteria.

### PCRP Supervisory Training

A 2-day training for regional supervisors/coaches identified during the overview meeting, with consultants and DBH liaisons regarding supervision techniques and coach methods for strengths based coaching to the PCRP model.

### PCRP Case Consultation Webinars

One-hour monthly technical assistance webinars with consultants, DBH liaison, and identified change teams within various regions. Staff present real cases and are given assistance in conceptualization and documentation of the PCRP model.

### PCRP Supervision Webinars

One-hour monthly technical assistance webinars with identified regional supervisors/coaches, DBH liaisons and consultants. Discuss issues and barriers to provision of the PCRP model with regional middle management and identified supervisory staff.

### PCRP State Workgroup Webinars

One-hour bimonthly webinars with management of Regional Boards, DBHDID Commissioner and Commissioner level staff, DBH leadership, DBH liaisons, and consultants to work through system level issues and support PCRP as a working model.

<b>Trainings Relevant to <span style="background-color: yellow;">Children's Services</span></b>			
<b>Type of Training</b>	<b>Intended Audience</b>	<b># of Participants Anticipated</b>	<b>Frequency/ Length of conference</b>
<b>Behavior Institute, co-sponsor</b>	Educators, administrators, agency service providers, and families	Approximately 1200	Biennially; 2.5 days
Trauma Informed Care Considerations for Children who are Deaf or Hard of Hearing	Teachers of the Deaf, Special Education teachers and administrators, Directors of Special Education, KY School for the Deaf staff, and Educational Interpreters	5-50 per session	1-1.5 hours at least twice per year and as requested
Resources for Serving Children who are Deaf or Hard of Hearing and Their Family Members	IMPACT Service Coordinators	20-30 per session	3 hour session as requested by CMHCs or SOC agencies

<b>Trainings Relevant to <span style="background-color: yellow;">Children's</span> Services</b>			
<b>Type of Training</b>	<b>Intended Audience</b>	<b># of Participants Anticipated</b>	<b>Frequency/ Length of conference</b>
Family Learning Vacation (Co-Sponsor)	Parents, Grandparents, and Other Caregivers of Children who are Deaf or Hard of Hearing	30 Families	2-3 day weekend of training, networking, and resource sharing
Parent Cafes	Parents or Caregivers of Children Who are Deaf, Hard of Hearing, or Deafblind	3-20 per session	2-3 hour block inclusive of a meal or snack, networking, and the cafe
Law Enforcement Responses to Youth Experiencing the Onset of a Mental Disorder or a Mental Health Crisis	School Resource Officers, Police, Sheriff Deputies	25-30 per Session	1.5 Hours, Two Sessions per Year
Introduction to Wraparound	HFW Facilitators, HFW Supervisors, and directors as well as community partners that may participate in a child and family team process	45	3 days
Engagement in the Wraparound Process	HFW Facilitators, HFW Supervisors, directors as well as community partners who may participate in child and family team process	45	2 days
Advancing Wraparound Practice	For HFW Supervisors	30	2 days
School-Based Suicide Prevention	School Administrator, Educators, Staff	40	As requested
<b>Child and Adolescent Needs and Strengths (CANS)</b>	CMHC and PCC child clinicians who will be administering the CANS		1 day Offered as needed
Child and Adolescent Service Intensity Index (CASII)	CMHC child clinicians	30	1 day Offered as needed
Early Childhood Service Intensity Index (ECSII)	CMHC child clinicians	30	1.5 days Offered as needed
<b>Structured Interview for Psychosis-risk Syndrome (SIPS)</b>	The training is required for professionals who will be administering the SIPS tool with clients/patients such as psychiatrists, psychologists, nurses, social workers, case managers or other mental health workers, peer specialists.	60	3 days As needed

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

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

### Behavior Institute (sponsor)

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

### **Plan of Safe Care**

Trauma Informed Care Considerations for Children who are Deaf or Hard of Hearing – The purpose of this workshop is to introduce providers to unique considerations in deaf-member families including higher risk for physical and sexual abuse, the presence of language and education deprivation, and language dysfluency. Strategies are provided for identifying behaviors that may be trauma-related, creating a more understanding environment, and referring for additional help.

Resources for Serving Children who are Deaf or Hard of Hearing and Their Family Members – Starting with scenarios derived from regions' real experiences, targeted case managers learn about the developmental, social, and emotional implications for children who are Deaf or Hard of Hearing. ADA rights and provider obligations are covered and resources are shared.

Family Learning Vacation – FLV is a weekend-long event co-sponsored by KY DBHDID. Families attend a series of workshops related to raising a child who is Deaf or Hard of Hearing. Parent Support Groups were added 3-4 years ago and Parent Cafes were introduced in 2017. For many families, this is the only time each year that they meet others with a Deaf-member.

Parent Cafes – Based on Kentucky's Strengthening Families, the Parent Cafes are offered by DBHDID and often in partnership with Kentucky Hands and Voices and/or the Kentucky School for the Deaf Outreach Team. Cafes focus on the Protective Factors and have been adapted to include questions and resources specific to families with children who are Deaf, Hard of Hearing, or Deafblind. Youth cafes are in the development process for this population.

### Law Enforcement Responses to Youth Experiencing the Onset of a Mental Disorder or a Mental Health Crisis

This training is part of a 40-hour training to improve law enforcement officers' capacity to effectively engage individuals with diminished capacity. The training focuses on behavioral health disorders youth experience, developmental considerations, crisis warning signs, and how to engage youth and parents as allies.

### Introduction to Wraparound

The purpose of this training is to gain an understanding of the critical components of the wraparound process in order to provide high fidelity wraparound practice and to practice these steps of the process to include eliciting the family story from multiple perspectives, reframing team missions, identifying needs, establishing outcomes, brainstorming strategies, and creating a plan of care and crisis plan that represents the work of the team and learn basic facilitation skills for running a wraparound team meeting.

### Engagement in the Wraparound Process

The purpose of this training is to identify barriers to engagement, develop skills around engaging team members and the family, and utilize research-based strategies of engagement for increased positive outcomes for youth and their families.

Advancing Wraparound Practice: Supervision and Managing to Quality

The purpose of this training is to identify the essential elements of quality wraparound implementation, develop an increased understanding of the role of the supervisor in quality wraparound implementation, learn how to manage quality throughout the phases of wraparound implementation, learn how to utilize supportive tools to develop quality wraparound practitioners, individualized and strength-based service plans, and team processes, and learn how to transfer knowledge and skills to the workforce.

School-Based Suicide Prevention

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

**CANS**

The CANS is the functional assessment used for children entering out-of-home care through DCBS. It is also the outcomes management tool that will be used for High Fidelity Wraparound

CASII

The CASII is required to determine medical necessity for the MCOs. It is also used as part of the eligibility determination process for High Fidelity Wraparound

ECSII

The ECSII is required to determine medical necessity for the MCOs. It is also used as part of the eligibility determination process for High Fidelity Wraparound

<b>Trainings Relevant for <i>Both Adult and Children's</i> Services</b>			
<b>Type of Training</b>	<b>Intended Audience</b>	<b>Number of Participants Anticipated</b>	<b>Frequency/ Length of conference</b>
Access Options for Consumers with Hearing Loss	Each CMHC Region and other Providers Upon Request	Ranges from 5-125 per Session	As Requested; In Partnership with Hamilton Relay
Adapting Substance Use Treatment for Deaf or Hard of Hearing Consumers	Any provider currently or interested in serving consumers with hearing loss.	Target 8-25 per Session	As requested. Tailored to needs of audience.
<b>American Sign Language Interpreter Peer Supervision Groups on Mental Health Interpreting</b>	Certified, Licensed Interpreters and interns working in mental health settings across the state. Groups exist or are forming in Lexington/Danville, Louisville, Northern KY, and Bowling Green	Target 5-10 per Session	Every 4-6 weeks One Day
<b>Assessing and Managing Suicide Risk: Core Competencies for Mental Health</b>	Behavioral Health Clinicians	Target-30 per Session	As requested One Day

**Trainings Relevant for *Both Adult and Children's* Services**

Type of Training	Intended Audience	Number of Participants Anticipated	Frequency/ Length of conference
<b>Cognitive Behavior Therapy for Consumers who are Deaf with Language and Learning Challenges</b>	Therapists, case managers, rehabilitation counselors for the deaf, and others.	40	As needed.
<b>Cognitive Behavior Therapy for Perinatal Depression</b>	Regional Perinatal Depression contacts, Early Childhood Mental Health Specialists	30-50 per Session	3 Times per Year 2 Days
<b>Cognitive Behavior Therapy with Psychosis (CBTp)</b>	Regional Board staff, DBH staff, state psychiatric facility staff, other providers of psychiatric services for youth and young adults	Approximately 50	3 Days As Needed
<b>CBTp Supervision Training</b>	Regional Board staff and other providers of psychiatric services who had been identified as supervisors/coaches during the 3 day training, DBH staff	Approximately 20	1 Day As Needed
Come Learn Presentations	DBHDID staff	Unlimited	Quarterly 1 hour
<b>Creating Community Connections: A Behavioral Health Case Management Conference</b>	TCM for adults with SMI, children with SED, individuals with SUD, and individuals with co-occurring complex physical health conditions. Also targets supervisors.	300-400 Maximum	2 Days Every Few Years
<b>Crisis Intervention Team Training (CIT)</b>	Law Enforcement Officers	Approximately 360 Total	12 per year 5 Days (40 hours)
<b>Cultural Competency Training</b>	Current and prospective providers of Cultural Competency Training at the KDBHDID operated or contracted facilities and Regional Board staff and KDBHDID central office staff	Varies depending on location across the state	As requested 2-3 Days
<b>Deaf and Hard of Hearing Providers' Symposia</b>	DHHS Specialists and other CMHC staff with consumers with hearing loss.	20	Quarterly

**Trainings Relevant for *Both Adult and Children's* Services**

Type of Training	Intended Audience	Number of Participants Anticipated	Frequency/ Length of conference
<b>Deafness 101</b>	Overview of Cultural and Linguistic Issues in Serving Deaf or Hard of Hearing Consumers for any interested providers of mental health, developmental disability, or addiction services	Varies depending on interest and location – available statewide. Target is 100.	As Requested by Any Provider or Educational Institution across the State. Goal is to have it offered at every CMHC and facility. 1.5 to 3 hours
<b>Deafness 102</b>	1.5 to 3 hour Overview of adapting clinical practices to be culturally and linguistically affirmative for those with hearing loss. Available to current or prospective providers	Varies depending on interest and location. Available statewide. Goal is 100.	As Requested by Any Provider or Educational Institution Across the State. Goal is to have it offered at every CMHC and facility. 1.5 to 3 hours
<b>Early Interventions for First Episode Psychosis</b>	Any community providers	50	3 hours As needed
<b>Emergency Services Training</b>	Behavioral health providers and administrators, community providers and leaders, local interest groups.	Available statewide	As needed
<b>Evidenced Based Care for the Client At-Risk for Suicide</b>	Behavioral health clinicians	Target-80	As requested One Day
<b>Feedback Informed Treatment</b>	Regional Board staff, DBH staff, other providers of psychiatric services for youth and young adults	Approximately 20	1 Day As Needed
<b>First Episode of Psychosis Overview of Early Interventions</b>	Regional Board staff, DBH staff, state psychiatric facility staff, other providers of psychiatric services for youth and young adults	Approximately 50	2 Day Annually
First Episode of Psychosis Site Consultation TA calls	Regional Board staff from iHOPE programs	One program at a time	1 Hour Monthly

**Trainings Relevant for *Both Adult and Children's* Services**

<b>Type of Training</b>	<b>Intended Audience</b>	<b>Number of Participants Anticipated</b>	<b>Frequency/ Length of conference</b>
<b>Heal the Healer Training and Retreat</b>	Behavioral health clinicians, case managers, supervisors	20-25	2 days Annually
<b>Hearing Voices that are Distressing</b>	Behavioral health providers and administrators and family members	Maximum of 40	As requested 3 hours
<b>Integrated Dual Diagnosis Treatment (IDDT) Training</b>	ACT team members Other providers	Approximately 40	3 Days Repeated in 3 locations across the state
IPS Supported Employment Conference	IPS Supported Employment staff from Regional Boards, other contracted entities, DBH staff, OVR.	Approximately 50	2 Days Annually
<b>Kentucky Registry of Interpreters for the Deaf (RID)</b>	DHHS Interpreters from across the state	17-40	Annually
KDBHDID Orientation	Newly Hired Central Office Staff	Average 4-8	Quarterly and as needed 1 Day
Kentucky Behavioral Health Planning and Advisory Council Member Orientation	New and current members.	15	Annually
<b>Kentucky School of Alcohol and Other Drug Studies</b> (Co-Sponsored by KDBHDID)	Behavioral health providers and administrators, consumers and family members	Approximately 800	Annually 4.5 Days
<b>KY School for Alcohol and Other Drug Studies-adolescent treatment and recovery track</b>	Mental health and substance use clinicians, case managers, peer specialists, prevention specialists, and others interested in working with young people	120 -150 in the track each year	Annual for 4 days
<b>Law Enforcement Response to Individuals with Special Needs</b>	Police Officers, Deputies, School Resource Officers	25	5 Days 40 Hours

**Trainings Relevant for *Both Adult and Children's* Services**

<b>Type of Training</b>	<b>Intended Audience</b>	<b>Number of Participants Anticipated</b>	<b>Frequency/ Length of conference</b>
Let's Talk Safety for Families: Access to Lethal Means	General Audience	New offering for suicide prevention	As requested 1.5 Hours
<b>Let's Talk Safety: Clinical Issues Associated with Access to Lethal Means</b>	Behavioral Health Clinicians	New offering for suicide prevention	As requested 1.5 Hours
Mental Health Interpreting Peer Supervision Groups	A supervision group for clinicians serving clients who are deaf or hard of hearing.	5-15	Monthly
<b>Motivational Interviewing</b>	Regional Board staff, other providers of behavioral health services, state psychiatric facility staff, DBH staff	Approximately 30	2 Days As Needed
<b>Motivational Interviewing Basics Training</b>	Clinicians, peer specialists, IPS employment specialists, case managers, supervisors). This training is required if you are interested in taking the Advanced Training.	40 per session	2 day training As needed
<b>Motivational Interviewing Booster/Advanced Training</b>	This training is for any staff who completed the MI Basics training and is interested in increasing their skill level in utilizing MI in their daily work. (clinicians, peer specialists, IPS employment specialists, case managers, supervisors).	40 per session	1 day booster training and/or 2 day advanced training As needed
<b>Motivational Interviewing Supervisor Training</b>	This training is for MI Supervisors who will be providing onsite coaching and skill building to staff within their agency who have completed the MI Basics, Booster Session and Advanced Training.	40 per session	1 day training As needed
<b>Multifamily Group Therapy</b>	Regional Board staff, DBH staff, other providers of psychiatric services for youth and young adults	Approximately 30	2 Days As needed
<b>Person Centered Recovery Planning (PCRP) Overview</b>	Regional Board staff, DBH staff, other community partners	Approximately 50	1 Day Overview Training (Kickoff)

**Trainings Relevant for *Both Adult and Children's* Services**

Type of Training	Intended Audience	Number of Participants Anticipated	Frequency/ Length of conference
<b>Plan of Safe Care</b>	Behavioral Health service coordinators, clinicians, prevention specialists	1000	Offered Regionally and Annually
Question, Persuade, and Refer Training (QPR)	Behavioral health service providers, state operated or contracted facilities, consumers, local interest groups and central office staff	Varies depending on location across the state	Quarterly and as Requested 1.5 Hours
<b>Structured Interview for Psychosis Risk Syndrome</b>	The training is required for professionals who will be administering the SIPS tool with clients/patients such as psychiatrists, psychologists, nurses, social workers, case managers or other mental health workers, peer specialists.	Approximately 60	3 Days Annually and as needed
<b>System of Care Academy</b>	primary care providers, clinicians, practitioners, educators, child care providers, Family Resource Youth Service Center staff, juvenile justice staff, community based services staff, public health staff, families/youth, and community members	Approximately 350	Annually 3 Days
Therapists' Retreat for those Serving Consumers with Hearing Loss	Behavioral health service providers, state operated or contracted facilities, consumers, local interest groups and KDBHDID central office staff	Ranges from 4-25	4 per year
Transition Aged Youth Launching Realized Dreams (TAYLRD)	Child and Adult Case Managers	60	As requested 1 Day
<b>Trauma Informed System of Care Training</b>	Any Community Providers	50	As requested 3 Hours
<b>Trauma Informed System of Care Training for Trainers</b>	Trainers within various community agencies	25	1 day, plus follow-up sessions, 2 per year

<b>Trainings Relevant for Both Adult and Children's Services</b>			
<b>Type of Training</b>	<b>Intended Audience</b>	<b>Number of Participants Anticipated</b>	<b>Frequency/ Length of conference</b>
<b>Working with the Suicidal Client</b>	Behavioral health clinicians	Target-200	As requested 2 Hours
Workshops for the Deaf Community	Existing consumers and others who may be in need of mental health services.	10-55	Monthly and as needed

**Descriptions of Trainings Related to Both Adult and Children's Services**

Access Options for Consumers with Hearing Loss

Training made available by DBHDID Deaf and Hard of Hearing Services (DHHS) staff to all providers as needed regarding access options.

Adapting Substance Use Treatment for Deaf or Hard of Hearing Consumers

Training made available by DBHDID DHHS staff specific to treating individuals with SUD and who are Deaf or Hard of Hearing.

American Sign Language Interpreter Peer Supervision Groups on Mental Health Interpreting

Training provided to certified, licensed interpreters and interns working in mental health settings across the state. Designed to address specific issues related to mental health while interpreting.

Assessing and Managing Suicide Risk: Core Competencies for Mental Health

Training for behavioral health clinicians in recognizing and managing risk for possible suicidal behaviors.

Cognitive Behavioral Therapy for Consumers who are Deaf with Language and Learning Challenges

Training to specifically educate how to adapt CBT for use with individuals who are Deaf and who may have learning challenges.

Cognitive Behavior Therapy for Perinatal Depression

Training for professionals specifically on adapting CBT for use with women who are experiencing depression in conjunction with pregnancy.

Cognitive Behavior Therapy for Psychosis (CBTp)

A 3-day training for clinicians regarding building skills to adapt CBT for use with individuals experiencing psychosis, in particular, with individuals experiencing very early symptoms of their first episode of psychosis. Douglas Turkington, M.D., from the United Kingdom, and Jesse Wright, M. D. of the University of Louisville provided this training. Clinicians from regional boards as well as other providers identified supervisory staff who receiving this training and agreed to go forward and coach others in their agency.

### **CBTp Supervision Training**

A one-day follow-up training for identified supervisors/coaches from across the state. This training was led by Jesse Wright, M.D. from the University of Louisville. The focus was on supervision methods and tips and tools to guide this evidence based practice in local agencies.

### **Come Learn Presentations**

One-hour educational presentations that are generally for DBH staff and designed as traditional “brown bag” opportunities to gain information on a variety of topics.

### **Creating Community Connections: A Behavioral Health Case Management Conference**

For Targeted Case Managers who work with adults with SMI, children with SED, individuals with SUD, and individuals with co-occurring complex physical health conditions and their supervisors.

### **Crisis Intervention Team (CIT) Training**

In collaboration with the National Alliance on Mental Illness (NAMI), KDBHDID provides training for law enforcement officers, via a contract with a retired police lieutenant, regarding how to better respond to encounters with individuals who may be experiencing a behavioral health crisis. This training is based on the evidence based Memphis Model of CIT.

### **Cultural Competency Training**

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

### **Deaf and Hard of Hearing Services Providers’ Symposia**

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

### **Deafness 101**

Overview of cultural and linguistic issues in serving individuals who are Deaf or Hard of Hearing.

### **Deafness 102**

Additional training on how to adapt clinical practices to be culturally and linguistically affirmative for individuals who are Deaf or Hard of Hearing.

### **Early Interventions for First Episode Psychosis**

This training will provide an overview of prevalence, signs and symptoms of psychosis-risk and first episode psychosis in youth and young adults as well as provide information on best practices for this population.

### **Emergency Services Training**

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

### **Evidence Based Care for the Client at Risk of Suicide**

Training for clinicians on skills for dealing with individuals at risk of suicide.

### **Feedback Informed Treatment**

Training from Ryan Melton, Ph.D., from Portland State University, in methods and procedures for evaluating behavioral health treatment in a collaborative manner and adjusting methods in a data driven manner, in collaboration with the person being served.

### **First Episode of Psychosis Overview of Early Interventions**

A two-day training from the Early Assessment and Support Alliance (EASA) from Portland State University regarding literature and best practices for early intervention in young people experiencing first episodes of psychosis. Includes screening and assessment methods, evidence based treatment and family support.

### **First Episode of Psychosis Consultation TA Calls**

Monthly TA calls between EASA consultants and iHOPE (Helping Others Pursue Excellence) programs across the state. iHOPE are programs offering Coordinated Specialty Care, an evidence based practice for young people experiencing first episode of psychosis.

### **Heal the Healer Training and Retreat**

This 2-day, annual training/retreat is an opportunity for “helping professionals” to learn self-care theory and practice applicable to both professionals and their clients.

### **Hearing Voices that are Distressing**

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

### **Integrated Dual Diagnosis Treatment Training**

Training regarding IDDT, an evidence based practice for individuals with co-occurring mental health and substance use disorders. ACT teams are targeted due to the high incidence of co-occurring disorders of individuals served by ACT.

### **IPS Supported Employment Conference**

DBH Adult Branch, in collaboration with the Office for Vocational Rehabilitation, hosts an annual, two-day training for staff in IPS Supported Employment programs, contracted fidelity monitors, contracted trainers and coaches, and others from across the state. Workshops regarding the Individual Placement and Support (IPS) Model of Supported Employment are provided.

### **Kentucky Registry of Interpreters for the Deaf (RID)**

Training for interpreters for individuals who are Deaf or Hard of Hearing from across the state.

### **KDBHDID Orientation**

Orientation is provided to all new staff. The training enhances staffs’ knowledge of the mission and vision of the agency, programs and services administered by the Department, and staff who lead those initiatives.

### **Kentucky Behavioral Health Planning and Advisory Council Member Orientation**

A 4-hour orientation is provided annually for all new members of this Council, or new state representatives on this Council, or other interested parties. Led by members of the Council.

### **Kentucky School of Alcohol and Other Drug Studies**

The Kentucky School of Alcohol and Other Drug Studies (KSAODS) is an annual week-long event where more than 800 Kentucky, Indiana and Ohio professionals from the alcohol and drug treatment, mental health, prevention and other related fields gather to hear from national and state leaders on the up-and-

coming theories of practice in the behavioral health world. As of 2015, the School began to specifically offer an adolescent track of workshops that provide professionals working with youth and young adults who may have substance use issues or co-occurring substance use and mental health issues targeted information for that population.

### **Law Enforcement Response to Individuals with Special Needs (Mental Health 101)**

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

### **Let's Talk Safety for Families: Access to Lethal Means**

Training for family members and others in the general population about prevention of suicide.

### **Let's Talk Safety: Clinical Issues Associated with Access to Lethal Means**

Training for clinicians about prevention of suicide.

### **Mental Health Interpreting Peer Supervision Groups**

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

### **Motivational Interviewing**

Trainings by a national consultant to introduce the concept of motivational interviewing and to allow participants to practice the techniques that are part of the methodology behind the concepts. These trainings are targeting staff in mental health, substance use, and other programming.

### **Motivational Interviewing (Basic/Booster/Advanced/Supervisor)**

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

### **Multifamily Group Therapy Training**

A two-day training by EASA from Portland State University in this evidence based family psychoeducation model, particularly effective when working with families of individuals experiencing their first episode of psychosis.

### **Person Centered Recovery Planning Overview**

A 1-day training event on Person Centered Recovery Planning. Consultants Janis Tondora, PsyD., and Diane Grieder, M.Ed., provided an overview of person centered principles, medical necessity requirements, and identified local change teams, supervisor/coaches, and DBH liaisons for several Regional Boards.

### **QPR Community Suicide Prevention Presentation.**

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

## **SIPS**

The Structured Interview for Psychosis-Risk Syndromes (SIPS) is a reliable and internationally-used assessment tool to assist in the identification of early symptoms of psychosis. This training will provide the skills necessary to professionals who will be administering the SIPS tool.

## **Structured Interview for Psychosis Risk Syndrome (SIPS)**

A 3-day training event for individuals wanting to be certified in using the SIPS assessment tool. Barbara Walsh of Yale University provides this certification training and teaches participants to score this standardized assessment tool in order to accurately identify individuals most likely experiencing early symptoms of their first episode of psychosis.

System of Care Academy This is an event planned to bring all child serving agencies together to discuss System of Care development across the state and across all agencies. Generally a theme around a specific topic (e.g., Co-occurring MH and SA among adolescents) emerges throughout the year and is the focus of the plenary session.

## **Therapists' Retreat for those Serving Consumers with Hearing Loss**

Networking and support opportunity that occurs four times per year.

## **TAYLRD**

This training provides an overview of barriers, developmental issues, cultural issues and best practices when providing services and supports to transition age youth.

## **Trauma Informed Care Training**

This training will provide an overview of trauma and the necessary components that support the provision of care that takes into consideration the trauma that individuals have experienced in their life.

## **Trauma Informed System of Care Training for Trainers**

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

## **Working with the Suicidal Client**

This is a clinical training appropriate for mental health providers, case managers or those working in the healthcare field. This workshop is flexible - 2hr, 3hr and full day lengths. Modules include: Prevalence; Risk & protective factors; Issues of provider competence; Understanding the suicidal mind; How to conduct a solid risk assessment; establishing a therapeutic connection; and effective treatment.

## **Workshops for the Deaf Community**

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

<b>Trainings Related to Prevention</b>			
<b>Type of Training</b>	<b>Intended Audience</b>	<b># of Participants Anticipated</b>	<b>Frequency/ Length of conference</b>
Kentucky Prevention Network Conference (KPN)	Regional Prevention Center staff, Prevention professionals.	Approximately 50 at each session	Annual 2 day training
Assessing and Managing Suicide Risk (AMSR)	Health and Behavioral Health professionals working in outpatient settings with a master's degree or above.	Approximately 40	1 Day 6.5 hours
Applied Suicide Intervention Skills Training (ASIST)	ASIST is widely used by healthcare providers, but there are no formal training required to attend the workshop. ASIST can be taught to and used by anyone.	From 15 – 40	7 trainings scheduled for 2019  2 days 14 hours
Question, Persuade, and Refer (QPR) T4T	QPR is designed and recommended for everyone regardless of background or occupation.	From 20 – 40	2 trainings scheduled for 2019  8 hours
Suicide to Help (s2H)	Designed primarily for clinicians and other professional caregivers who work with former at risk persons.	Varied	1 training  6.5 hours
Too Good for Drugs Implementer Training	Majority grade school educators, or former educators. Regional Prevention Center Staff.	Maximum of 30 per training.	4 trainings 2 days each 12 hours total
Too Good for Drugs Training of Trainers*	Only those that have completed the implementer trainings can attend and be certified.	Maximum of 10 per training.	3 trainings 2 days each 12 hours total
Sources of Strength	Middle and High School aged youth and Adult Advisors.	35-50 Youth 5-8 Adults	4-5 hours for adults 6 hour for youth peer leaders
Mental Health First Aid	Adults	Maximum of 30 per session.	1 day as needed
Youth Mental Health First Aid	Adults who regularly interact with adolescents.	Maximum of 30 per session.	1 day as needed

<b>Trainings Related to Prevention</b>			
<b>Type of Training</b>	<b>Intended Audience</b>	<b># of Participants Anticipated</b>	<b>Frequency/ Length of conference</b>
Prevention Academy	Individuals seeking Prevention Specialist Certification.	Varied	4 days Annually/ More frequently if needed
Substance Abuse Prevention Skills Training	Individuals who are interested in the basics of prevention. RPC Staff, etc..	Maximum of 30	2-3 times a year 4 days

### **Description of Trainings Relevant to the Prevention Branch**

#### Kentucky Prevention Network Conference (KPN)

Promotes collaboration and quality substance abuse prevention efforts, through training, education and networking.

#### Assessing and Managing Suicide Risk (AMSR)

Increased knowledge in the following core competencies: Maintaining an effective attitude and approach, collecting accurate assessment information, formulation risk, developing a treatment and services plan, and managing care.

#### Applied Suicide Intervention Skills Training (ASIST)

Two-day interactive workshop in suicide first-aid. ASIST teaches participants to recognize when someone may be at risk of suicide and work with them to create a plan that will support their immediate safety.

#### Question, Persuade, and Refer (QPR) (T4T)

This certification course trains instructors to teach QPR for suicide prevention to their community. Participants will learn about the nature of suicidal communications, what form these communications take and how they may be used as the stimulus for QPR intervention.

#### Suicide to Help (s2H)

This training is intended to highlight how to improve health and well-being leading to a self-directed and fuller life or, in other words, growth. Hoping to end the cycle of relapse followed by another round of coping, s3H aims for goals of more lasting significance.

#### Too Good for Drugs Implementer Training

Implementation Competency is essential for any instructor delivering an evidence-based prevention program like *Too Good for Drugs*. The fidelity model for *Too Good for Drugs* includes completion of a Curriculum Training session as part of its built-in quality assurance mechanism. To implement the Too Good programs with confidence, results, and fidelity to the implementation model, participation in a Too Good Curriculum Training is the first step.

#### Too Good for Drugs Training of Trainers (ToT)

This training is specifically for implementers of the Too Good program and is intended to increase the capacity surrounding the program. Each of the trainees will go through a two day training and at

completion they will be able to take their knowledge and experiences to in return train others interested in the curriculum.

#### Sources of Strength

Sources of Strength is an evidence-based, peer-led mental health wellness model that taps into the power of young people to use social networking to change unhealthy norms and cultures. For this model, leaders from all identified school/organization groups (sports, academics, ethnicity, religion, etc..) work together to deliver messages to the school population at large to promote help-seeking, school connectedness, adult connectedness, mental and emotional strength building, and more through a series of self-designed strategic message campaigns.

#### Mental Health First Aid

This training provides participants skills to help an individual who is developing a mental health issue or experiencing a mental health crisis.

#### Youth Mental Health First Aid

This training provides participants skills to help an adolescent who is developing a mental health issue or experiencing a mental health crisis.

#### Prevention Academy

This training provides individuals an opportunity to increase their knowledge about the field of prevention. Participants learn about substance use, building community capacity to address substance related issues, the Regional Prevention System in Kentucky, and other related topics.

#### Substance Abuse Prevention Skills Training (SAPST)

SAPST is for entry-level prevention practitioners and is appropriate for professionals working in related fields, e.g. treatment, mental health etc. The SAPST training is grounded in current research and SAMHSA's Strategic Prevention Framework.

MENTAL HEALTH BLOCK GRANT ALLOCATIONS FOR FISCAL YEAR 2020 7-19-2019

CONTRACTED TO THE REGIONS FOR SERVICES:

Region	SMI-SED Emergency	Adult SMI	Children SED	Consumer Operated Programs	MHA (Northkey) Bridgehaven(SCS)	Forensic Act Team Reintegraton Sys.	SMI/SED Deaf & HoH	MHBG 10% Set Aside	TOTAL
Four Rivers	11,950	209,936	88,938	35,000				100,000	445,824
Pennyroyal	10,303	252,530	74,385					3,000	340,218
River Valley	10,490	260,569	85,009					3,000	359,068
LifeSkills	15,803	265,171	91,839	35,000				100,000	507,813
Communicare	15,364	212,444	100,328	35,000				100,000	463,136
Centerstone	30,614	677,556	187,485	35,000	143,000	50,000	38,900	100,000	1,262,555
North Key	13,256	309,375	121,276	35,000				3,000	481,907
Comprehend	7,298	81,795	77,722					3,000	169,815
Pathways	13,608	254,434	100,332					100,000	468,374
Mountain	12,381	198,952	85,275	35,000				100,000	431,608
Kentucky River	8,820	124,842	93,383					3,000	230,045
Cumberland River	13,986	288,263	102,891				34,500	100,000	539,640
Adanta	11,702	174,910	86,197					3,000	275,809
Bluegrass	21,818	252,988	149,176				34,500	100,000	558,482
<b>TOTAL</b>	<b>197,393</b>	<b>3,563,765</b>	<b>1,444,236</b>	<b>210,000</b>			<b>107,900</b>	<b>818,000</b>	<b>\$6,534,294</b>

STATEWIDE PROJECTS:

Program or Service	Amount
Children's Training/TA	70,000
Adult MH Training/TA	90,000
First Episode Psychosis	75,000
Supported Employment Fidelity Initiative	25,000
Crisis Intervention Training (CIT)	90,000
Mental Health and Aging	20,000
SIAC Support	5,000
Statewide Deaf & Hard of Hearing Services (DHHS)	34,800
	<b>\$409,800</b>

OTHER:

Eastern Kentucky University	6,837
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/State Travel	6,850
NAMI KY - Recovery Oriented Family Support	145,054
NAMI of Lexington (Participation Station) - Recovery Oriented Training	150,190
University of Kentucky - Institute for Pharmaceutical Outcomes & Policy (IPOP)	100,000
University of Kentucky - Human Development Institute (HDI)	323,059
Technical Assistance Collaborative (TAC) SASA	83,600
Wellspring	50,000
	<b>\$1,021,924</b>

TOTAL BLOCK GRANT ALLOCATIONS

**\$7,966,018**

# Environmental Factors and Plan

## 10. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

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### Criterion 1

#### Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

- i) Screening  Yes  No
- ii) Education  Yes  No
- iii) Brief Intervention  Yes  No
- iv) Assessment  Yes  No
- v) Detox (inpatient/social)  Yes  No
- vi) Outpatient  Yes  No
- vii) Intensive Outpatient  Yes  No
- viii) Inpatient/Residential  Yes  No
- ix) Aftercare; Recovery support  Yes  No

b) Services for special populations:

- Targeted services for veterans?  Yes  No
- Adolescents?  Yes  No
- Other Adults?  Yes  No
- Medication-Assisted Treatment (MAT)?  Yes  No

## **Criterion 2**

**Criterion 3**

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability?  Yes  No
2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities?  Yes  No
3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care?  Yes  No
4. Does your state have an arrangement for ensuring the provision of required supportive services?  Yes  No
5. Has your state identified a need for any of the following:
  - a) Open assessment and intake scheduling  Yes  No
  - b) Establishment of an electronic system to identify available treatment slots  Yes  No
  - c) Expanded community network for supportive services and healthcare  Yes  No
  - d) Inclusion of recovery support services  Yes  No
  - e) Health navigators to assist clients with community linkages  Yes  No
  - f) Expanded capability for family services, relationship restoration, and custody issues?  Yes  No
  - g) Providing employment assistance  Yes  No
  - h) Providing transportation to and from services  Yes  No
  - i) Educational assistance  Yes  No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Pregnant Women and Women with Dependent Children (PWWDC)

- Kentucky behavioral health system of care has incorporated multiple programs to address the needs of pregnant and parenting women. These programs address substance use disorder by developing a continuum of care consisting of residential services, transitional housing, intensive outpatient, outpatient, peer support, case management and community supports.

**Criterion 4,5&6****Persons Who Inject Drugs (PWID)**

1. Does your state fulfill the:
- a) 90 percent capacity reporting requirement  Yes  No
- b) 14-120 day performance requirement with provision of interim services  Yes  No
- c) Outreach activities  Yes  No
- d) Syringe services programs  Yes  No
- e) Monitoring requirements as outlined in the authorizing statute and implementing regulation  Yes  No
2. Has your state identified a need for any of the following:
- a) Electronic system with alert when 90 percent capacity is reached  Yes  No
- b) Automatic reminder system associated with 14-120 day performance requirement  Yes  No
- c) Use of peer recovery supports to maintain contact and support  Yes  No
- d) Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)?  Yes  No
3. States are required to monitor program compliance related to activities and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.
- Contractual requirements include guidelines for providing education and referral services for individuals identified at risk for diseases associated with intravenous drug use. The Department of Behavior Health includes the Program Integrity Branch to monitor provider compliance with program deliverables and performance indicators. Funding is contingent upon completion of performance indicators.
- Syringe Service Programs
- The Kentucky Department for Public Health has supported the development of needle exchange programs across the state. There are currently over sixty (60) local Needle Exchange Programs in Kentucky. Several of these programs provide outreach services, Peer Support and referral to treatment.

**Tuberculosis (TB)**

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery?  Yes  No
2. Has your state identified a need for any of the following:
- a) Business agreement/MOU with primary healthcare providers  Yes  No
- b) Cooperative agreement/MOU with public health entity for testing and treatment  Yes  No
- c) Established co-located SUD professionals within FQHCs  Yes  No
3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.
- Contractual requirements include guidelines for providing education and referral services for individuals identified at risk for diseases associated with tuberculosis. The Department of Behavior Health includes the Program Integrity Branch to monitor provider compliance with program deliverables and performance indicators. Funding is contingent upon completion of performance indicators.

**Early Intervention Services for HIV (for "Designated States" Only)**

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for  Yes  No

HIV in areas that have the greatest need for such services and monitoring the service delivery?

2. Has your state identified a need for any of the following:
- a) Establishment of EIS-HIV service hubs in rural areas  Yes  No
  - b) Establishment or expansion of tele-health and social media support services  Yes  No
  - c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS  Yes  No

**Syringe Service Programs**

- 1. Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.C.Â§ 300x-31(a)(1)F)?  Yes  No
- 2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?  Yes  No
- 3. Do any of the programs use SABG funds to support elements of a Syringe Services Program?  Yes  No

If yes, please provide a brief description of the elements and the arrangement

**Criterion 8,9&10****Service System Needs**

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement?  Yes  No
2. Has your state identified a need for any of the following:
  - a) Workforce development efforts to expand service access  Yes  No
  - b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services  Yes  No
  - c) Establish a peer recovery support network to assist in filling the gaps  Yes  No
  - d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, sexual and gender minorities)  Yes  No
  - e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations  Yes  No
  - f) Explore expansion of services for:
    - i) MAT  Yes  No
    - ii) Tele-Health  Yes  No
    - iii) Social Media Outreach  Yes  No

**Service Coordination**

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care?  Yes  No
2. Has your state identified a need for any of the following:
  - a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services  Yes  No
  - b) Establish a program to provide trauma-informed care  Yes  No
  - c) Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education  Yes  No

**Charitable Choice**

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C. § 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)?  Yes  No
2. Does your state provide any of the following:
  - a) Notice to Program Beneficiaries  Yes  No
  - b) An organized referral system to identify alternative providers?  Yes  No
  - c) A system to maintain a list of referrals made by religious organizations?  Yes  No

**Referrals**

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs?  Yes  No
2. Has your state identified a need for any of the following:
  - a) Review and update of screening and assessment instruments  Yes  No
  - b) Review of current levels of care to determine changes or additions  Yes  No

- c) Identify workforce needs to expand service capabilities  Yes  No
- d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background  Yes  No

**Patient Records**

- 1. Does your state have an agreement to ensure the protection of client records?  Yes  No
- 2. Has your state identified a need for any of the following:
  - a) Training staff and community partners on confidentiality requirements  Yes  No
  - b) Training on responding to requests asking for acknowledgement of the presence of clients  Yes  No
  - c) Updating written procedures which regulate and control access to records  Yes  No
  - d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure  Yes  No

**Independent Peer Review**

- 1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers?  Yes  No
- 2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C. § 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

The Department contracts with independent reviewers (including peers) to review three (3) CMHCs per year.

- 3. Has your state identified a need for any of the following:
  - a) Development of a quality improvement plan  Yes  No
  - b) Establishment of policies and procedures related to independent peer review  Yes  No
  - c) Development of long-term planning for service revision and expansion to meet the needs of specific populations  Yes  No
- 4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds?  Yes  No

If Yes, please identify the accreditation organization(s)

- i)  Commission on the Accreditation of Rehabilitation Facilities
- ii)  The Joint Commission
- iii)  Other (please specify)

Accreditation is not required but all of the funded service providers are accredited by one or more of the organizations. of the fourteen CMHCs, six are Joint Commission and eight are CARF.

**Criterion 7&11****Group Homes**

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program?  Yes  No
2. Has your state identified a need for any of the following:
  - a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service  Yes  No
  - b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing  Yes  No

**Professional Development**

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:
  - a) Recent trends in substance use disorders in the state  Yes  No
  - b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services  Yes  No
  - c) Performance-based accountability  Yes  No
  - d) Data collection and reporting requirements  Yes  No
2. Has your state identified a need for any of the following:
  - a) A comprehensive review of the current training schedule and identification of additional training needs  Yes  No
  - b) Addition of training sessions designed to increase employee understanding of recovery support services  Yes  No
  - c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services  Yes  No
  - d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort  Yes  No
3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?
  - a) Prevention TTC?  Yes  No
  - b) Mental Health TTC?  Yes  No
  - c) Addiction TTC?  Yes  No
  - d) State Targeted Response TTC?  Yes  No

**Waivers**

*Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924, and 1928 (42 U.S.C. § 300x-32 (f)).*

1. Is your state considering requesting a waiver of any requirements related to:
  - a) Allocations regarding women  Yes  No
2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:
  - a) Tuberculosis  Yes  No
  - b) Early Intervention Services Regarding HIV  Yes  No
3. Additional Agreements
  - a) Improvement of Process for Appropriate Referrals for Treatment  Yes  No

b) Professional Development  Yes  No

c) Coordination of Various Activities and Services  Yes  No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

There are statutes and regulations in place that govern Behavioral Health programs in Kentucky.

<https://apps.legislature.ky.gov/law/statutes/chapter.aspx?id=38158>

<https://apps.legislature.ky.gov/law/kar/TITLE908.HTM> DBHDID

<https://apps.legislature.ky.gov/law/kar/TITLE907.HTM> Medicaid

Office of the Inspector General/Division of Audits and Investigations is responsible for investigating and auditing for possible fraud, waste or abuse of the programs administered by the Cabinet as mandated by KRS 194A.030. The Division is responsible for enforcing the Kentucky Controlled Substances Act as outlined in KRS 218A.

**Footnotes:**

Criterion 1

Improving access to treatment services

- Kentucky's behavioral health system of care includes fourteen (14) Community Mental Health Centers (CMHC) as well as multiple licensed and credentialed private providers as specified on the DBHDID provider directory. These programs provide access within the state to a full continuum of services, including screening, education, brief intervention, assessment, withdrawal management, outpatient, intensive outpatient, residential, and recovery supports. Kentucky is continuously identifying specific populations of need and works to provide targeted services to those populations. Those populations include veterans, adolescents, pregnant and parenting women, homeless, older individuals and others as identified. Kentucky promotes the use of medication assisted treatment (MAT) as a valuable treatment tool through twenty-three (28) methadone clinics, and over one thousand (1,000) DATA-2000 waived physicians.

Criterion 7

Oxford House: DBH has operated a revolving loan fund in partnership with the Kentucky Housing Authority (KHC) since the early 1990s. At that time, it was decided to utilize the Oxford House model, a now evidence based practice, for the purposes of establishing new recovery homes utilizing the loan fund. Beginning in January 2016, DBH contracted directly with Oxford House, Inc. to expand the recovery home network from 32 recovery beds, in Northern KY, to 388 beds statewide. In an effort to continue growth of the network, funds have been added to the revolving fund. While no memorandums of understanding have been instituted between providers and homes, the contract with Oxford House provides KY with Oxford House Outreach Workers who establish relationships with service providers to ensure linkages within the continuum of care.

KY Recovery Housing Network (KRHN): As community based recovery residence capacity has growth through DBH's partnership with Oxford House, Inc., a lack of support and standardization of more structured recovery housing along the continuum, including transitional housing and halfway houses has become apparent. With increased funding through federal and state initiatives, it has become even more evident that adoption of standards for recovery residences is a necessity in KY. Through technical assistance and site correspondence, it has been decided that the most appropriate way to address this issue is for KY to become a National Alliance of Recovery Residences (NARR) affiliate and implement standards for recovery housing in KY. Using the model that Ohio Recovery Housing has instituted around these standards, this implementation project has two primary purposes: Development of an advisory council; and Administration of programmatic certification. Plans are underway to begin certification in SFY 2020.

## Environmental Factors and Plan

### 11. Quality Improvement Plan- Requested

#### Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

#### Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2018-FFY 2019?  Yes  No

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

N/A

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

#### Footnotes:

## Environmental Factors and Plan

### 12. Trauma - Requested

#### Narrative Question

**Trauma**<sup>57</sup> is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma<sup>58</sup> paper.

<sup>57</sup> Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

<sup>58</sup> *Ibid*

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

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues?  Yes  No
2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?  Yes  No
3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?  Yes  No
4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?  Yes  No
5. Does the state have any activities related to this section that you would like to highlight.

Since 2008 the Division of Behavioral Health has been facilitating trainings on Trauma Informed Care and on Seeking Safety, a manualized treatment for Co-occurring Substance Abuse and PTSD. All 14 CMHCs regularly require training for all new staff and provide continuing education for current staff. Many CMHCs have trained trainers of Trauma Informed Care and many participate on the state level workgroup to promote and refine this practice.

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

**Footnotes:**

## Environmental Factors and Plan

### 13. Criminal and Juvenile Justice - Requested

#### Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.<sup>59</sup>

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.<sup>60</sup>

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

<sup>59</sup> Journal of Research in Crime and Delinquency: : *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice*. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNeil, Dale E., and Ren?e L. Binder. [OJJDP Model Programs Guide](#)

<sup>60</sup> <http://csgjusticecenter.org/mental-health/>

#### Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services?  Yes  No
2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms?  Yes  No
3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system?  Yes  No
4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances?  Yes  No
5. Does the state have any activities related to this section that you would like to highlight?  
N/A  
Please indicate areas of technical assistance needed related to this section.  
N/A

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#### Footnotes:

No revisions are needed due to the Guidance letter of February 11, 2020.

## Environmental Factors and Plan

### 14. Medication Assisted Treatment - Requested (SABG only)

#### Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

SAMHSA is asking for input from states to inform SAMHSA's activities.

#### Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders?  Yes  No
2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women?  Yes  No
3. Does the state purchase any of the following medication with block grant funds?  Yes  No
  - a)  Methadone
  - b)  Buprenorphine, Buprenorphine/naloxone
  - c)  Disulfiram
  - d)  Acamprosate
  - e)  Naltrexone (oral, IM)
  - f)  Naloxone
4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately\*?  Yes  No

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

Since 1996, Kentucky has had comprehensive legislative regulations to address the implementation and continued quality assurance of Narcotic Treatment Programs (NTPs), specifically those providing methadone. The Division of Behavioral Health (DBH) employees the State Opioid Treatment Authority (SOTA) with the responsibility of ensuring regulatory compliance.

Additionally, the Division of Behavioral Health (DBH) coordinates the annual Kentucky School for Alcohol and Other Drug Studies targeting providers of services throughout the Commonwealth's behavioral health continuum of care. As part of this annual event, continuing education classes are provided on Medication Assisted Treatment (MAT) and other Opioid Use and Substance Use Disorder evidence based treatment.

DBH also supports specialized MAT services for pregnant and parenting women with a substance use disorder. These additional supports include:

- Utilizing funds through Kentucky's Office of Drug Control Policy (ODCP), DBH has facilitated a grant process for providers to expand services to those families affected by neonatal abstinence syndrome (NAS), encouraging innovative residential and recovery support service programs for pregnant and parenting women; and
- DBHDID has encouraged and supported Community Mental Health Centers (CMHC) and other residential programs across the state to increase residential treatment capacity for pregnant and parenting women and their children that incorporates MAT services into their programs.

- Funding services at two publicly funded Narcotic Treatment Programs to target services to pregnant women as a priority population

*\*Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

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**Footnotes:**

# Environmental Factors and Plan

## 15. Crisis Services - Requested

### Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.<sup>61</sup> SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427)<sup>62</sup>,

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

<sup>61</sup><http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848>

<sup>62</sup>Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. <http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427>

### Please check those that are used in your state:

#### 1. Crisis Prevention and Early Intervention

- a)  Wellness Recovery Action Plan (WRAP) Crisis Planning
- b)  Psychiatric Advance Directives
- c)  Family Engagement
- d)  Safety Planning
- e)  Peer-Operated Warm Lines
- f)  Peer-Run Crisis Respite Programs
- g)  Suicide Prevention

#### 2. Crisis Intervention/Stabilization

- a)  Assessment/Triage (Living Room Model)
- b)  Open Dialogue
- c)  Crisis Residential/Respite
- d)  Crisis Intervention Team/Law Enforcement
- e)  Mobile Crisis Outreach
- f)  Collaboration with Hospital Emergency Departments and Urgent Care Systems

#### 3. Post Crisis Intervention/Support

- a)  Peer Support/Peer Bridgers
- b)  Follow-up Outreach and Support
- c)  Family-to-Family Engagement
- d)  Connection to care coordination and follow-up clinical care for individuals in crisis

- e)  Follow-up crisis engagement with families and involved community members
- f)  Recovery community coaches/peer recovery coaches
- g)  Recovery community organization

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

DBHDID would like to highlight the following CMHC initiatives to enhance crisis system capacity:

- Expansion of telehealth delivered services. CMHCs are increasing telehealth capacity by purchasing necessary technology, increasing telehealth sites, training staff, and contracting with off-site providers. Due to recently passed legislation, more expansion of telehealth services is expected. The new law allows patients to access telehealth from home (instead of a clinical setting) and with a greater diversity of providers.
- Integration and expansion of services for individuals experiencing a substance-involved crisis. CMHCs are increasing the number of staff trained in serving individuals with co-occurring disorders, reconfiguring their crisis stabilization units to serve individual with SUD or co-occurring disorders; establishing Quick Response Teams; including SUD specialists on ACT teams; training staff on the administration of Narcan, embedding ASAM into their electronic health records, and providing rapid linkage to SUD treatment services.
- Enhanced organizational capacity to ensure client safety and provide suicide-specific care. CMHCs are engaging in various activities to support a Zero Suicide culture: maintaining Zero Suicide committees; conducting workforce surveys; providing training opportunities for staff and community partners; enhancing in-house training capacity; embedding prompts, alerts and safety planning into electronic health record platforms; utilizing evidence-based suicide screening, assessment and treatment practices; enhancing organizational policies; providing follow-up calls, caring letters and outreach to clients at risk and for clients who miss an appointment; and conducting safety audits of facilities.
- Crisis line improvements. CMHCs are increasing text and chat capabilities, establishing regional warm lines, and seeking membership with the National Suicide Prevention Lifeline network.
- Crisis services improvements. The following enhancements are ensuring better services for individuals in crisis: the state's second 23-hour observation program (Living Room Model) opened; every CMHC has at least one active ACT team and they have all completed fidelity monitoring; some CMHCs have increased their capacity to provide rapid crisis evaluations at hospitals; all CMHCs offer open access for individuals in crisis and individuals discharging from hospitals; and CMHCs are increasing peer bridging services in the state psychiatric hospitals and increasing linkages with ACT teams and IOP programs.
- Increased Peer Support Specialist and Community Support Associate services for individuals in crisis. There is an increase in the number of regions providing the services and an increase in the number of peer support and community support staff in crisis programs statewide.
- Enhanced community partnerships and relationships. CMHCs are engaging in cross-system crisis plans for individuals who are high utilizers of community services; enhancing regional Crisis Intervention Team Boards; and initiating memoranda of understanding with partners.

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

DBHDID was provided with technical assistance for crisis services from 2017-2018. We are still working on those recommendations.

The Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) has an expectation that all Kentuckians have access to a robust behavioral health crisis prevention and response system of care. The fourteen community mental health centers (CMHCs) serve as the backbone and "safety net" for Kentucky's crisis system of care and new opportunities are developing as Kentucky's behavioral health provider network and service infrastructure expands in response to implementation of the Affordable Care Act and other catalysts for change.

Timeline of the Development of the Emergency/Crisis Services System of Care in Kentucky

1999: The Community Mental Health Center License Regulation (902 KAR 20:091) was amended to include residential crisis unit standards.

2002: DBHDID prepared a white paper on the status of adult and child crisis stabilization programs in Kentucky. The information was used to secure funding to complete the crisis network.

2002: DBHDID recruited stakeholders from across the state to developed its first state suicide prevention plan. These stakeholders continued to meet and became the Kentucky Suicide Prevention Group (KSPG), a grassroots organization dedicated to supporting suicide prevention, intervention, and postvention services throughout the state.

2003: DBHDID introduced performance indicators for crisis stabilization programs in conjunction with the Annual Plan and budget process.

2004: Every CMHC within Kentucky developed an Adult and Child Crisis Services Program. A major change from the initial years of adult program development was that several regions developed mobile crisis programs instead of crisis stabilization units.

2004: Kentucky hired its first Statewide Suicide Prevention Coordinator, Jason Padgett.

2005: Children's residential crisis stabilization programs began using the Brief Psychiatric Rating Scale for Children (BPRS-C).

2006: State general funding was appropriated to bring each CMHC up to \$400,000 of for each adult and child crisis program. Additional funds were appropriated for the urban areas of the state (Louisville, Lexington and Covington). A line item in the state's budget to the Louisville area established the David J. Block Center Crisis Stabilization Unit.

2007: Kentucky receives its first Garrett Lee Smith Suicide Prevention Grant.

2013: The Suicide Prevention Consortium of Kentucky (SPCK) is a stakeholder group of suicide survivors, attempt survivors, mental

health professionals, community leaders and all others who have an interest in suicide prevention in the Commonwealth of Kentucky. Its mission is to cultivate and coordinate suicide prevention resources for all Kentuckians to end deaths by suicide. 2013: DBHDID convened a series of stakeholder meetings late in the year to discuss Kentucky's Emergency's Response and Crisis Prevention System in a changing healthcare environment, including alternative reimbursement methods for the CMHCs, ideal array of services, ideal benefit packages for individuals without insurance coverage, outcome measures, data needs, and a statewide crisis hotline.

2014: Three crisis services are approved to become Medicaid billable on January 1st: residential crisis stabilization, mobile crisis, and crisis intervention.

2014: DBHDID developed standards for the three new Medicaid billable crisis services.

2015: DBHDID made a wide sweeping change to its contract with the fourteen CMHCs. It reviewed and revised deliverables and re-introduced performance indicators, including one performance indicator for the crisis stabilization programs. The CMHCs' incentive for achieving the outcome was one percent (1%) of their crisis state general fund fiscal year allocation.

2017: Kentucky convened its first Kentucky Zero Suicide Academy. Teams of senior leaders from fifteen behavioral health care organizations participated in this two-day academy learned how to incorporate best and promising practicing into their organizations and processes to improve safety and care for individuals at risk of suicide.

2017-2018: The Substance Abuse and Mental Health Services Administration awarded technical assistance to DBHDID to enhance the behavioral health crisis system of care, for individuals experiencing a substance use-related crisis. The following needs were identified in the August 2018 report: consistency statewide, culture change, financing structure, and integration of substance use disorder and intellectual and developmental disabilities services into crisis delivery at all levels.

Kentucky's Crisis System of Care Guiding Principles

- Embraces Recovery

In a recovery-oriented approach to crisis care, the risks of harm to self or others are recognized; however, crises are viewed as challenges that present opportunities for growth and empowerment.

1.1 Preferred Practice: A recovery-oriented crisis system carefully engages the experiences, capabilities, and compassion of people who have experienced behavioral health crises.

- Zero Suicide/Suicide Safer Care

The Zero Suicide framework is a system-wide, organizational commitment to safe suicide care in health and behavioral health care systems, a call to relentlessly pursue a reduction in suicide and improve the care for those who seek help.

1.1 Preferred Practice: Lead a system-wide culture change committed to reducing suicides.

1.2 Preferred Practice: Train a competent, confident, and caring workforce.

1.3 Preferred Practice: Identify individuals with suicide risk via comprehensive screening and assessment

1.4 Preferred Practice: Engage all individuals at-risk of suicide using a suicide care management plan.

1.5 Preferred Practice: Treat suicidal thoughts and behavioral using evidence-based treatments.

1.6 Preferred Practice: Transition individuals through care with warm hand-offs and supportive contacts.

1.7 Preferred Practice: Improve policies and procedures through continuous quality improvement.

- Respect

Emergency services programs and staff respect the needs and wishes of each person and/or family experiencing a behavioral health crisis. They value and protect the rights, privacy and confidentiality of each person in crisis, unless the person presents an imminent risk and confidentiality would compromise the required intervention.

1.1 Preferred Practice: Each system considers the strengths and resources of the person in crisis, the person's family and the community.

1.2 Preferred Practice: Each program collaborates with others involved with the person in crisis whenever appropriate and possible.

- Comprehensive Array

Each CMHC shall design an emergency service system that is comprehensive in order to meet regional, client, and family needs in emergency situations.

2.1 Preferred Practice: Each system will be flexible to account for regional differences.

2.2 Preferred Practice: Each system will have a method to determine needs for crisis interventions, including mobile crisis, a crisis stabilization unit, and crisis intervention.

2.3 Preferred Practice: Crisis services are seen as a primary practice to prevent suicide and crimes against others in the community. All regional staff receives training in suicide prevention, assessment and intervention.

- Accessibility

The CMHC is responsible for providing behavioral health crisis responses to all citizens who seek services when experiencing a behavioral health or intellectual and other developmental disabilities crisis, regardless of age, diagnosis, priority population group, location in the region or agency of origin.

3.1 Preferred Practice: Each region is served by a hotline that operates 24/7/365.

3.2 Preferred Practice: Each CMHC has at least one designated place where an evaluation can be completed, including law enforcement initiated cases.

3.3 Preferred Practice: Each CMHC values crisis services as a critical element to an essential community safety net to prevent suicide and other unnecessary loss of human potential.

3.4 Preferred Practice: Transportation resources are available within the region to permit rapid access to acute care services.

- Timeliness

Quick response times are a critical feature of an effective behavioral health emergency system.

4.1 Preferred Practice: A reasonable response time for a face-to-face interaction with a clinician is 30 minutes for a walk-in crisis assessment.

4.2 Preferred Practice: On a crisis call, the individual or family member will be able to speak to a clinician within 15 minutes.

- Inclusion

Every person has the right to receive a timely, effective crisis response from their CMHC.

5.1 Preferred Practice: Each CMHC will have the capacity to respond to individuals in crisis with mental health disorders, development and intellectual disabilities, substance use disorders, co-occurring disorders or acquired brain injuries.

- Least Restrictive Setting

Emergency Services preserve community placement whenever possible and prevent institutionalization, hospitalization or increased levels of care. Services preserve natural supports of the individual experiencing the emergency to the greatest extent possible.

6.1 Preferred Practice: Each region has a secure, safe environment that is non-stigmatizing to conduct crisis evaluations and interventions.

6.2 Preferred Practice: When possible, each region makes use of natural community supports, crisis prevention plans, support groups, and peer-run centers.

- Accountability

The emergency service system is accountable to individuals, their caregivers, families, communities and funding sources.

7.1 Preferred Practice: The emergency services system will reduce the use of higher levels of care. The CMHC will be able to demonstrate a relationship between crisis intervention activities and the reduction of hospital admission/utilization rates.

7.2 Preferred Practice: The CMHC will demonstrate a relationship between crisis intervention services (diversion activities) and the criminal justice system so that law enforcement and jails experience fewer cases of individuals in a behavioral health crisis.

7.3 Preferred Practice: The CMHC will maintain reasonable cost planning for financial accountability and financial sustainability.

- Collaboration

Program design and delivery should be developed through a collaborative process that includes all pertinent stakeholders, including law enforcement, private and public hospitals, consumers, youth and family members.

8.1 Preferred Practice: Clients and family members are included in the annual process for designing and improving the crisis services system.

8.2 Preferred Practice: Memoranda of Understanding or other formal mechanisms exist with key stakeholders in the community to outline roles and responsibilities.

- Data Informed

Decision making at the individual and systems level is guided by data.

9.1 Preferred Practice: So that information is available for decision making, all CMHCs will report crisis services data faithfully and consistently using the DBHDID data system.

9.2 Preferred Practice: Data will be used to drive quality improvement activities.

- Evidenced Based Practice

Emergency services responses need to be delivered in a holistic manner using evidenced based and best practices.

10.1 Preferred Practice: Trauma informed care is a guiding practice in all crisis services.

10.2 Preferred Practice: Standardized tools (such as the Mental Health Triage Tool, CTRS, TAS, LOCUS, CASII, and ASAM) are used for determining the level of care needed.

10.3 Preferred Practice: All services need to be co-occurring capable as measured by the DDCAT or DDMHT.

- Cultural Competence

Crisis services shall be provided by staff who are culturally and linguistically competent.

11.1 Preferred Practice: All regions shall have culturally competent staff with access to language and culturally appropriate resources to meet clients' needs.

- Community Awareness

The procedure for accessing emergency behavioral health services should be common knowledge in the community.

12.1 Preferred Practice: The toll free crisis hotline number, a description of the available crisis services, and how to access those services should have prominent placement on the agency website and other community outreach materials.

12.2 Preferred Practice: Law enforcement, first responders and other community partners should receive training on how to access crisis services.

#### Sources of Funding for Crisis Services

CMHC behavioral health crisis services are provided with the following blended funding:

##### State General Funds

The department provides state general funds for crisis services and for services for diverting individuals from the justice system.

The department allocated approximately \$15.3 M for SFY 2020 to the CMHCs for crisis services and for services for diverting individuals from the justice system and psychiatric hospitalization.

##### Federal and Local Funds

In addition to state general funds, statewide the CMHCs allocated \$340,393 of their SFY 2020 mental health block grant funds and \$528,199 of their substance abuse prevention and treatment block grant funds for crisis services. This equals 4.9% of the state's total MHBG allocation and 2.6% of the state's total SAPT BG allocation. A few CMHCs receive funds through local taxes and may allocate part or all of that funding to crisis services.

##### Medicaid Billable Services

On January 1, 2014, the following three crisis services were approved for payment by the Centers for Medicaid and Medicare Services:

- Crisis Intervention: clinic-based crisis services
- Mobile Crisis: face-to-face crisis stabilization provided in the community
- Residential Crisis Stabilization: residential crisis stabilization in a crisis stabilization unit

#### Commercial Health Insurance

Crisis program also submit claims for crisis services to commercial health insurance providers. Below is a table that notes the three Medicaid billable services (crisis intervention, mobile crisis and residential crisis stabilization) and the percent of individuals served with commercial insurance as the intended payment source.

Percent of CMHC Clients with Commercial Health Insurance as the Intended Payer in SFY 2015\* Percent of CMHC Clients with Commercial Health Insurance as the Intended Payer in SFY 2019\*\*

Crisis Intervention for Clients Age 0-17 9%\*\*\* 11%

Crisis Intervention for Clients Age 18 and Over 3% 6%

Mobile Crisis for Clients Age 0-17 11% 6%

Mobile Crisis for Clients Age 18 and Over 3% 4%

Residential Crisis Stabilization for Clients Age 0-17 9% 12%

Residential Crisis Stabilization for Clients Age 18 and Over 4% 7%

\* The data in this table reflects the percent of clients for whom commercial health insurance is the intended payer (i.e., a claim was submitted for payment), not the percent of crisis clients with commercial insurance paid claims.

\*\* State fiscal year 2019 data reflects year-to-date data. This is not a complete year of data and this data has not been certified.

\*\*\*Percent of Individuals Served with Commercial Insurance is obtained by combining the totals for the following CMHC data field "Payer" responses: F (Commercial Insurance Company), I (HMO) and P (Blue Cross).

#### Medicare

Medicare covers a range of outpatient services such as individual, group and family psychotherapy, psychiatric evaluation, medication management, partial hospitalization and prescription medications and is the primary health insurance provider for individuals age 65 and older. Community mental health centers submit claims to Medicare for individuals who are experiencing behavioral health crises. The table below depicts the percent of CMHC clients who received a crisis service and had Medicare as the intended payer for state fiscal years 2015 and 2019.

Percent of CMHC Clients with Medicare as the Intended Payer in SFY 2015\* Percent of CMHC Clients with Medicare as the Intended Payer in SFY 2019\*\*

Crisis Intervention for Clients Age 18 and Over 3% 4%

Mobile Crisis for Clients Age 18 and Over 1% 0%

Residential Crisis Stabilization for Clients Age 18 and Over 0% 4%

\* The data in this table reflects the percent of clients for whom Medicare is the intended payer (i.e., a claim was submitted for payment), not the percent of crisis clients with Medicare paid claims.

\*\* State fiscal year 2019 data reflects year-to-date data. This is not a complete year of data and this data has not been certified.

#### TRICARE

Some CMHCs are behavioral health providers in the TRICARE network and provide crisis services to service members and their families; however, crisis services claims submitted to TRICARE tend to be fewer than 10 per year statewide.

#### Self Pay

All 14 CMHCs assist, directly or through referral, clients and families with insurance enrollment. For clients and families who refuse to participate in the insurance enrollment process, a sliding fee scale is available. Clients who present with a behavioral health crisis are not charged for crisis services if they no means to pay.

Percent of CMHC Clients with Self Pay as the Intended Payer in SFY 2015\* Percent of CMHC Clients with Self Pay as the Intended Payer in SFY 2019\*\*

Crisis Intervention for Clients Age 0-17 2% 2%

Crisis Intervention for Clients Age 18 and Over 2% 1%

Mobile Crisis for Clients Age 0-17 1% 1%

Mobile Crisis for Clients Age 18 and Over 1% 0%

Residential Crisis Stabilization for Clients Age 0-17 3% 1%

Residential Crisis Stabilization for Clients Age 18 and Over 3% 2%

\* The data in this table reflects the percent of clients for whom Self Pay is the intended payer (i.e., a claim was submitted for payment), not the percent of crisis clients with Self Pay paid claims.

\*\* State fiscal year 2019 data reflects year-to-date data. This is not a complete year of data and this data has not been certified.

#### Community Mental Health Centers: Kentucky's Safety Net

DBHDID requires CMHCs to provide emergency behavioral health services to all individuals who seek services when in an emergency. Crisis services are provided to all individuals in crisis who request assistance regardless of payor source or ability to

pay. The primary purposes of crisis services is to assess the individual in crisis to determine services needed and assist him/her in receiving the least restrictive, most effective treatment available, and referral to needed follow-up services. The CMHC's system shall serve individuals with mental health disorders, substance use disorders and individuals with intellectual and developmental disorders. The CMHC must provide services twenty-four hours per day, seven (7) days per week. The CMHC must provide or arrange for the provision of the following services under this contract, and as described in the CMHC's approved Plan and Budget (P&B) submission for the current fiscal year, to each individual experiencing a crisis, depending on one's individualized plan of care:

- Assessment and Screening
- Psychiatric Evaluation
- Medication Management and Medication
- Crisis Intervention (clinic based)
- Residential Crisis Stabilization
- Mobile Crisis (face-to-face services provided in the community)
- Access to Withdrawal Management Services
- Transportation

DBHDID's CMHC contract requires crisis programs to ensure individuals in crisis have access to a team of professionals. This multidisciplinary team shall include a prescriber (Psychiatrist/Advanced Practice Registered Nurse) and other staff trained in crisis response such as a crisis clinician, nurse, peer support specialist, I/DD staff trained in risk assessment and mitigation, or other behavioral health providers knowledgeable about the needs of a specific population.

CMHCs may use DBHDID funding until the crisis is resolved (up to 72 hours anticipated) or the individual is referred to another level of care, however, once the crisis is stabilized the CMHC is expected to seek reimbursement from all third party payor sources, leaving DBHDID as the payor of last resort. The CMHC shall not require co-payments from individuals served for emergency behavioral health services funded by DBHDID.

DBHDID's contract states that the CMHCs shall develop a service plan with each client that receives crisis services. The service plan shall include a written description of the individual's immediate assessed needs, a specific description of the crisis intervention and stabilization services the CMHC will provide and a plan of follow-up care (or documentation of referral to another level of care). Prior to discharge from the crisis service, the individual shall have developed a safety plan with the individual's continuing care provider, if appropriate and applicable. This brief plan shall include a description of the concrete steps the individual or the individual's family/significant others should take should the person become a danger to himself or others.

#### SFY 2020 Kentucky Community Mental Health Center Adult and Children's Crisis Services Array

The following is a list of crisis services and service components provided by Kentucky's fourteen (14) community mental health centers and the number of agencies that provide the service to individuals in their catchment areas:

Adult Services Children's Services

Adult Peer Support – Crisis Services 14 \*

Commitment Hearing Attendance 4 3

Criminal Justice Drop-Off Sites 7 5

Crisis Case Management 11 11

Emergency Apartments 2 \*

Emergency Psychiatric Evaluation and Medication Management 14 13

Emergency Respite 5 4

Family Peer Support – Crisis Services 10 11

Intensive In-Home Services \* 8

Intensive Outpatient Crisis Counseling 12 9

Mobile Crisis 13 13

Partial Hospitalization 3 3

Residential Crisis Stabilization 11 7

Safety Planning for Suicide Risk 14 14

Telehealth 12 13

Transportation Services 9 8

Virtual Crisis Support – Chat 2 3

Virtual Crisis Support – Email 2 3

Virtual Crisis Support – Text 4 3

Walk-in Crisis Intervention after Business Hours 12 12

Walk-in Crisis Intervention during Business Hours 14 14

Warm Line 8 6

Withdrawal Management 6 1

Youth Peer Support – Crisis Services 7 10

23-Hour Observation 3 \*

23-Hour Beds 4 0

24/7 Crisis Hotline 14 14

\* Data is not collected for this service.

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

N/A

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

**Footnotes:**

## Environmental Factors and Plan

### 16. Recovery - Required

#### Narrative Question

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The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see [SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders](#).

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

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#### **Please respond to the following:**

1. Does the state support recovery through any of the following:

- a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?  Yes  No
- b) Required peer accreditation or certification?  Yes  No
- c) Block grant funding of recovery support services.  Yes  No
- d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?  Yes  No

2. Does the state measure the impact of your consumer and recovery community outreach activity?  Yes  No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Currently, Kentucky's Division of Behavioral Health (DBH) offers, through contracts with fourteen (14) CMHC regions and a variety of other community partners, the following recovery support services to individuals with SMI: targeted case management (TCM), peer support, Individual Placement and Support (IPS) supported employment, supportive housing based on Permanent Supportive Housing Toolkit through SAMHSA, assertive community treatment with peer specialists embedded, self-help facilitation, residential supports for individuals living in the community with greater supervision needs, comprehensive community support services, clubhouse model therapeutic rehabilitation programming, warm lines, services through consumer run services programs (COSP) as defined in SAMHSA toolkit, Wellness Recovery Action Planning (WRAP) and other wellness activities, person centered recovery planning which includes a shared decision making component, and a full array of crisis services including mobile crisis. DBH encourages all of these services on the continuum to include the involvement of individuals with lived experience. While peer support and COSP services are entirely provided by individuals with lived experience, peer support specialists can be embedded in each service along the continuum. In addition, Kentucky's four (4) state psychiatric hospitals also provide a "recovery mall" to assist adults with SMI who want to work on meaningful recovery activities prior to hospital discharge. One (1) of the state psychiatric hospitals has a contract that provides peer support specialists to assist with recovery mall work, group and individual peer support to individuals who are hospitalized as well as working with families during visitation times. Self-help groups offered throughout the state include Double Trouble in Recovery (DTR) and recovery support groups for individuals with mental illness facilitated by people with lived experience, often peer support specialists.

Currently, Kentucky's DBH offers, through contracts with fourteen (14) CMHC regions and a variety of other community partners, the following recovery support services for children with SED: targeted case management (TCM); high fidelity wraparound; youth and family peer support; Individual Placement and Support (IPS) supported employment; supported housing; comprehensive community support; drop-in centers employing youth peer support; coordinated specialty care services; service planning; Wellness Recovery Action Planning (WRAP); SMART Recovery (including SMART Recovery Family and Friends); Youth People in Recovery; and a full array of crisis services including mobile crisis. Again, DBH encourages involvement of children, youth, and family members with lived experience along the service continuum, and encourages all services and supports to have the goal of enhancing resiliency and promoting recovery.

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

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

- A curriculum rubric has been developed by the DBHDID, outlining the required hours of training, based on the core competencies listed in the Medicaid state plan amendment and subsequent regulations;
- Agencies across the state will be able to submit curricula based on the rubric, for approval by the DBHDID;
- Once approved, agencies may provide certification training for peer support;
- Individuals with lived experience must complete training requirements and pass an examination at 70% or above to receive certification; and
- Agencies are required to submit names and numbers of peer support specialists who successfully complete training requirements.

In addition, CMHC contracts include a requirement to hire at least 2.0 FTE peer support specialist to work with adults with SMI who are at risk of institutionalization, as well as a requirement to hire at least .50 FTE peer support specialist to work on assertive community treatment (ACT) teams.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

Currently, Kentucky's Division of Behavioral Health (DBH) offers, through its provider base, the following recovery support services to persons with substance use disorders: targeted case management (TCM), peer support, self-help facilitation, supported employment, transitional housing, recovery housing, and medication for Opioid Use Disorder (MOUD). Kentucky's recovery support services aim to enhance effects and improve outcomes of existing treatment services in effort to make long-term recovery sustainable. Utilizing DBH approved curricula, providers are required to ensure that those providing TCM and peer support services are appropriately trained. Self-help groups offered throughout the state include: Alcoholics Anonymous, Narcotics Anonymous, Al-Anon, Double Trouble in Recovery (DTR), SMART Recovery (including SMART Recovery Family and Friends), and Young People in Recovery as well as the Comprehensive Opioid Response paired with 12 Steps (COR-12) self-help component.

Using a modified Individual Placement and Support (IPS) supported employment model, DBH providers now offer supported employment services to those with a substance use disorder. Transitional housing is available in certain regions focused on providing stable living environments for those currently in on-going treatment. Recovery housing is established through the Commonwealth's Group Home Loan Program. Due to being a recognized evidence based practice, Kentucky utilizes the Oxford House model for recovery homes and contracts directly with the organization to provide outreach to our state. Using regulatory compliance measures, the State Opioid Treatment Authority (SOTA) monitors provision of MAT at state approved sites offering primarily methadone. Additionally, Kentucky partners with People Advocating for Recovery (PAR) as a training and technical assistance center to assist individuals and organizations with recovery efforts. PAR provides services to individuals in all states of recovery, their family and friends, along with staff, programs, public, quasi-public, and private organizations and other entities that influence the recovery services within Kentucky.

5. Does the state have any activities that it would like to highlight?

Since the mid-1980s, the DBHDID has been convinced of the importance of involvement by individuals in recovery and family members in program development and service delivery. The Department continues to provide funds for a variety of statewide and local support initiatives for individuals in recovery and family members. These initiatives have traditionally been focused on goals related to self-advocacy, discrimination and stigma reduction, wellness and recovery programs, peer support, education and training, and other support. During SFY 2010, Division staff used recommendations from individuals in recovery and family members to rewrite contracts to be awarded to statewide groups. Four (4) contracts were awarded during SFY 2011, as prescribed by the Request for Proposal (RFP) process monitored by the Finance Cabinet, the Recovery Oriented Training and Technical Assistance for adults with mental health issues contract, the Recovery Oriented Family Support Services for family members of adults with mental health issues, the Recovery Oriented Training and Technical Assistance for individuals with substance use disorders, and the Family Guided, Youth Driven Training and Technical Assistance contract for children and families. A liaison from DBH was designated as a program monitor for 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 2020 includes the following requirements:

- Provide a series of recovery oriented education and supports for family members across the state;
- Assess regional needs with regards to mental health treatment, family member involvement, 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 one (1) "Train the Trainer" session per year to individuals who are targeted to provide family education and support groups;
- Provide at least one (1) In Our Own Voice training annually;
- Provide at least twenty (20) In Our Own Voice presentations across the state annually;
- Provide at least two (2) NAMI SMARTS trainings across the state (NAMI SMARTS teaches advocacy skills to family members and individuals with mental illness);
- Participate actively in Individual Placement and Support (IPS) Supported Employment implementation and training activities;
- Utilize established training modalities and implement other support groups across the state that are established as best and promising practices;
- 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;
- Provide at least quarterly 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. 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 quarterly conference call. 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 IPS 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 recovery listserv that is staffed by NAMI Kentucky.

NAMI Kentucky also collaborates with DBH on training efforts regarding IPS for young people and education regarding the First Episode of Psychosis.

The Recovery Oriented Training and Technical Assistance for adults with mental health issues contract was awarded to the National Alliance on Mental Illness (NAMI) Lexington affiliate, and initially required the development of a Technical Assistance Center for individuals in recovery and the provision of recovery oriented trainings across the state. Stakeholders were gathered from across the state, including individuals 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.

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

The COSPs typically provide a drop-in service, psychoeducational groups, support groups, and other new and frequently innovative peer support services. KYSTARS continues to provide educational classes and technical assistance in implementation and developing policies and procedures, form development, grant writing and fundraising, program evaluation, and other issues, to the COSPs across the state. Kentucky currently has COSPs in seven (7) of the fourteen (14) CMHC regions.

KYSTARS provides an annual fidelity review and technical assistance regarding outcome measures to all of the COSPs. Results of these reviews assist in shaping the educational opportunities made available at the annual KYSTARS statewide conference. An entire tract at this conference is dedicated to individuals working in COSPs across the state.

KYSTARS has provided an annual statewide conference since SFY 2011. During SFY 2019, KYSTARS hosted the 6th Annual Peer Excellence Awards, in a ceremony that occurs the night before the actual conference. This award ceremony recognizes an outstanding individual in recovery from each CMHC region across the state. It also recognizes supporters of peers and individuals with lived experience who have made significant contributions in the field of recovery. For the last four (4) years KYSTARS has also recognized a youth peer specialist and a family peer specialist who have been nominated for their stellar performance in supporting recovery and resiliency.

The NAMI LEX contract for SFY 2020 includes the following requirements:

- Maintain the statewide training and technical assistance center with the goal of incorporating recovery principles throughout the public mental health system;
- Establish recovery support groups for individuals with lived experience across the state;
- Assess statewide needs regarding mental health recovery;
- Provide a statewide recovery oriented conference annually along with a peer recognition ceremony;
- Provide training and technical assistance to support Participation Station in Lexington, Kentucky;
- Provide FACIT reviews to all DBH funded COSPs annually;
- Provide technical assistance to all DBH funded COSPs based on results of reviews;
- Provide assistance with the POP outcome measure for all COSPs;
- Provide Mental Health First Aid (MHFA) training across the state, including coordination of MHFA trainings occurring statewide and including having some in-state trainers for MHFA; and
- Provide an annual needs assessment regarding recovery oriented system of care;
- Sustain nine (9) Double Trouble in Recovery (DTR) groups in the identified high-risk regions. Note: There currently are 23 groups statewide.

The Family Guided, Youth Driven Training and Technical Assistance contract was awarded to the Kentucky Partnership for Families and Children (KPFC). KPFC is a statewide family-run advocacy and support organization for children and youth at risk of developing or with an already identified behavioral health need, and their families and is Kentucky's Federation of Families for Children's Mental Health chapter. DBHDID contracts with KPFC for a variety of services and supports aimed at creating a family- and youth- driven System of Care that supports youth and family involvement and leadership at all levels of the System of Care.

KPFC achieves these goals by providing training and technical assistance in:

- DBHDID-approved curricula for Family and Youth Peer Support Specialists;
- Coaching for supervisors of Family and Youth Peer Support Specialists;
- Special education law;
- Engaging families and youth;
- Youth Mental Health First Aid;
- Family Leadership; and
- Integrating KY Strengthening Families protective factors into system change efforts.

KPFC also supports DBHDID in the implementation of several SAMHSA grants to participate on councils and attend state and national training (stipends, travel, child care, etc.). KPFC employs state-level staff for Kentucky's SAMHSA Healthy Transitions grant, including the Project Director and two Youth Coordinators. This staff is responsible for improving access to treatment services and recovery and community supports for youth and young adults who have or are at risk of developing serious behavioral health (mental health and substance use) conditions.

KPFC provides leadership in statewide advocacy activities regarding children and youth at risk of developing or with an already

identified behavioral health need, and their families. To this end, KFPC participates in activities with other organizations or coalitions to support improved services, reduce stigma, and increase empowerment and resiliency for children and youth at-risk of developing or with already identified behavioral health concerns and their families.

Finally, KFPC conducts a strengths-based family and youth involvement status assessment in CMHC programming in three (3) Regional CMHCs per year. The review focuses on the extent to which family and youth are meaningfully involved at all levels of the child-serving system and in decisions about the services and supports that they receive. The KPFC include non-staff family members and youth in the review process.

For SFY 2020, DBH is also collaborating with Bridgehaven, a behavioral health services organization, to assist with supporting the infrastructure for peer support specialists who are working in the behavioral health workplace. This work includes:

- Maintaining a Center for Peer Excellence, including an experienced board or advisory committee to guide activities;
- Providing Wellness Recovery Action Plan (WRAP) training working with national;
- Identifying peer specialists with WRAP Training to become Advanced WRAP facilitators;
- Making available trainings for staff from CMHCs and other agencies that employ peer specialists on recruiting, retaining, and supporting peer
- Coordination of a peer support specialist database regarding peers who are working;
- Providing conference calls, newsletters, webinars, for peer specialists who are working and others, regarding issues related to recovery; and
- Provide at least one (1) Advocacy Academy training, which targets individuals who have lived experience and want to learn leadership skills to contribute in their communities.

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

N/A

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**Footnotes:**

## Environmental Factors and Plan

### 17. Community Living and the Implementation of Olmstead - Requested

#### Narrative Question

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

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

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

#### Please respond to the following items

- Does the state's Olmstead plan include :
  - Housing services provided.  Yes  No
  - Home and community based services.  Yes  No
  - Peer support services.  Yes  No
  - Employment services.  Yes  No
- Does the state have a plan to transition individuals from hospital to community settings?  Yes  No
- What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

Kentucky has an Olmstead Compliance Plan in response to the landmark civil rights case of Olmstead v. L.C. in 1999, when the Supreme Court held that it is discriminatory and unlawful for governments to keep persons with disabilities in segregated settings when they are capable and desire to reside in the community. Kentucky's first Olmstead Compliance Plan was in 2002. Kentucky's current Olmstead Plan created in 2015, consists of nine (9) goals:

- 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.
- Education/Outreach to prevent facility placement, with input from his/her family and legal guardian, as required.
- 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.
- 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.
- Increase available, accessible, quality, and affordable community housing.
- Ensure a safe and appropriate transition from an institution to a community setting.
- 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.
- 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 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 that meet Olmstead criteria. 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 Olmstead committee was developed and is hosted by the Division of Behavioral Health (DBH), and includes representatives from DBH, the corresponding Community Mental Health Centers, state psychiatric facilities, state nursing facilities, the National Alliance on Mental Illness (NAMI) and other community partners. Committee meetings provide a venue for discussion of systemic issues/barriers to necessary community services.

DBH staff believes that housing services are essential and provides funding to the Kentucky Housing Corporation (KHC) specifically for the Olmstead Housing Initiative (OHI). These funds specifically serve "Olmstead clients" and can be used in a variety of ways including payment for rent, security deposits, furniture, utility deposits, etc. This provides the flexible funding needed to make a transition successful. During SFY 2018, \$400,000 additional dollars were added to fund OHI for a total of \$786,000. In addition, the Louisville Metro Housing Authority, in collaboration with DBH, provides set-aside Housing Choice Vouchers for individuals who meet Olmstead criteria in Jefferson County.

DBH staff also believes that employment services are essential and has developed a robust Supported Employment (SE) program, utilizing the Individual Placement and Support (IPS) model. In SFY 2019, 273 Employment Specialists served 4,111 individuals, across 66 of Kentucky's 120 counties. Of the 4,111, 1340 are working (618 new jobs this year) and 44 are engaged in educational pursuits. In August 2013, the Cabinet for Health and Family Services (CHFS) entered into an Interim Settlement Agreement (ISA) with Kentucky Protection and Advocacy, to avoid litigation concerning the institutionalization of adults with SMI who resided in personal care homes in Kentucky. Estimates of persons impacted under this agreement range as high as 2,300 individuals, with an original list of one hundred, thirty-three (133) individuals with SMI who expressed a desire to move out of personal care homes and into housing in the community. The original agreement was to move at least six hundred (600) individuals with SMI out of personal care homes within a three (3) year period. As a result of ISA, efforts were made by DBH to create a new and expanded system of care for these individuals. DBH contracted with CMHCs to provide Direct Intervention: Vital Early Responsive Treatment System (DIVERTS) services across the state to individuals with SMI who were institutionalized or at risk of institutionalization and expressed a desire to live in the community.

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 in funding for the first year and approximately \$6 million in funding for the next two (2) years for the ISA. These funds were made available partially from state psychiatric facility budgets, thus "rebalancing" some behavioral health funding into the community. CMHCs developed new services and began providing in reach to individuals with SMI in personal care homes and other institutions. DBH program administrators were reorganized in an effort to assist with program development and the terms of the ISA. An entirely new web-based data system was created to track ISA data and milestones. The Adult Mental Health and Recovery Services Branch was restructured to support the work necessary to make the settlement agreement a priority.

October 1, 2015, an Amended Settlement Agreement (ASA) was signed by the Cabinet of Health and Family Services and Kentucky Protection and Advocacy. This agreement extended terms to move at least six hundred, seventy-five (675) individuals with SMI out of personal care homes into community based housing of their choice before October of 2018. At this point, all but five (5) of the original expressers have been transitioned from personal care homes. In June of 2016, a state administrative regulation was filed regarding the transition of individuals with serious mental illness into communities of their choice.

<http://www.lrc.ky.gov/kar/908/002/065.htm>

The desired outcomes of the ASA are as follows:

- Individuals with a serious mental illness, who reside in the Commonwealth of Kentucky, are afforded the opportunity for safe, productive and fully integrated lives within their chosen communities;
- CHFS 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 ASA are met or exceeded; with progress and quality measured by defined formal reports and established processes.

Due to these efforts, several collaborative efforts have resulted in positive changes in the service system for adults with SMI. For example, collaboration with the Department for Medicaid Services and the Department for Community Based Services resulted in a change in the traditional state supplement for individuals with SMI living in personal care homes. The program is now called Community Integration Supplement (CIS) and can now be effective for these individuals as an effort to prevent institutionalization, not just available when they are in an institution. Another example is the collaboration with the Department for Aging and Independent Living (DAIL) and their state guardianship office. State guardians are collaborating with service providers in securing community housing for individuals on their caseload with SMI. Work with the Kentucky Housing Corporation (KHC) has been monumental to the success of transitioning individuals. Work involving the state Long-Term Care Ombudsman and the Office of the Inspector General has also been pivotal. In addition, a movement to implement person centered planning across the service system was strengthened by the efforts to meet the terms of this agreement.

In October 2018, the CHFS continued the Settlement Agreement with Kentucky Protection and Advocacy, agreeing to transition 1,275 adults with SMI, living in personal care homes, over the three Agreements. During two previous agreements, 926 individuals transitioned, leaving 350 adults with SMI to be transitioned from personal care homes, into community based living, by October 2021.

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

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

As a part of the Second ASA, DBHDID contracted with the Technical Assistance Collaborative (TAC) to provide consultation services to provide strategic recommendations to create and maximize permanent supportive housing options that comply with the Second Amended Settlement Agreement (SASA) population. This will include performing a gap analysis, interviewing stakeholders, working with DBHDID's SASA committee and submitting a report of recommendations to the Department.

TAC is a national nonprofit organization that offers strategic planning; policy and systems design; financing and reimbursement strategies; program development and implementation; evaluation and quality improvement, and customized technical assistance and training.

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

N/A

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**Footnotes:**

## Environmental Factors and Plan

### 18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

#### Narrative Question

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MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.<sup>63</sup> Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.<sup>64</sup> For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.<sup>65</sup>

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.<sup>66</sup> Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.<sup>67</sup>

According to data from the 2015 Report to Congress<sup>68</sup> on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

<sup>63</sup>Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

<sup>64</sup>Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

<sup>65</sup>Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from [www.cdc.gov/injury/wisqars/index.html](http://www.cdc.gov/injury/wisqars/index.html).

<sup>66</sup>The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

<sup>67</sup>Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from <https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM>

<sup>68</sup>[http://www.samhsa.gov/sites/default/files/programs\\_campaigns/nitt-ta/2015-report-to-congress.pdf](http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf)

**Please respond to the following items:**

- Does the state utilize a system of care approach to support:
  - The recovery and resilience of children and youth with SED?  Yes  No
  - The recovery and resilience of children and youth with SUD?  Yes  No
- Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:
  - Child welfare?  Yes  No
  - Juvenile justice?  Yes  No
  - Education?  Yes  No
- Does the state monitor its progress and effectiveness, around:
  - Service utilization?  Yes  No
  - Costs?  Yes  No
  - Outcomes for children and youth services?  Yes  No
- Does the state provide training in evidence-based:
  - Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families?  Yes  No
  - Mental health treatment and recovery services for children/adolescents and their families?  Yes  No
- Does the state have plans for transitioning children and youth receiving services:
  - to the adult M/SUD system?  Yes  No
  - for youth in foster care?  Yes  No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

In response to question #1 above, Kentucky offers the following additional information.

The state has had an established statewide system of care approach in place since 1990 and recently completed its fourth SAMHSA Children’s Mental Health Initiative (System of Care) cooperative agreement. Youth substance use treatment was adopted under the System of Care umbrella over ten (10) years ago when Kentucky received its first CSAT grant that focused on building an infrastructure to support youth/adolescent treatment services and supports. Simultaneous to this, Kentucky received its second System of Care (SOC) grant and selected youth with severe emotional disabilities who had or were at risk of co-occurring substance use as its population of focus. The State Interagency Council for Service and Supports to Children and Transition-age Youth (SIAC), has served as the governing body for all SOC and adolescent CSAT grants. The SIAC was created statutorily in 1990 and is comprised of representatives from state child- and transition-age-youth serving agencies, youth with lived experience with behavioral health challenges, parents of children with lived experience with behavioral health challenges, and a family-run organization. It was created and continues to serve as a created as a structure for coordinated policy development, comprehensive planning, and collaborative budgeting for services and supports to children and transition-age youth with or at risk of developing behavioral health needs and their families. The SIAC currently operates three standing committees that support the work of the SIAC. The standing committees are Social & Emotional Health, Racial & Ethnic Disparities, and Outreach & Promotion. The Children’s Behavioral Health and Recovery Services Branch embraces the SAMSHA-recognized System of Care (SOC) Values of

youth- & family-driven; community-based; culturally- & linguistically responsive. The Children's Branch has adopted two additional SOC values endorsed by the KDBHDID: trauma-informed and recovery-oriented. Contracted providers are required operate their services and supports for children, youth, and families in alignment with the SOC values and principles and can access training and technical assistance related operationalizing the SOC philosophy across their agencies. Children's Branch staff is engaged in ongoing planning in order to be prepared for additional SAMHSA funding opportunities in the future and recently submitted applications for both System of Care and Project LAUNCH grants. Funding from these grants will provide additional support to both infrastructure and service delivery across the state.

The State Interagency Council for Services and Supports to Children and Transition-age Youth (SIAC) was created in 1990 as a structure for coordinated policy development, comprehensive planning, and collaborative budgeting for services and supports to children and transition-age youth with or at risk of developing behavioral health needs and their families. It is charged with serving as the governing body for Kentucky's System of Care by:

- Making annual recommendations to the Governor and the Legislative Research Commission;
- Directing Regional Interagency Councils (RIACs) to 1) Operate as regional locus of accountability for the SOC, and 2) Participate on the Family Accountability, Intervention, and Response (FAIR) Teams;
- Assessing effectiveness of RIACs;
- Meeting monthly;
- Developing a comprehensive array of services and supports; and
- Adopting interagency agreements as necessary

In response to question #2 above, Kentucky offers the following additional information.

The SIAC is comprised of commissioners of the primary agencies that serve children and transition-age youth and their families a family representative, a youth representative, and a statewide family-run organization. SIAC has served as the interagency oversight body for federal grants related to children's mental health; adolescent substance use; school mental health; early childhood; transition-age youth; youth court diversion, and others. Additionally, agencies share information about initiatives aimed at improving child, youth, and family functioning across life domains. The SIAC mission statement is "Promoting healthy children across Kentucky: Building collaborative partnerships to promote children's social and emotional needs where they live, learn, play, and work."

To support the integrated work under the SIAC umbrella, DBHDID has ongoing collaboration with several state agencies specific to improving the mental health of Kentucky's children, youth, and their families.

DBHDID works with the KY Department for Education through the State Interagency Council's Social Emotional Health Task Force and Social Emotional Health Standing Committee; Project AWARE grant; the Kentucky Educational Collaborative for State Agency Children; Safe School Assessments, and other initiatives and will strive to continue these to collectively address the needs of children, youth, and families. The lead contact for education within the Children's Behavioral Health and Recovery Services Branch is Diane Gruen-Kidd (Diane.Gruen-Kidd@ky.gov). Additionally, DBHDID has had preliminary discussions with staff from the Governor's Office of Early Childhood to identify areas of collaboration available through the Preschool Development Grant. As mentioned, the Kentucky Department for Community Based Services, Kentucky's child welfare agency, is an early implementer of FFPSA, with an October 2019 start date. This fits within Kentucky's larger effort around Child Welfare Transformation aimed at three (3) broad areas of safely reducing the number of children entering out-of-home care; reducing caseloads; and improving timeliness to appropriate permanency. A steering committee and eight (8) subcommittees are implementing activity-based work plans to achieve transformation goals. DBHDID currently has staff representation on these committees to ensure that the behavioral health needs of children with child welfare involvement is considered across groups and to provide consultation as needed. Recently, a position was created within the DBH Children's Behavioral Health and Recovery Services Branch to serve as the DBH liaison to child welfare transformation efforts and to coordinate work across DBH staff involved with various child welfare initiatives.

The Kentucky Department for Juvenile Justice (DJJ) is recent recipient of a Second Change Act "Ensuring Public Safety and Improving Outcomes for Youth in Confinement and while Under Community Supervision" grant through the Council of State Governments Justice Center. With the support of this grant, the DJJ will focus on screening, assessment, and treatment to support successful reentry to the community for 14-18 year old youth with co-occurring substance use and mental health challenges. DBHDID staff is on the steering committee for this grant and is providing information and resources to support planning, implementation, and evaluation.

Kentucky has a network of Crisis Intervention Team (CIT) Regional Advisory Boards, community partners representing law enforcement, judicial system, hospitals, guardianship, behavioral health services and advocates who meet monthly to plan for local CIT trainings for law enforcement officers and to discuss ways to better meet the needs of community members with behavioral health disorders, including youth and young adults. As a new initiative, BHDID is allocating funds to each CIT Regional Advisory Board to assist with community training events, emergency respite and crisis services for individuals who have frequent encounters with law enforcement.

In response to question #3 above, Kentucky offers the following additional information.

Kentucky will monitor and track service utilization, costs and outcomes in a variety of ways. These are highlighted below:

- Data analysis, data sharing with other child serving agencies, and qualitative data gathering
- Financial Mapping supported by Kentucky Youth Treatment – Implementation and TAYLRD grants
- Annual Plan and Budget Submission with quarterly and semi-annual reporting requirements
- Consultation from national leaders in financing and program development (Sheila Pires, Collette Croze, Mary Armstrong, etc.) and with local providers and other state agency partners
- IMPACT Outcomes Management System for Children with SED who are receiving High Fidelity Wraparound/Targeted Case

#### Management (TCM) services

- Adolescent Kentucky Treatment Outcomes System (AKTOS) for youth who receive substance use treatment services
- Regional Interagency Council strategic plans
- Functional Assessment and outcomes monitoring via the Child and Adolescent Needs and Strengths for children in out-of-home care.

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

The DBHDID provides training and coaching to service providers in a number of ways. Specific to youth and young adults, DBHDID hosts annual System of Care Academy. This annual event brings together approximately 500 participants from across the system of care: primary care providers, clinicians, prevention specialists, educators, child care providers, Family Resource and Youth Services Centers staff, juvenile justice staff, community-based services staff, public health staff, families, youth, and interested community members. The theme for 2019 is Supporting Social and Emotional Health Across the Lifespan: It Begins with Us. Additionally, DBHDID offers learning collaboratives in a variety of evidence-based practices through relationships with universities, training consortia, and experts in the field. Block grant, state general, and discretionary grant funding is utilized to support this work. Finally, the DBHDID partners with other child-serving agencies to offer training related to topics such as Trauma-informed Care; Implicit Bias; System of Care values and principles; the Child and Adolescent Needs and Strengths (CANS); Solution Based Casework; High Fidelity Wraparound; Nurturing Parenting; In-home Cognitive Behavior Therapy, the Structured Interview for Psychosis-risk Syndromes Assessor Training, and other topics related to specific programs, populations, or identified needs such as First Episode Psychosis programming. Twenty-one (21) is the age at which services from the child/adolescent system have traditionally ended. Currently much work being done to address the population of transition aged youth, including those aging out of foster care/child welfare system.

In October 2014, Kentucky was awarded a SAMHSA Healthy Transitions Grant. This grant, Transition Age Youth Launching Realized Dreams (TAYLRD), supported the implementation of a transition-age, youth-guided, specialized array and continuum of behavioral health care. The purpose of TAYLRD is to improve outreach, engagement, and access to treatment and support services for youth and young adults between 16 and 25 years old that either have, or are at risk of developing serious behavioral health (mental health and/or substance abuse) conditions. The focus was on building an array that interests young people, such as peer support, employment and education supports and career planning, life skills supports, medication supports, support in health care navigation, and age-specific and developmentally-appropriate behavioral health services in an environment that is engaging to youth and young adults. It is also integral to provide these services and supports in an environment that is engaging to youth and young adults. Kentucky modeled this project after the nationally recognized Youth M.O.V.E. Oregon Program and their youth-guided Drop-In Centers. There are now twenty (20) drop-in center locations across the state that are connected to the community mental health centers. In March 2019, Kentucky was again awarded a SAMHSA Healthy Transitions Grant. Building on the success of the 2014 Healthy Transitions Grant entitled TAYLRD; TAYLRD 2.0 will be an expansion of the drop-in center model of behavioral health care. The goals for this grant are: 1) Youth and young adults will be able to access behavioral health care more easily and in a more timely fashion; 2) Improvement in behavioral health service options available to youth and young adults based on their interests and clinical needs; 3) Increase in the coordination of a youth behavioral health leadership network; 4) Improvement in the public's awareness of behavioral health issues and supports for youth and young adults; 5) Improvement in coordination of services and supports for youth and young adults; and 6) Increase in behavioral health providers' expertise in working effectively with youth and young adults.

With the success of TAYLRD, more areas of the state have begun focusing on specialized care for transition age youth. All fourteen (14) community mental health centers (CMHCs) now have Transition Age Youth Leads in their agency. These staff provide networking and technical assistance regarding transition age youth issues. Several of the CMHCs are now focusing efforts on enhancing easy access to behavioral health care for this population, including the development of specialized drop-in centers. There is now 644 staff across all CMHC regions (an average of 46 staff per region) who work with both youth under 18 years old and young adults over 18 years old at the same time. All regions also have both a child lead and an adult lead for first episode psychosis programming, and eight (8) regions are providing Coordinated Specialty Care in their region through the iHOPE Program (see additional information under Environmental Factors and Plan - #4).

In addition to the DBHDID-led activities via TAYLRD, Kentucky's child welfare agency, the Department for Community Based Services (DCBS), will be an early implementer of the Family First Prevention Services Act (FFPSA). Signed into law in 2018, the FFPSA implements widespread child welfare reform that specifically focuses on safely keeping families together to prevent children from entering the foster care system, and encouraging kinship or family foster home placements when they do have to be removed from their parents. Kentucky intends to be an early implementer of the law. The FFPSA does not provide any new funding, but it dramatically shifts how states' child welfare programs can use federal dollars. It expands the use of funds designated for child welfare programming, sometimes referred to as Title IV-E funding, for quality, evidence-based preventive services for children, parents and/or kin/relative caregivers that could prevent a child's entry into out-of-home care. Under the FFPSA, prevention services could include in-home, skill-based parenting programs, substance use treatment and prevention provided by a clinician, and mental health treatment provided by a clinician. The implementation of FFPSA is also a part of the state's Child Welfare Transformation, with goals to safely reduce the number of children entering out-of-home care, improve timeliness for children to have appropriate permanency, and reduce caseloads for frontline staff.

The FFPSA made several changes to services available to transition age foster youth and youth who aged out of foster care including:

- Revised the John H. Chafee Foster Care Program for Successful Transition to Adulthood (the Chafee program) to specify that it is available to youth who have experienced foster care at age 14 or older.
- Permits states to provide the Chafee program up to age 23. Kentucky has elected not to offer extended foster care beyond 21 at

this time. However, it did extend Chafee services to youth who are aging out of care, up to 23 years old.

- Revised the limitation on use of funds for room and board by extending eligibility to youth who have aged out of care to 23 years old.
- Revised the eligibility for education and training vouchers (ETV) to youth who have aged out of foster care to 26 years old for a maximum of 5 years.
- Requires states to provide official documentation to youth aging out of care that they were in foster care.

Fostering Success is another program that started during the summer of 2016. Fostering Success is a 10-week summer employment program for current and former foster youth (18 to 23 years old). The program provides a paid internship in either a local DCBS office or local business. The program matches participants with Job Coaches who will assist them with professional development and career planning support. High performing participants will have the opportunity to remain in the program for 9 months.

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

N/A

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**Footnotes:**

## Environmental Factors and Plan

### 19. Suicide Prevention - Required for MHBG

#### Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

#### Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years?  Yes  No

2. Describe activities intended to reduce incidents of suicide in your state.

The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (KDBHDID) employs one FTE as the State Suicide Prevention Coordinator, housed in the Behavioral Health Prevention and Promotion Branch, within the Division of Behavioral Health. Additionally, the KDBHDID works through its Community Mental Health Centers (CMHC)/Regional Prevention Centers to deliver clinical care and community prevention efforts across the fourteen (14) CMHC regions in the state. The KDBHDID provides focused and intentional training and technical assistance to staff of these centers in order to ensure the broadest reach of suicidal care to the residents of Kentucky.

During SFYs 2018 and 2019, the regional prevention centers conducted needs assessments for communities within their catchment area to determine regional priorities to implement suicide prevention programming and substance abuse. As of June 2019, about half of the state's Regional Prevention Centers have identified Suicide Prevention as one of their top three priorities. Identified Intervening Variables include social and community norms, access and availability of means, low capacity for addressing needs, and perception of risk and harm. Identified Contributing Factors include bullying, stigma, ineffective school policies, stigma around help-seeking, high access to lethal means, need for increased capacity, low perception of risk of youth suicide, home access to lethal means, and peers who have died by suicide.

Garrett Lee Smith Memorial Act Suicide Prevention Funding (GLSMASP)

Kentucky's third implementation of the SAMHSA-funded Suicide Prevention Grant ends in September 2019. Kentucky applied for but did not receive a 2019 GLS grant. The state will conduct capacity building activities during SFY 2020 in order to be ready to apply if/when an RFP is released in the spring of 2020.

Current objectives identified by a statewide needs assessment include:

- Increasing protective factors for all youth in the state;
- Identifying, referring, treating and following up with at-risk youth, including those discharged from emergency departments after an attempt or from inpatient facilities after a crisis; and
- Addressing identified needs of youth from the target populations identified through Kentucky surveillance systems, but including all youth ages 10-24 for participation.

Proposed activities to meet these objectives include:

1. Increase the identification of at-risk youth and reduce the impact of suicidal behavior on individuals and families by
  - a. Expanding the number of individuals trained by certified trainers in EBPs to identify at-risk youth;
  - b. Expanding the number of child-serving individuals trained by certified trainers or subject-matter experts to identify at-risk youth;
  - c. Expanding the number of youths identified as at-risk for suicidal behavior through screening processes in child-serving agencies;
  - d. Expanding the number of at-risk youths receiving early intervention services by licensed or certified providers;
  - e. Expanding the number of at-risk youths receiving referrals for treatment services from child-serving agencies;
  - f. Expanding the number of family members of at-risk youth who receive resources and support;
  - g. Expanding the number of state-generated Lifeline calls and texts answered in-state;
  - h. Expanding the number of state-generated Lifeline calls and texts from at-risk residents answered in-state;
  - i. Expanding the number of clinicians and youth-serving providers trained by certified trainers or subject matter experts in military culture to increase awareness of impacts of military service; and
  - j. Expanding the number of individuals receiving Postvention services through child-serving agencies.

2. Increase the number of health care providers trained to screen, assess, manage, and treat at-risk youth for suicide by
  - a. Expanding the number of primary care providers trained by certified trainers or subject matter experts to screen and refer at-risk youth to behavioral health care;

- b. Expanding the number of clinicians trained by certified trainers in evidence-based treatment modalities (AMSR, CAMS);
  - c. Providing training by certified in evidence-based treatment modalities in substance use disorder settings to increase identifications of those with SUDs and suicide risk;
  - d. Providing evidence-based care modalities by certified trainers to increase identification and suicide safe care by non-clinical providers; and
  - e. Expanding the number of behavioral health care providers adopting a suicide-safe care (Zero Suicide Framework) model.
3. Increase the number of educational systems implementing policies and procedures related to suicide safe schools and training staff in identifying youth at risk for suicide by
- a. Expanding the number of schools who complete an assessment of policies and procedures related to suicide safe schools;
  - b. Expanding the number of schools who complete a work plan to address any gaps found in the assessment of policies and procedures related to suicide schools;
  - c. Expanding the number of school staff who complete and evidence-based training (Kognito) to increase capacity to identify at-risk youth;
  - d. Expanding the number of school staff who are provided training in district-level policies and procedures for identifying, referring and following up with at-risk youth; and
  - e. Expanding the number of school staff receiving training by certified trainers or subject matter experts in trauma-informed practices.
4. Increase the number of schools that provide evidence-based or evidence-informed suicide prevention materials/curriculum by
- a. Expanding the number of schools implementing evidence-based curriculum; and
  - b. Expanding the number of youth receiving evidence-based suicide prevention programming through juvenile justice, foster care, child welfare and other child-serving agencies.
5. Increase data surveillance to inform the delivery of prevention, intervention, treatment and Postvention services by
- a. Increasing the number of coroners and their staff trained by subject matter experts to accurately report suicide deaths to improve data collection;
  - b. Aggregating self-harm and suicide-related data collection at the local, regional and state level;
  - c. Increasing the number of data collection resources; and
  - d. Supporting the development of a real-time data dashboard to identify hot spots and clusters.

In the event that we are not successful in securing funding in the next round of GLSMASP grants, we intend to implement what components we can through other funding sources.

- 3. Have you incorporated any strategies supportive of Zero Suicide?  Yes  No
- 4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments?  Yes  No
- 5. Have you begun any targeted or statewide initiatives since the FFY 2018-FFY 2019 plan was submitted?  Yes  No

If so, please describe the population targeted.

#### Zero Suicide Initiative

Each of the 14 Community Mental Health Centers continue to receive Technical Assistance as they move forward with implementation of the ZSI, or prepare to implement ZSI.

#### Coalitions, Collaborations and Partnerships

KDBHDID works collaboratively and in partnership with many different agencies and organizations in regards to suicide prevention activities. Some of those collaborations include: Kentucky Department for Public Health; Kentucky Department of Education; Kentucky Department for Community Based Services; Kentucky Department for Veterans Affairs; Kentucky Partnership for Families and Children; Louisville Health Advisory Board; Kentucky Suicide Prevention Workgroup; Suicide Prevention Consortium of Kentucky; Owensboro Suicide Prevention Group; REACH of Louisville; Kentucky Safety and Prevention Alignment Network; Kentucky Prevention Network; Kentucky Injury Prevention and Research Center; Kentucky YMCA; Kentucky Boys and Girls Clubs; University of Louisville; Eastern Kentucky University; University of Kentucky; Kentucky Faith Based Coalition; and others. The goal of these collaborative efforts is to empower professionals across the state to embed suicide prevention activities into their deliverables as appropriate to their mission and vision.

KDBHDID increased statewide capacity during SFY 2018/2019 by hiring a collaboration specialist at each of the 14 Community Mental Health Centers/Regional Prevention Centers. Collaboration specialists are tasked with increasing the connection of community partners with not only substance use but also suicide prevention and mental health promotion efforts.

#### Improved Surveillance

A key focus has also been on increasing surveillance measures to develop a better understanding of the environmental risk factors that are woven into the thread of Kentucky's culture, offering prevention opportunities. In 2017, a Kentucky Suicide Data and Surveillance Committee was formed to investigate suicide trends, specifically related to a large increase in youth suicide deaths was seen in a one-year period. This interdisciplinary group of data scientists and suicide prevention experts include representatives from the Department of Behavioral Health, Developmental and Intellectual Disabilities, the Department for Public Health, the Department of Vital Statistics, the Department of Education, the Child Fatality Review Team, the University of Kentucky's Injury Prevention and Research Center, the Kentucky Violent Death Reporting System, and the Kentucky Poison Control

Center of Norton Children's Hospital. This team examined multiple sources of morbidity and mortality data by demographic and geographic characteristics over time. After this initial investigation, this group has continued to meet annually and on an ad hoc basis when needed to address particular concerns. The formation of this group has greatly improved communication across these agencies and allowed for improvements in surveillance efforts of the state. These improved surveillance efforts help to inform Kentucky's suicide prevention efforts, in identifying vulnerable populations, high-risk geographic areas or "hot spots", and improving data available to evaluate suicide prevention efforts.

In addition to the administrative data collected through the partner agencies in the Surveillance Committee, KDBHDID relies upon data from the Kentucky Incentives for Prevention (KIP) Survey of over 128,000 middle and high school students across the state for prevalence of suicide ideation and behaviors among youth, as well as numerous suicide risk factors. Because of the large size and broad scope of the survey, KDBHDID has the ability to access prevalence data and conduct detailed analyses at a small geographic level.

Finally, the Child Fatality Review Team now has a direct communication channel with the Department of Behavioral Health's suicide prevention staff so that the Department is notified of suicide deaths within days after the death so that suicide postvention and prevention outreach can occur in the communities affected.

We continue to work with the Kentucky Violent Death Reporting System; Child Death Review; Kentucky Incentives for Prevention (KIP), Kentucky's statewide youth risk behavior survey; the CDC Youth Risk Behavior Survey; Vital Statistics, and Treatment Episode Data Set, Medicaid, and other data sources to accurately assess and identify the need for suicide prevention efforts in the state.

#### Training and Technical Assistance to Schools

In addition to supporting implementation of the Sources of Strength, Lifelines, and Too Good for Drugs programs, the Kentucky Division of Behavioral Health, through the regional prevention centers, is providing one-on-one technical assistance to schools as they meet state laws around suicide prevention education for district-wide school staff and suicide prevention information for middle and high school students.

#### School Curricula Implementation

In addition to the implementation of Sources of Strength in Kentucky's schools, KDBHDID provides support for the implementation of evidence-based curriculums, such as Lifelines and Too Good for Drugs in Kentucky's schools. These curricula help meet the state mandate that requires all middle and high school students receive some type of suicide prevention information by Sept. 15 of each school year.

#### National Suicide Prevention Lifeline

Eight (8) of Kentucky's Community Mental Health Centers are currently Lifeline certified: Four Rivers, Pennyroyal, RiverValley, LifeSkills, Centerstone, Mountain, Adanta and Cumberland River.

One (1) is in the clinical review process: Pathways.

The FY20 contracts between KDBHDID and the 14 CMHCs require non-certified centers to participate in a needs assessment process to determine the barriers that are prohibiting certification and work with the department to ensure that calls to the NSPL from their region are answered in state.

One of the Lifeline certified centers, Pennyroyal, is equipped to answer texts sent to the NSPL.

The state is applying for a capacity building grade from the National Suicide Prevention Lifeline in order to increase the percentage of calls that are answered in state, and to sustain that answer rate beyond the life of the grant.

#### Military-connected

Service members, veterans, and their families are at higher risk for suicide across numerous data sources and studies. In Kentucky, one unique identified population identified is youth with military connections. Through self-report, these youth identify (Kentucky Incentives for Prevention Survey) as being at a higher risk of substance use, serious psychological distress, and suicidal thoughts and behaviors. Because of this elevated risk, Kentucky's prevention network has been working with military partners and in areas with high populations of military youth to better reach these youth.

#### Opioids/Heroin/NMUPD

Substance abuse, particularly the diversion and abuse of prescription drugs along with heroin and illicit fentanyl, remains one of the most critical public health and safety issues facing Kentucky. Over the past decade, the number of Kentuckians who die from drug overdoses has steadily climbed to more than 1,500 (2017 overdose deaths) each year, exacting a devastating toll on families, communities, social services and economic stability and growth. The largest number of deaths related to opioids and heroin in Kentucky were among those ages 35-44, followed by those aged 45-54. Seventy-six youth under the age of 25 died by overdose.

According to 2017 findings in the Overdose Fatality Report released by the KY Office of Drug Control Policy (ODCP), fentanyl, either in combination with heroin or alone, was involved in 52% of overdose deaths, up from 47% in 2016. Heroin was present in 22% of all cases in which autopsy and toxicology reports were available to the Kentucky Medical Examiner's Office. The top five counties for heroin-related overdose deaths were Jefferson, Fayette, Kenton, Campbell and Boone, representing the three largest urban areas in the state. These five also represented the top five counties for fentanyl-related deaths. The top five counties for overdose deaths per capita were Estill, Kenton, Campbell, Boyd and Mason, all of which – except Kenton and Campbell – are considered rural.

The prescription-drug monitoring program in Kentucky is referred to as the Kentucky All Schedule Prescription Electronic Reporting (KASPER) system. In 2016, the total number of opioid and benzodiazepine prescriptions dispensed in Kentucky was 4,495,050 opioid prescriptions (101 prescriptions/100 persons), according to the 2017 needs assessment compiled for implementation of the Kentucky Opioid Response Effort. The highest numbers of opioids were dispensed in Jefferson, Fayette and Kenton counties, which corresponds with the highest number of overdose deaths in the state. The counties with the highest opioid dispensing rates were Owsley, Whitley and Bell, all in the Eastern portion of the state. The Kentucky opioid overdose

emergency department visit rate was 6,499 visits in year 2016. Individuals aged 25-34 comprised the largest percentage of individuals treated for opioid overdoses in Kentucky emergency departments (EDs) (38%), followed by those aged 35-44 (20%), and those under the age of 25 (19%). TEDS data shows a 34% of admissions were for opiates. --

Kentucky Incentives for Prevention (KIP) results show that 2% of 10th graders report that they first used a prescription drug (such as OxyContin, Percocet, Vicodin, etc.) without a doctor's prescription before the age of 12. This rate has been steady for 10th and 12th graders since 2012 when the question was added to the KIP survey, but has increased significantly for 6th and 8th graders in that time frame, rising from 2% to 2.6% for 8th graders (30% increase) and from 1.3% to 1.7% for 6th graders (31% increase). Past year prescription drug use, as reported on the KIP has shown a steady decrease since 2004, dropping 56.6% among 10th graders, 62.5% among 12th graders, 41.5% among 8th graders and 33.3% among 6th graders since 2010. Thirty-day use of prescription drugs has similarly declined in that time frame, falling 59.6% among 10th graders, 68% among 12th graders, 40% among 6th graders and 20% among 8th graders. These declines speak to the significant prevention efforts that have been in place across the state over this time frame and serve as effectiveness indicators of strategies implemented to address the non-medical use of prescription drugs in that time frame. However, past-year and 30-day prescription opioid use, specifically, OxyContin, Percocet, Vicodin and Codeine) has increased in the same timeframe (see table for specifics). Additionally, 5.4% of 10th and 12th graders reported in 2018 they had taken any prescription drug as measured on at least one of the four prescription drug questions on the survey (answered "yes" to any four separate prescription drug questions).

Percentage of Change in Painkiller Usage 2004-2018

Percentage of change in

Past Year Painkiller Usage 2010-2018 Percentage of change in 30 Day Painkiller Usage

2010-2018

6th 700% 300%

8th 284% 237.5%

10th 52.7% 75%

12th 29.2% 37.5%

Personal disapproval of prescription drug use without a doctor's prescription was high across the grades, with 96.5% of 6th graders and 91.9% of 12th graders reporting they felt it was "wrong" or "very wrong" to use prescription drugs without a doctor's orders. This rate has remained steady since 2012 when the question was added to the KIP survey. Perception of parental disapproval of prescription drug use without a doctor's prescription is similarly high with percentages ranging from from 96.7% of 12th graders reporting they thought their parents felt it was "wrong" or "very wrong" for them to use use prescription drugs without a doctor's prescription to 98% 98% of 6th graders. Perception of peer disapproval was, lower however, with just 81% of 12th graders and 82.1% of 10th of 10th graders reporting they felt their friends would think it "wrong" or "very wrong" to use prescription drugs without a doctor's order. These rates, however, have remained consistent across the period, 2012-2016. The perception of peer use, however has decreased significantly since 2012, especially among 10th and 12th graders. The percentage of 10th graders reporting that they had at least one of their four best friends taking a prescription drug without specific direction from a doctor fell 43.9% between 2012 and 2016 and the percentage of 12th graders answering the same way dropped 50.8%. Risk perception increased among younger students but decreased among older students in the 2012-2016 timeframe. Sixth-graders reporting they felt that using a prescription drug without a doctor's orders was a "moderate" or "great risk" climbed 7.5% while the percentage of 8th graders answering similarly increased 0.37%. Conversely, the percentage of 10th and 12th graders who reported moderate or great risk fell 4% and 5.3% respectively.

Students were first asked about their heroin usage in 2014 with 1% of 12th graders reporting they had used heroin in the past year. That percentage fell to 0.7% in 2018. Among 10th graders, 0.6% reported use in 2018, down from the 2014 percentage of 0.9. Thirty-day heroin usage is even lower with 0.6% of 12th graders, 0.5% of 10th graders, 0.3% of 8th and 0.2% of 6th graders reporting heroin use, representing just 328 students across the entire state of Kentucky. Risk perception regarding heroin use has remained relatively steady across the grade levels between 2014 and 2018, with between 74.6% (6th graders) and 82.6% (12th) reporting moderate or great risk in using heroin.

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

N/A

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

**Footnotes:**

## Environmental Factors and Plan

### 20. Support of State Partners - Required for MHBG

#### Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

#### Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period?  Yes  No
2. Has your state identified the need to develop new partnerships that you did not have in place?  Yes  No

If yes, with whom?

The KY Department of Corrections has reorganized and created a new Division to assist with individuals being released and they are interested in partnering with DBHDID to optimize "Re-Entry" services for individuals with behavioral health risk/concerns. DBHDID has participated in Re-entry Fairs and has met with the new reentry program staff to share information and develop programming.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

Adults with SMI

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 psychiatric hospital and other facilities to the community. Providing appropriate aftercare following a hospital stay or transition from a higher level of care is critical to reducing hospital readmission rates, enhancing community housing tenure and ultimately improving quality of life.

KDBHDID addresses continuity of care for adults with SMI through several avenues. Through contracts with the fourteen (14) Regional Boards, KDBHDID requires the regions 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, contract language 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. There are also a series of various meetings designed to assist with continuity of care planning.

- Continuity of Care committee meetings occur at least quarterly within each state operated/contracted psychiatric hospital, and include DBHDID staff, CMHC staff, other community partners, as well as hospital staff, in order to facilitate collaboration between the hospitals and the Regional Boards. Agendas include system wide issues such as admission and discharge processes, follow up processes for outpatient appointments and medication access, strategies to reduce readmission rates, and general communication issues.

- Olmstead committee meetings occur monthly within each state operated/contracted psychiatric hospital, and include DBHDID staff, CMHC staff, other community partners, as well as hospital staff, in order to facilitate collaboration and planning for transitioning to lower levels of care for individuals identified under the Olmstead Act. DBHDID provides funding to each state operated/contracted psychiatric hospital Catchment area. Olmstead funds are overseen by a Regional Board in each of the four (4) state psychiatric hospital Catchment areas. These flexible funds are designated for necessary goods and services for identified individuals that meet the Olmstead criteria:

- o Have resided in the hospital over 90 days;

- o Have had repeat admissions to the hospital over the course of one year and need flexible funding to remain in the community;

- o Treatment professionals determine that community placement is appropriate;

- o Community treatment is chosen via fully informed awareness; and

- o Placement can be reasonable accommodated.

- Regional Transition committee meetings occur within each state operated/contracted psychiatric hospital, and include DBHDID, CMHC staff, Kentucky Protection and Advocacy, Department for Aging and Independent Living, Department for Community Based Services, Kentucky Long Term Care Ombudsman, Managed Care Organizations, the Independent Reviewer of the Amended Settlement Agreement, and other community stakeholders for that Catchment area. The purpose for these meetings is to discuss and plan for transitioning individuals that fit the ASA criteria:

- o Adults with SMI who are transitioning from personal care homes or at risk of being readmitted to a personal care home.

- o Adults with SMI who have been admitted to the state psychiatric hospital and fit the above criteria.

DBHDID has worked with each of the state operated/contracted psychiatric hospitals and their assigned Regional Boards to assist with the development of a Memorandum of Agreement (MOA) between the two entities. In order to assure a seamless system of care, the need 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, additional behavioral health crisis services, such as mobile crisis, continued development of other community support services as effective alternatives to inpatient services for adults with serious mental illness, as well as opportunities for community partners to discuss pertinent strategies for creating "warm hand-offs".

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, peer support, and comprehensive community supports. 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. 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, peer support, and assertive community treatment;

- 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.

#### Children with SED

The State Interagency Council for Services and Supports to Children and Transition-age Youth (SIAC) is a group consisting of state agency representatives, a youth, a parent of a child or transition-age youth with a behavioral health need, and a member of a nonprofit family organization.

SIAC oversees coordinated policy development, comprehensive planning, and collaborative budgeting for services and supports to children and transition-age youth with or at risk of developing behavioral health needs and their families. SIAC strives to design and implement a system of care that is youth- and family-driven, community-based, culturally- and linguistically-responsive, trauma-informed, and recovery-oriented. SIAC conducts monthly meetings that are open to the public.

Regional Interagency Councils (RIACs) operate as the locus of accountability for the system of care, providing a structure for coordination, planning and collaboration of services and supports at the local level to children, adolescents, and transition-age youth and their families, to help them function better at home, in school, in the community and throughout life.

There are 18 RIACs across the commonwealth. Each council is composed of members representing the following: Regional Community Mental Health Centers; Administrative Office of the Courts; Department for Community Based Services; Division of Family Resource and Youth Services Centers (FRYSC); Office of Vocational Rehabilitation; Kentucky Education Cooperatives/Special Education Services; Department for Juvenile Justice; local health departments; a parent of a child with a behavioral health need who is or has been a consumer of system of care services and supports; and one transition-age youth who has a behavioral health disorder who is receiving or has received a service to address mental health, substance use, or co-occurring mental health and substance use disorder. Collaboration is encouraged with any other local public or private agency that provides services and supports to children and transition-age youth with behavioral health needs.

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

N/A

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**Footnotes:**

## Environmental Factors and Plan

### 21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

#### Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created [Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration](#).<sup>69</sup>

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

<sup>69</sup><https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf>

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

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.
  - a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

The KY Behavioral Health Planning and Advisory Council is charged with advising the Department on mental health and substance use prevention and treatment services. The Planning Council's membership provides rich information about prevention, treatment and recovery supports needed for individuals in recovery, their parents and family members. The Council and its committees meet approximately eight (8) times per year. All information about the Council and all of the meeting summaries can be accessed on line at <http://dbhdid.ky.gov/dbh/kbhpac.aspx>.

The Department has been sponsoring an annual Kentucky School of Alcohol and Other Drug Studies for forty-six years. Individuals who work in the fields of behavioral health prevention, treatment and recovery, corrections, juvenile justice, homeless services, child welfare, behavioral health, Medicaid, court services, and others attend KY School. Many individuals in recovery and their family members attend and participate in the planning of this conference. During this conference, staff receives vital feedback on the system of care, particularly related to service gaps and workforce needs. Evening film reviews with facilitated discussions provide opportunity for discussion. This year's conference, held July 21-25 was attended by over 1,300 individuals, over the week.. Planning Council members are provided scholarship to attend (registration and lodging).

Department staff also solicits input from the regional substance use prevention and treatment directors at quarterly peer group meetings. Directors and department staff collaboratively create the agendas for meetings.

Diversity is important to the Kentucky Behavioral Health Planning and Advisory Council. When choosing new members, the Membership Committee pays particular attention to the ways each applicant will increase the diversity of voices and experiences on the Council. The Council's membership application includes the following diversity statement:

The Kentucky Behavioral Health Planning and Advisory Council has an ongoing commitment to advancing diversity within its membership. We acknowledge that diversity includes any aspect of an individual that makes him or her unique. Our Council values and actively promotes diverse and inclusive participation by its officers, members, and staff. We recognize that diversity is vital to all elements of our mission. At your option, you may state how you would contribute to the diversity of the Council.

For the Membership Committee's review of applications for 2019, 100% of applicants chose to answer this question. Committee members report that this is extremely valuable as they consider membership. The diversity responses are usually the most influential to Committee members because members learn where an applicant can fill a gap and provide a voice on the Council. The following are types of diversity reported by applicants reviewed by the Council in 2019:

- "I am an adoptive parent."

- "I add to diversity in that I am a woman who has struggled with a mental health disability. One day I wish to no longer to be considered disabled."
- "I am an African-American woman and I have a strong voice in my community."
- "Being a mother who has dealt with addiction for so long, and that has educated myself in every way I can find, makes me valuable because I can understand how others feel."
- "My diversity might be one of age, since I am retired, and my life's experience with depression and recovery."
- "I am a single mother who has raised 1 child and is working on my last two teenagers."
- "I'm a recovering addict myself and have had services."
- "I am a recovering heroin addict who has literally lost everything and had to rebuild her life. Today I help others. I've gained my life back and so much more."

One tool that the Membership Committee uses to ensure geographic diversity is a state map with the county of residence of current members indicated. The Committee gives greater consideration to applicants who would represent an area of the state that is not currently represented or is underrepresented. The Council experiences difficulty in recruiting parents of children with behavioral health challenges, young adults in recovery, and individuals from the western portion of the state. Parents and young adults report the following barriers: education/employment responsibilities, child caring responsibilities, transportation and financial barriers. Barriers for recruiting individuals from western Kentucky include distance and a different time zone.

Planning Council members also identified the following underrepresented populations to focus recruitment: Hispanics, LGBTQ, and African-Americans. Members volunteered to outreach to specific organizations to increase awareness of the Council and recruit potential members. The Council shares its brochure at annual conferences to increase awareness of the Council and to recruit applicants from underrepresented populations. The Council's Member Orientation includes cultural awareness as a topic. The Member Orientation is led by members and is presented annually.

The Planning Council is comprised of the following individuals who bring their diverse experiences and the input of those they represent to the Council:

- Six 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;
- Two young adults 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.

**b)** Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?  Yes  No

**2.** Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?  Yes  No

**3.** Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The following is an excerpt from the Bylaws of the Council duties:

- Report directly to the Commissioner of the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (BHDID).
- Assist BHDID in designing a comprehensive, recovery-oriented system of care.
- Advise BHDID on the use of Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funds and Mental Health Block Grant (MHBG) funds and on the quality of statewide, recovery-oriented behavioral health services.
- Review the biennial combined SAPTBG and MHBG Application and annual Implementation Report pursuant to Public Law 102-321, Section 1915 (a) and to submit recommendations to BHDID, prior to the September 1 and December 1 due dates, respectively.
- Advocate for individuals in recovery, children and youth with behavioral health challenges, and family members.
- Monitor, review, and evaluate, not less than once a year, the allocation and quality of statewide, recovery-oriented behavioral health services.

Council members lead and serve as members to the following committees: Membership, Finance and Data, Bylaws, and Policy and Advocacy.

Each of the Planning Council's statewide behavioral health advocacy organizations are connected with thousands of members and contacts. They are a valuable resource for sharing information across the state via email and newsletter.

The Membership Committee finalized a Member Handbook during 2017. The Member Handbook serves as another resource to orient new members, especially those who are unable to attend the annual Member Orientation or who join the Council after the Orientation has been held. The resource is available on the Planning Council's website.

The Department for Behavioral Health, Developmental and Intellectual Disabilities regularly offers scholarships (conference registration plus lodging) to members of the Planning Council to various conferences and training events. Scholarships have been awarded to all who have requested them. This includes representatives of individuals in recovery, young adults in recovery,

parents of children with behavioral health challenges, family members and state agencies.

All information about the Council and all of the meeting summaries can be accessed on line at

<http://dbhdid.ky.gov/dbh/kbhpac.aspx>. The brochure and membership handbook detail all of the duties and responsibilities of the Council.

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

N/A

*Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.<sup>70</sup>*

<sup>70</sup>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.

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

**Footnotes:**

# Kentucky Behavioral Health Planning & Advisory Council

Gayla Lockhart, Chair      Maggie Krueger, Vice Chair      Robin Osborne, Secretary  
275 East Main Street, 4W-G, Frankfort, Kentucky 40601

August 15, 2019

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 and Advisory Council to confirm that Council members have reviewed Kentucky's drafted FY 2020-21 SAPT and CMHS Block Grant Behavioral Health Assessment and Plan. Time was allocated at today's Council meeting to discuss the state plan and the tables required for this submission by the September 1<sup>st</sup> due date. The Department for Behavioral Health, Developmental and Intellectual Disabilities welcomes recommendations and comments prior to and after submission of the Plan.

Our Council has met quarterly over the past year. The committees have met to carry out their work and members have been diligent as we continue to build a solid Council that guides the development of Kentucky's behavioral healthcare.

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,



Gayla Lockhart  
Chair, Kentucky Behavioral Health Planning and Advisory Council

Cc: Michele Blevins, Assistant Director, Division of Behavioral Health

## Environmental Factors and Plan

### Advisory Council Members

For the Mental Health Block Grant, there are specific agency representation requirements for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency  
 State Vocational Rehabilitation Agency  
 State Criminal Justice Agency  
 State Housing Agency  
 State Social Services Agency  
 State Health (MH) Agency.

Start Year: 2020 End Year: 2021

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Susan Abbott	State Employees		Kentucky Protection and Advocacy Frankfort KY, 40601 PH: 502-564-2967	susan.abbott@ky.gov
Mike Barry	Persons in recovery from or providing treatment for or advocating for SUD services		People Advocating Recovery Louisville KY, 40206 PH: 502-552-8573	mike@peopleadvocatingrecovery.org
Urika Berry	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Lexington KY, 40511 PH: 859-494-3576	urikaberry@gmail.com
Becky Clark	Family Members of Individuals in Recovery (to include family members of adults with SMI)		Ewing KY, 41039 PH: 606-267-4101	simplifylife321@gmail.com
Cookie Crews	State Employees		State Criminal Justice Agency LaGrange KY, 40032 PH: 502-225-6513	cookie.crews@ky.gov
Melony Cunningham	Others (Advocates who are not State employees or providers)		NAMI Kentucky Somerset KY, 42501 PH: 606-677-4066	namikyed@gmail.com
Sharon Darnell	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Ewing KY, 41039 PH: 606-584-2716	sharon@namibuffalotrace.org
Sherri Estes	Providers		Regional Prevention Center Director Somerset KY, 42501 PH: 606-679-9425	sestes1@adanta.org
Kelly Gunning	Others (Advocates who are not State employees or providers)		NAMI Lexington Lexington KY, 40504 PH: 859-309-2856	kelly@namilex.org
David Gutierrez	State Employees		State Social Services and Child Welfare Agency Frankfort KY, 40601 PH: 502-564-9433	david.gutierrez@ky.gov

Stephanie Hager	Parents of children with SED/SUD		2011 Meadows Edge Lane Louisville KY, 40245 PH: 502-262-4325	hanson4517@gmail.com
Lynn Haney	Family Members of Individuals in Recovery (to include family members of adults with SMI)		PO Box 54 Florence KY, 41022 PH: 859-240-5603	haneyl@fuse.net
Bill Heffron	State Employees		Department for Juvenile Justice Frankfort KY, 40601 PH: 502-573-2738	billm.heffron@ky.gov
Maggie Krueger	Parents of children with SED/SUD		Columbia KY, 42728 PH: 270-250-9923	maggiemc.krueger@windstream.net
Gayla Lockhart	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Bowling Green KY, 42101 PH: 270-586-3367	gayla@kypartnership.org
Steve Lyons	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Shelbyville KY, 40065 PH: 502-321-1951	lyonssadsack@aol.com
Valerie Mudd	Family Members of Individuals in Recovery (to include family members of adults with SMI)		Lexington KY, 40504 PH: 859-230-3978	val@namilex.org
Ron O'Hair	State Employees		State Vocational Rehabilitation Agency Morehead KY, 40351 PH: 606-783-8615	ronniel.o'hair@ky.gov
Robin Osborne	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Covington KY, 41015 PH: 513-972-7221	redbird_12001@yahoo.com
Carmilla Ratliff	Others (Advocates who are not State employees or providers)		Kentucky Partnership for Families and Children Frankfort KY, 40601 PH: 502-875-1320	carmilla@kypartnership.org
Jeanette Rheeder	State Employees		State Housing Agency Frankfort KY, 40601 PH: 502-564-7630	jrheeder@kyhousing.org
Peggy Roark	Family Members of Individuals in Recovery (to include family members of adults with SMI)		Nicholasville KY, 40356 PH: 859-396-1561	peggyroark8@gmail.com
Sherry Sexton	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Lexington KY, 40517 PH: 606-336-4106	sherry.l.sexton606@gmail.com
Steve Shannon	Providers		Kentucky Association of Regional Programs Lexington KY, 40515 PH: 859-272-6700	sshannon.karp@iglou.com

Koleen Slusher	State Employees		State Mental Health Agency Frankfort KY, 40601 PH: 502-564-4456	koleen.slusher@ky.gov
Matthew Smith	Family Members of Individuals in Recovery (to include family members of adults with SMI)		Lexington KY, 40511 PH: 859-388-0559	msmith@campbellandsmithlaw.com
Angela Sparrow	State Employees		State Medicaid Agency Frankfort KY, 40601 PH: 502-564-6890	angela.sparrow@ky.gov
Kathryn Tillett	State Employees		State Education Agency Frankfort KY, 40601 PH: 502-564-4970	kathryn.tillett@education.ky.gov
Tonia Wells	State Employees		State Agency on Aging Frankfort KY, 40601 PH: 502-330-6861	toniaa.wells@ky.gov
Connie White	State Employees		State Health Agency Frankfort KY, 40601 PH: 502-564-3970	connie.white@ky.gov

\*Council members should be listed only once by type of membership and Agency/organization represented.

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**Footnotes:**

# Environmental Factors and Plan

## Advisory Council Composition by Member Type

Start Year: 2020 End Year: 2021

Type of Membership	Number	Percentage of Total Membership
<b>Total Membership</b>	<b>37</b>	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	6	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	5	
Parents of children with SED/SUD*	2	
Vacancies (Individuals and Family Members)	7	
Others (Advocates who are not State employees or providers)	3	
Persons in recovery from or providing treatment for or advocating for SUD services	1	
Representatives from Federally Recognized Tribes	0	
<b>Total Individuals in Recovery, Family Members &amp; Others</b>	<b>24</b>	<b>64.86%</b>
State Employees	11	
Providers	2	
Vacancies	0	
<b>Total State Employees &amp; Providers</b>	<b>13</b>	<b>35.14%</b>
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	2	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	2	
<b>Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations</b>	<b>4</b>	
Youth/adolescent representative (or member from an organization serving young people)	0	

\* States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

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**Footnotes:**

# Environmental Factors and Plan

## 22. Public Comment on the State Plan - Required

Narrative Question

[Title XIX, Subpart III, section 1941 of the PHS Act \(42 U.S.C. § 300x-51\)](#) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

### Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?
- a) Public meetings or hearings?  Yes  No
- b) Posting of the plan on the web for public comment?  Yes  No
- If yes, provide URL:  
<http://dbhdid.ky.gov/dbh/kbhpac-bg.aspx>
- c) Other (e.g. public service announcements, print media)  Yes  No

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#### Footnotes:

The Kentucky Behavioral Health Planning and Advisory Council (Planning Council or Council) reviews the annual Combined Behavioral Health Assessment and Plan during quarterly meetings in August and Behavioral Health Reports during November meetings. Department staff draft the plans and reports. Council members and the general public are encouraged to provide recommendations and feedback. Staff send a draft of the plan/report to individuals on the Planning Council listserv and place it as a "Hot Topic" on the Department's website home page. The website also contains a document that details opportunities to provide written and/or verbal feedback. An archive of draft, submitted and approved plans and reports is maintained on the Council's webpage. Council meetings provide one opportunity for individuals to provide verbal and/or written feedback. All Council members with a term (which includes Individuals in Recovery, Family Members, Parents and Young Adults in Recovery) are offered lodging, travel reimbursement, childcare reimbursement, and a stipend to support their attendance. During the August and November Council meetings, staff provide copies of the plan/report and a PowerPoint presentation of the drafted plan/report. Time is provided on the agenda for attendees to provide feedback and recommendations. Council members may provide verbal or written feedback. The Council creates a letter confirming the Council's participation and opportunity to review and provide feedback on the plan/report. At the Council meeting, staff encourage Council members and the public to continue to submit feedback/comments on any drafted, submitted or approved plan or report. Information is provided on how to submit comments via email, US Mail, or fax to the Block Grant State Planner (Michele Blevins). Comments and recommendations are reviewed and incorporated into the documents as applicable.

Kentucky has state law requirements (KRS 45.350 – KRS 45.359) for block grant applications. Per KRS 45.351, the Department provides a draft of the plan to the Legislative Research Commission (the administrative and research arm of the General Assembly) for review by the Interim Joint Committee on Health, Welfare, and Family Services. The public may go to the Committee's webpage for the meeting calendar, meeting materials and minutes. The calendar is also available via Twitter at @LRCTweetBot. Kentucky Educational Television (KET), the PBS affiliate, provides live legislative coverage of meetings via television and the KET Legislative App for iOS and Android.

Department for Behavioral Health, Developmental and Intellectual Disabilities  
275 East Main Street, 4W-G  
Frankfort, KY 40621

Mental Health and Substance Abuse Prevention and Treatment Block Grants  
Comments on Application for 2020/2021

(1) A Behavioral Health Planning and Advisory Council meeting was held on August 15, 2019, at the Transportation Building at 200 Mero Street, Frankfort, KY 40601, from 10:00am until 2:00pm Eastern Time. The Block Grant process and pending application were discussed at this meeting. Individuals were instructed to go to the Department website at [www.dbhdid.ky.gov](http://www.dbhdid.ky.gov) and review available written portions of the application and submit comments to [Michele.Blevins@ky.gov](mailto:Michele.Blevins@ky.gov), by August 28, 2019. Individuals were also welcomed to provide comments to Michele Blevins in writing at the above address, or to call her at 502-782-6150.

(2) DBHDID received the following comments;

1. Comment: Specific contract deliverables of statewide advocacy organizations should be Included.

Response: DBHDID staff added these as requested

2. Comment: Post updated drafts of block grant application to DBHDID website often

Response: DBHDID staff will make every effort to post updated application drafts to the DBHDID website.

3. Comment: New term for MAT (Medication-Assisted Treatment) is MOUD (Medication for Opioid Use Disorder).

Response: Term will be corrected as requested.

# Kentucky Behavioral Health Planning & Advisory Council

Gayla Lockhart, Chair    Maggie Krueger, Vice Chair    Robin Osborne, Secretary  
275 East Main Street, 4W-G, Frankfort, Kentucky 40601

August 15, 2019

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 and Advisory Council to confirm that Council members have reviewed Kentucky's drafted FY 2020-21 SAPT and CMHS Block Grant Behavioral Health Assessment and Plan. Time was allocated at today's Council meeting to discuss the state plan and the tables required for this submission by the September 1<sup>st</sup> due date. The Department for Behavioral Health, Developmental and Intellectual Disabilities welcomes recommendations and comments prior to and after submission of the Plan.

Our Council has met quarterly over the past year. The committees have met to carry out their work and members have been diligent as we continue to build a solid Council that guides the development of Kentucky's behavioral healthcare.

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,



Gayla Lockhart  
Chair, Kentucky Behavioral Health Planning and Advisory Council

Cc: Michele Blevins, Assistant Director, Division of Behavioral Health